POLITICAL ECONOMY OF HEALTH IN BANGLADESH

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CERTIFICATE

This is to certify that the dissertation entitled "POLITICAL ECONOMY OF HEALTH IN BANGLADESH" submitted by M. REDWANUR RAHMAN is in partial fulfillment for the award of the degree of MASTER OF PHILOSOPHY (M. Phil.) of this university, is his original work. This dissertation has not been submitted for any other degree of this or any other university. We recommend that this dissertation should be placed before the examiners for evaluation.

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TO THE MEMORY OF

MUJIBUL HAQUE
&
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ACRONYMS

ADB	Asian Development Bank
AL	Awami League
ARI	Acute Respiratory Infection
BADC	Bangladesh Agricultural Development Corporation
BBS	Bangladesh Bureau of Statistics
BIDS	Bangladesh Institute of Development Studies
BMDC	Bangladesh Medical and Dental Council
BMRC	Bangladesh Medical Research Council.
BNP	Bangladesh Nationalist Party.
BSMMU	Bangabundhu Sheikh Mujib Medical University
CDR	Crude Death Rate
CIDA	Canadian International Development Association
CMR	Child Mortality Rate
DFI	Development Finance Institution
DGHS	Director General of Health Service
DSE	Dhaka Stock Exchange
EPI	Expanded Programme on Immunization
FWA	Family Welfare Assistant
GDP	Gross Domestic Product
GOB	Government of Bangladesh
GTZ	Gesellschaft Foer Technische Zusammenarbeit (Germany)
HA	Health Assistant
HPSP	Health and Population Sector Program
HPSS	Health and Population Sector Strategy
ICB	Investment Corporation of Bangladesh
ICDDR'B	International Centre for Diarrhoeal Diseases and Research, Bangladesh

ICPD	International Conference on Population and Development.
ICRH	Institute for Cancer Research and Hospital
ICVD	Institute of Cardio-Vascular Disease.
IDCH	Institute of Disease of Chest and Hospital
IDH	Infectious Disease Hospital
IEDCR	Institution of Epidemiology and Disease Control Research
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPH	Institute of Public Health
IPHN	Institute of Public Health and Nutrition
JP	Jatiya Party
JSD	Jatiya Samajtantric Dal
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MOHFW	Ministry of Health and Family Welfare.
MP	Member Parliament
NEC	National Economic Council
NGO	Non-Government Organization
NIO	National Institute of Opthalmology
NIP	New Industrial Policy
NIPSOM	National Institute of Preventive and Social Medicine
ORT	Oral Re-hydration Therapy
PHC	Primary Health Care
RIHD	Institute of Rehabilitation and Hospitals for the Disabled
RIP	Revised Industrial Policy
SAP	Structural Adjustment Policy
SIDA	Swedish International Development Association

TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
THC	Thana Health Complex
TK	Taka
TT	Tetanus Toxoid
UHFWC	Union Health and Family Welfare Centre
UNICEF	United Nations International Children's Emergency Fund
USAID	United State Agency for International Development
USC	Union Sub-Centre
VHSS	Voluntary Health Service Society
VHV	Village Health Volunteer
VO	Voluntary Organization
WB	World Bank
WDR	World Development Report
WHO	World Health Organization

INTRODUCTION

The health of a nation refers to the physical and mental state of its population. In healthy nations, the mental and physical needs of its masses are adequately met. These needs usually include adequate nutrition, elimination of poverty, an environment, conducive to health and hygiene and infrastructural facilities like improved supply of portable water, well planned housing and fully trained medical personnel, committed to social cause are as important necessities (Agbonifo1983). The state of health of a nation is related to the developments in the socio-economic parameters of the health system. In other words, the improvement in the status of health is indicated by a declining trend in morbidity, mortality and fertility among the people. Better health naturally contributes to higher labour productivity, economic and social development in all aspects and well-being of all citizen in general.

Health is an important indicator of socio-economic and political conditions within a society. Health service system determines and tells us about the health status of the people. The socio-political and economic structures determine the nature of the health policies, plans and programs for dealing with the health problems and health practices of a community. It is generally observed that the linkage between health care and political economy and development plays an important role in the health delivery system. Health service systems are invariably dependent upon the political and economic developments of a country. A sustained political commitment to universal health and well-being a major factor, that can ensure the success in the health care system in countries with low per capita income. Here strong political

will can create good governance, which in turn, can create good health and health services systems (Bridsall1989). Benevolent government with efficient and effective administrative system and equitable allocation of resources with particular attention to the distressed and the vulnerable groups in the society, are preconditions for improving the health status of a society. The political forces are found to shape and reshape the health service system in accordance with their own priorities. All the decisions concerning resource allocation, manpower policy, choice of technology, the extent of accessibility and availability to the different sections of the society is largely determined and directed by the prevalent political forces. (Banerji1981:85). Economics, too, plays an important role in shaping the health service system. This is with regard to the allocation of resources among various health promoting activities, the quantity of resources used in health service delivery, the organization and funding of health service institutions. Effectiveness of these allocations and the effects of preventive, curative and rehabilitative health service on the individuals and the society need, also, to be taken into account, (Lee and Mills 1979). Therefore, it is observed that both politics and economics play the most vital roles in shaping the health services system by looking into the needs, demand, utilization, efficiency, effectiveness, expenditure, financing etc. In other words political economy is an important determinant for health situations in a society.

Approaches to Political Economy:

The definition and scope of political economy depends upon the theoretical understanding of particular phenomena. Different scholars perceive it differently. It is one of the more complex and contested concepts in social science

(Staniland1985;Caporaso and Levine1992). It consists of a variety of ideological and theoretical perspectives and paradigms. It cannot be defined in an equivocal way.

There are various forms of political economy, giving precedence to economic or political factors as primary determinants (Reich 1994: 414). There is plurality in the basic approaches to the analysis of political economy. Three approaches are prominent in the development of a widely accepted taxonomy of political economics viz: Liberal, Marxist and economic realist. Liberal political economy emphasizes upon "methodological individualism"[1], while Marxist political economy can be noted as an extreme form of intellectual and analytical collectivism. Economic realism lays stress upon the historical and institutional framework within which economic development takes places (Barry Jones 1988:4-9). Each approach has its own dimension of understanding. Every thing follows the historical sequence in which it develops.

However, political economy's major guiding principle is either Marxian or non-Marxian approach. Non-Marxian approach is widely known as liberal approach, endorsing free market economy, recognition of private property and liberal political democracy. We can look at it from both economic and political angles. It may be seen as an analytical theory of economic activity, with many implications for the policies and practices of the governmental authorities. Politically, it is a set of normative theories of political institutions and activity, which have strong implications for the conduct of economic affairs (Barry Jones1988:28). Liberal political economy firmly opposes intervention by public authorities in the fields of economic progress, production and distribution. Its analysis is rooted in normative terms, such as value, welfare and utility and draws heavily on the assumption of

natural law (Mydral1954, Cropsey1960, Staniland1985),On the other hand, Marxian political economy takes into account economic as well as non-economic factors while analyzing a particular phenomenon. It focuses on the antagonism between the classes and the relationship between classes and the state and its economy. The social, political and economic systems are deeply rooted in the production system, which subsequently determines the distribution, exchange and the consumption pattern of the society.

Liberal Approach

This approach emphasizes upon the value of free market. The importance of market has been recognized from the classical era to the present globalization era. The related roles of the market and the state in enhancing economic growth and common good have been widely discussed. Classical liberal political economy focuses upon the basic issues of economic life, concern for the sources of value, growth and distribution along with the well-being of the members of an economic community (Barry Jones 1988:30). Here the market assure the full utilization of society's capital stock, and the state is an agent acting for private interests. It works as a self-regulating body, remains a facilitator and never fails as a whole. Neo-classical political economy focuses on the virtues of free market economy with a notion of marginal utility, general equilibrium and marginal analysis (Barry Jones 1988:30). It draws our attention to the limits of the market i.e. market failure, and the necessary role of the state for welfare. It points towards the circumstances in which the market falls short of enabling individuals to achieve the highest level of want fulfillment and satisfaction. Individual welfare is equated with fulfillment of preferences (Caporaso and Levine 1992:86-87). If market forces fail to attain this,

then the state has to come to the forefront to ensure this welfare (ibid. 97). Here the market works as a self-regulator, extending its ideas into domain of non-market institutional facilities, especially the state. The state may provide goods, correct externalities and solve the collective action problems even through coercion (Ibid. 219) Keynesian political economy argues that if free market economy is not able to work smoothly, the state has to come forward to make the capitalist state active Keynes shows that 'in a market economy, there is an in-built trend towards stagnation, i.e. the effective demand tends to be less then what is required for full utilization of productive capacity and as a consequence the source of capital accumulation will dry up' (Brown1984:18; Narayana1991). He, therefore, argues in favor of state intervention. He argues that a self-regulating market cannot be relied upon to secure the livelihood or the savings patterns of the dependents. Hence state intervention is essential. The state works to secure the macro-economic conditions, which also ensures private interest (Caporaso and Levine 1992:119). Besides, state intervention is accepted whenever it is necessary to ensure the livelihood of the people.

Within the doctrine of liberal political economy, health and health care have been identified as both a commodity and investment. As a commodity like other economic goods and services, it is individual-centred and is concerned with the material aspect of life. The state here has no special responsibility in the promotion of health, and leaves decisions to an individual. The state role is thus, minimal. It only maintains the quality of service. Here, a perfect competitive market determines the exchequer value of health. Such a market is denoted as 'market plus'[2] model The United States of America's health care system has been developed in this way

Here, the market forces determine its utility and the individual consumption pattern. The idea of health as an investment is as important as other economic investments because it is linked with the productive ability of the workforce. Investment in health sector reduces illness, improves productive capacity of worker. With that aim in view, the government invests on health. The common people get benefited by the state investment. This type of health care pattern is seen in most of the West European and, Scandinavian countries, Canada etc. The health care pattern of U.K., for example, is denoted as 'market extreme minus' health care system.

The political economy of health transition in the Third World countries is discussed by Reich (1994) on the basis of liberal political economy approach. He discusses the different actors and factors that shape the health care system in a given society. He also mentions the role of various international agencies and foreign governments in shaping health care systems. The role of politics and economics with regard to health is discussed by Jeffery (1988). He also discusses the role of the state, in pre-partition and independent India, in providing health care. The importance of indigenous medicines, nature of Indian Medical Service, its pattern of involvement and the pattern of expenditure in pre-partition India is delved into by the author. In independent India health care pattern has developed with a new vision. The nature of its development, linkages with the world health economy, and the expenditure pattern had therefore, to be looked into. Barraclough(1997) mentions that the investment pattern in Malaysian health sector is making the corporate bodies to emerge in health sector. The policy of the government is also encouraging for such corporate investments. Private sector health care is also expanding. But growing dominance of the corporate sector threatens the very role of the state. Thus health

policy in terms of equity, cost and quality, becomes a matter of a big question and re-thinking.

Marxian Approach

The theory of Marxian political economy points an opposite picture. It analyzes the society with the criteria of the mode of production and production relations. Production relations are guided by the ownership of the means of production The owners of the means of production they control the society, polity and economy Production relations also determine the individual's position in the society and his/her class-consciousness. The proletariat owns the labour power and the bourgeoisie own the means of production and distribution. In a capitalist society the means of production and distribution are controlled by a few. The economic power is transformed into political power, which gives the capitalist class control over the entire political process and institutions. The capitalist class accumulates profit through the exploitation of labour, engaging the laborer beyond his optimal capacity and labour time. It can coerce workers to do extra hours of work because profit tends to accumulate with exploitation of labour (Abraham 1997:116). Such economic exploitations break the society into two hostile classes viz: the bourgeoisie and the proletariat. Yet, this process crystallizes the social relations. The two groups can become more streamlined and homogeneous. This exploitation process of the bourgeoisie pauperizes the proletariat class more and more, alienating the proletariat from the capitalist system totally.

The class struggle intensifies more and more, ultimately destroying the structure of the capitalist society and establishing the social dictatorship of the proletariat. The Marxian studies the social relation, which evolve between people in the process of

production, distribution, exchange and consumption of the material benefit (Buzuev and Gorodnov1987:108; Volkov1985: 275). It gives a better idea of the society 'as a science of the conditions and forms in which production and exchange are carried out in various societies, and how products are distributed'. (Engles in Anti Duhring, quoting Volkov 1985). The theory believes in collective ownership of the means of production. It entrusts the public authorities to intervene in the fundamental economic activities of production and distribution.

The approach also analyses the nature of political power, class content of the state, nature of economy and the relation between the state and the international community (Popov 1984). These are based on historical materialism and the theory of class struggle and surplus value. It analyzes the power structure very deeply to identify the base of power, the relationship between power and authority and other relevant social aspects of the problem (Gurley1971:55 quoting Chandhoke1994). Marxian political economy goes beyond a general understanding of a phenomenon. It is a comprehensive understanding of the totality of a phenomenon.

Under such understanding health is regarded as a basic and fundamental right. The state authority cannot just deny this right. State makes necessary provision to ensure equity in providing health care. There is no discrimination on the basis of race, religion, etc; so no one can be denied health care. It is obligatory on the part of the state to ensure this basic right. Health gets such recognition in Cuba, where the government is determined to provide health care facilities to every citizen despite acute economic crisis. The health service system maintains universal coverage and accessibility through free service (Ochoa and Pardo1997). Different studies, following Marxist approach, are available on the political economy aspect of health.

Doyal (1979) discusses the impact of capitalism on health. He expresses that capitalist mode of production and production relation with the social forces shapes the health care pattern. He shows that health and illness is nothing but activities of social production. He indicates that the health problem of the third World countries are not their own. They are caused and perpetuated by the capitalist expansion in those countries. Elling(1981) points out that international capitalist world order is the root cause of human degradation, deprivation and exploitation and therefore health problems all over the world. The value system is getting drastically altered due to medical cultural hegemony in the Third World countries. The capitalist world exports their "banned" medicines, reject technologies, and sets up hazardous and polluting industries in the peripheral nations. The Third World thus gets appropriated by the capitalist world order.

Navarro (1976) discusses that socio-political forces are the main actors that shape the health care system. He mentions that production relations determine the health facilities in a society. The nature of class relation, political power and the state influence medicine and medical care. Crawford (1984) discusses the cultural meaning of health in capitalist society. He shows the nature of the appropriation process of health and health service in said society. The capitalist system denies disease as a cause of social degradation and hence undermines the demands for the rights and entitlements for health and health care services. Eyer (1984) admits that capitalism made some advances in the medical field; but it did more harm than good. It is destroying some fruitful, positive gains of the mankind. Derber (1984) discusses capitalist-controlled market mechanisms have changed the earlier good Samaritan role of a doctor. His position is down graded by the market-sponsored

hospital systems and also by the excess availability of physicians. Salmon (1984), Himmelstein and Woolhandler (1990) analyze the corporate nature of health care. The large profit companies are driving out small-scale operators or independent entrepreneurs. Multinational corporations are shaping the health care pattern. Whiteis (1997) mentions that the increasing role of corporate hospitals in U.S. A causes the declining trend in the public health amenities for the poor and the minorities in the urban neighborhoods. Political negligence and absence of monetary investments make the situation worse. The poor are not allowed necessary preventive and curative care.

Banerji (1984) analyses the factors that call for the presence of Western medicines in the Third World countries. The western world has changed the culture, and the behavior pattern of the Third World countries through their drugs, manpower, technology and research. The forces of colonialism and imperialism also increased the dependence of these countries on the First World. Bodenheimer (1984) and Tucker (1996) examine the role of transnational pharmaceutical industries in shaping the health care, health practices, policy guidelines, drug pricing etc. of Third World countries. Even unsafe drugs are sent to these developing countries for excess profit. The present international capitalist order thus, has ruined welfarism (Navarro 1984). It is dismantling itself from health and welfare for the purposes of more capital accumulation. Berliner and Regan (1987) look into the transfer process of international private organizations to the Third World countries, their impact on the access to the health services and the effects on the health policies.

State and Market

The 'fundamental concern of political economy, namely the interaction of state and market, are in different terms, politics and economics' (Hettne 1996:2). Without both state and market, there would be no political economy. The absence of either the state or the market would establish the domination of only one, i e either of politics or economics (Gilpin 1987:8 quoting Hettne 1996:3). It is a marriage between economics and politics i.e. the state and the market. The logic of the market is to locate the economic activities where they are most productive and profitable and the logic of the state is to control and capture the process of economic growth and capital accumulation (Gilpin 1987:11; Heilbroner1985: 94-5; quoting Hettne1996:3). The orthodox separation of politics and economics has been rejected by academicians. Marxian ideology has, for long, rejected their separation and has, in fact, integrated them. Marxian understanding place economics over politics while mercantilist priorities place politics over economics. Barry Jones (1988) rightly states that theories that maintain the political domination of economics or economic determination of politics, constitute forms of political economy (1988:2). So, the interaction between politics and economics or the state and the market, is the broader field of political economy. The relationship is also dialectic. It focuses on the evolution process of economic and political institutions or on the 'the inter-connection between dynamic market system and an evolving set of social institutions and political decision making.

The studies on the political economy of health have implicitly or explicitly adopted one of the two broad normative approaches. The government intervention school emphasizes upon the major role of a government in providing health care to its

population. Its major target is to improve the health status of the masses. The state tries to provide health care at the doorstep of the population. It provides an effective distribution pattern of health facilities, resource allocation, and manpower distribution. In these case no one would be denied the provision of health care notwithstanding the differences in caste, creed and economic status. The theory is based on the idea that governments have the capability to provide better health care and also are interested in improving the general health status of masses. On the other hand, "the market forces" school believes that the public sector provides inefficient, ineffective service. The free market economy ensures the efficacy of the production and distribution of a large number of goods and services. It provides greater consumer preferences. Both schools refer to each other as both problem or solution. But, such classification is over simplified. It is not possible to understand the health requirements of the developing nations by either state or market criteria, because these states do not follow any single mechanism. In Bangladesh, does not follow any single criterion. There is public provision of health care as well as private. The country emphasizes neither on state nor on market forces. The policy documents of the state also reveal mixed provisioning of health care.

Importance of Political Economy

Political economy is the study of rational decisions in the context of political and economic institutions (Alt and Shepsle:1990). It gives a holistic picture of phenomena. We can see a systematic relationship between economic and political process and the resulting impact on the distribution of resources within a particular community(Reich 1994). It helps to explicate political and economic phenomena as well as other conditions and also helps to 'locate or contextualise the practices of

individuals and collectivities (Chandhoke1994). It gives a broader understanding of any and all studies dealing with the aspects of public policies (Staniland1983:3). The philosophical and methodological issues related to human relations can also be studied by political economy (Barry Jones1988:2). It reveals the totality of a particular phenomenon. It facilitates comprehensive and effective understanding of a society, politics and economics. It is a kind of integration among ideology, economy, social stratification and the state mechanisms to study specific problems in terms of the whole.

Relevance of Political Economy in Health

Health and health services systems are deeply affected by the political economy in which they operate. It focuses on the role of political as well as economic forces that shape and reshape the health services system. While doing so, it examines the nature of the state, nature of decision making pattern, role of dominant forces in decision-making, nature of political commitment for health, pattern of health strategies, mode of operation, choice of technology and expenditure pattern.

However, economic structure and forces of a country do not operate within its geographical boundaries. They are linked with international forces. Hence political economy examines the role of international political and economic forces in influencing decision-making process of the country. It is more so for a small and economically backward and dependent country like Bangladesh. Today different multinational corporations are operating in the health care industry. National corporations or corporate houses are also engaging themselves in the health care industry. The private sector has emerged as an important actor in providing health care facilities, which is visible in the both developed, and the developing countries.

Political economy serves as an important tool for understanding the emerging patterns of the corporate and the private sectors; they are more interested in profit than facilitating better provision of health care. Political economy facilitates a wider understanding of the behavior patterns of the physician, and the patients, the nature of cost etc.

Review of Literature: Special References to Bangladesh

Various types of studies covering the different aspects of health and health care in Bangladesh are available. We shall examine a few studies, which are relevant to the present study. This may give us an opportunity to identify the gaps in the literature and justify the undertaking of the present study.

Studies on Health Care, Policies and Plans

The existing pattern of health care in Bangladesh is discussed by Ahmed and Shauib (1995). They discuss a wide range of issues including organizational structure of health care systems, policy plans in different plan periods, major health programs, the state of human development in health sector, nature and coverage of health care system. They also discuss health-related issues like housing, sanitation, and environment. The financing pattern and the performance of non-governmental organizations in health sector is also discussed by them.

Bjorkman (1988) points out that different countries are experiencing different types of health care. There are many factors and various groups, which play different roles in shaping health care systems. His idea is based on research conducted in South Asia, U.S.A., Europe and Africa. He mentions that the affluent people of both rural and urban areas enjoy best medical care. The larger cities have good health facilities.

He argues that each country should redesign its own health strategy and redefine the roles of each actor to achieve better health.

Khan (1990) discusses the successive planning and strategies of health sector from 1979 to 1990 in Bangladesh. He argues that health is a constitutional right, so it should not be left to the market. The allocation pattern in health sector is declining from 4.7 per cent in the First plan to 2.2 per cent in the Third Plan. The plan document prioritizes better provision for health care but the practical experiences are quite the opposite. He shows that a bulk of the area is under cover of government health care facilities. Government is unable to involve the entire population in the health sector. He points out that the state of health can be improved if government takes active part in educating the population about health care, general hygiene, nutrition, sanitation and immunization.

Rahman (1995) views that health care systems in developing countries are hierarchically structured both in terms of health personnels and facilities in the public, the private and the voluntary sectors. He discusses the nature of the provisions and the operating systems, classifying the health care facilities according to their location, management and service pattern.

Studies on Governance

Barkat (1997) discusses the nature of governance in the health sector of Bangladesh. He shows that poor performance, mismanagement, lack of governability ruins the total public health system. He also mentions the quality of provision of health care, nature of health policy and health administration in Bangladesh. He argues that health and health-related issues have lost their importance due lack of governance, causing poor state of health.

Study on Health Problems

Khan (1997) while discussing the health problems in Bangladesh, talks about the epidemiological issues of different diseases, malnutrition problems and also problems related to communicable and non-communicable diseases. He points out that the country should make a priority list, which includes child survival, diarrhoea, EPI, ARI, STD, nutrition, family planning and also formulation of national health policy. He recommends the reorganization of the present health service system in order to provide better and cost-effective service delivery. The present pattern of resource utilization, facilities, manpower engagement and above all, the state of health of the population, are other areas of focus.

Study on Poverty and Health

Begum and Sen (1997) discuss the relationship between poverty and ill health. They show that poverty is associated with higher incidence of sickness and disease. They point out that the improvement of health is also dependent on the performance of the other sectors. Hence integrated programs and policies should be taken to improve the health state of the population. They throw light on the fact that the public sector is facing problems such as under-funding, lack of equipment, personnel resulting in the poor condition of the health system.

Studies on Impact of SAP on Health

Rahman and Ali (1996) discuss the adverse impact of the structural adjustment policies (SAP) on the health service of Bangladesh. They also talk about the impact on access to PHC and the interrelationship between the households usages of health care and family planning service and of the socio-economic status of the beneficiaries. The study reveals that the introduction of SAP has reduced the volume

of public expenditure in the health sector, affecting the poorer and the vulnerable groups much more.

Sen and Koivusalo (1998) while discussing the impact of the structural adjustment policies on health, mention that policies of World Bank(WB) and International Monitary Fund(IMF) ruin the health systems of the developing countries. They are persuaded by WB and IMF to introduce SAP. The socio-economic realities of the Third World countries are not taken into consideration. These policies are guided purely by the principles of market economy. The policies call for either contractual arrangements or private sector involvements in the provision of health care. The developing countries now have no other option but to follow the neo-liberal economic policies in all aspects of activities including the health sector. This de-emphasizes public sector funding on social sectors, including health. The authors also mention the growing role of international health care industry and their hold over developing countries in the provision of health care.

Study on Private Health Care

Khan (1996) discusses the natures of development of private health care in Bangladesh in the context of cost, access, and quality. He explicates that the problems faced by the of public sector encourage the growth of the private sector. The latter's growth rate has been double within a span of fifteen years. This growing trend can be helpful for the rich but the condition of the poor remains the same. This can be a threat for the entire society.

Study on Accessibility to Health Care

Muralleedharn (1993) discusses some fundamental questions of health policy making. He analyzes the issues of accessibility to health care. In analyzing the

meaning of accessibility, he brings many ideas such as equity in public expenditure, cost of care, physical accessibility, use and the equal benefits of health. He talks about the ways of promoting to accessibility, viz: prevention of illness, caring for the sick, regulation of the health care system and protection of the interest of patients and the provider. He also analyses the market and the non-market issues that increase the accessibility to the health care system. He mentions that there are problems with both economics and politics. He ultimately emphasizes that political and community commitment and involvement are important way for equitable health care.

The studies above cover a wide range of issues such as health care, governance, accessibility, poverty, reforms, nature of private sector development, corporatization, notion of health in capitalism, role of pharmaceutical industry, i.e. political economy within both national and global context. Some studies have discussed specific issues related to the country's perspectives while others have talked of general state of health or international dimension of health linkage. Most of the studies examine fertility, diarrhoeal disease, family planning, health care pattern, governance, etc.

Objectives of the Study

These studies are mainly on diseases and health care system. They do not deal with socio-economic and political determinants of health. Framework of political economy in relation to health is missing. It is an endeavor of the present study to make a preliminary effort at understanding political economy of the health situation in Bangladesh.

The important questions that the study will seek to answer are as follows:

1. How society, politics and economy is linked with the health service system?

2. What kind of policy has so far been opted for in Bangladesh since independence?

Methodology

This study is based on secondary materials including books, reports, articles, journals, seminar papers. The various domestic and international publications include government documents and those from the UN agencies, The World Bank, USAID, The Asian Development Bank etc. The relevant literatures on politics, economics and sociology have also been consulted.

Chapterization

It consists of three chapters and a conclusion.

First Chapter

The first chapter analyses Bangladesh with specific focus on its socio-economic parameter. Major focus is on the nature of power structure i.e. the people who have been controlling the state apparatus, taking major decisions with regard to policy formulations and implementations. The economic policies of the different regimes are also analyzed, there is brief discussion on Bangladesh' relations with the world community.

Second Chapter

The second chapter analyzes the health determinants and major diseases of Bangladesh. A wide range of factors have been discussed while analyzing the health determinants.

Third Chapter

The third chapter analyses the pattern of health care system of Bangladesh. The nature of delivery system, education and training, administration etc. are also discussed. The nature of health policies and programs over the regimes along with the health care financing pattern are also analyzed. The development of the private sector is also an important matter of discussion.

Conclusion

A comparison of health status of Bangladesh with the world community, the role of politics and economics in the health sector are the major themes taken up in the conclusion.

NOTES

1. Methodological individualism rests upon a philosophical presumption that individual human beings are the only ultimate reality or causal agency, in human affairs. It not only emphasizes the individual rather it also include large scale social phenomena like inflation, political revolution etc. which should be explained in terms of situation dispositions and beliefs of individuals. (Berry Jones 1988:48).

2. Market plus model- This idea is given by Anderson (1989) where exchange is determined by perfect competitive market. Market is the sole regulator of every thing. On the other hand state play major role in market extreme minus model.

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CHAPTER 1

ROLE OF STATE IN DEVELOPMENT IN BANGLADESH SINCE INDEPENDENCE

Bangladesh emerged as an independent state in 1971. Located in South Asia with a land area of 14,7570 square kilometers, the total population of the country is 124.3 million and 826 persons live in per sq. km. They are homogenous in race, language and religion. There are small minorities of tribes, Christians, Buddhists, and Hindus. The society is dominated by the middle class. Language and culture are the major inspirations behind national identity and integration.

There are 20 million households and the average household size is 5.6. Around 22 per cent of total population live in the urban area. Administratively, the country is divided into six divisions, sixty-four districts, four hundred and ninety thanas and four thousand, four hundred and fifty-one unions, which serve as a basic unit of administration. The country has a unitary form of government with in the framework of parliamentary democracy. The total labour force constitutes 56 million, of which 34.7 million are men and the rest are women. Of the total 64 per cent are in the agriculture, 15.5 per cent in the industrial and the transport sectors and the rest are in other sectors. The adult literacy (15 + yrs.) is 59 per cent for men and 42 per cent for women. The incidence of poverty is 47.5 per cent is defined by intake capacity of 2122 kilo calories per day. Electricity is available for only 20 per cent of the country and 15 per cent of the total population. The per capita GNP is US$ 260 and the annual GDP growth rate is 4.3 per cent in 1990s.

Soon after independence, Bangladesh had been able to make its position recognized in the world community. Within a short span of time, most of the world community

had recognized it as an independent state and extended their cooperation to build up war-ravaged country. Various types of bilateral and multilateral agreements had been signed by many countries and the UN organizations to rebuild the devastated economic infrastructure. As a dependent economy, Bangladesh has been able to establish good relation with the donor organizations and the donor nations. With the global world order having changed over a period and the world community emphasizing on liberal democracy, economic liberalization and globalization, Bangladesh is also committed to build up liberal democracy, and liberalize her economy to obtain maximum benefit. She joined the global community to improve her status in social, political and economic arena. She underwent a process of adjustment and adaptation to the new realities of the world order. She has been given large sums of foreign aid to foster economy. Necessary guidelines were also provided to improve the state of her population in terms of economy. The flow of aid has compelled Bangladesh to accept donor policy guidelines. She has no other option. Since her independence, the world community has disbursed US$ 31.97 billion aid of which 49 per cent is grant and 51 per cent is in the form of concessional loan. Export accounts for very low share of the country's GDP while import continues to be overwhelmingly credit financed. Foreign invest is very minimal.

The share of aid in ADP is still very high (70 per cent-85 per cent). Net foreign financing in economy is about 50 per cent in 1990s. It is evident that Bangladesh could not have managed her economy without the assurance and assistant of foreign aid. She has been given money, technology, manpower and even policy guidelines as a result of foreign aid. She has no political clout to control foreign aid. We, thus,

see how foreign resources play pivotal role in shaping a country's relations with the world community. The relation of Bangladesh with the donar countries is dependency relation or patron-client relation or both[1]. The foreign countries are thus able to appropriate and accumulate money from Bangladesh and also help in the emergence a new dependent client class who have now become part of the appropriation racket. This new emerging class has had a linkage with the metropolitan capitalist class who works as a patron in providing aid and the recipient's works as clients. So it is evident that Bangladesh's relation with the world community is more economic than political.

Bangladesh has experienced several changes in the last few decades. The changes have been reflected in her society, polity and economy. She was under British colonial rule for about two hundred years (1757-1947). The independence movement and the creation of Pakistan brought an end of external colonial rule but imposed internal colonialism (Nations 1971, Hechter 1975) to Bangladesh. The united Pakistan could not survive because of internal and external, socio-economic and political dynamics. Bangladesh emerged as an independent and sovereign country. Following her independence, drastic changes have taken place in the socio-economic and political fields. The dominant elites and groups are emerging with diverse strategies and policies. The changing nature of political economy has shaped the nature of dominance and its policies over a period of time. So different regimes have flourished differently, with diverse policies and programs.

Pakistan Period (1947-71)

During the Pakistan period, the power base and decision making authority was either directly or indirectly civil-military bureaucracy, and most of them were from West

Pakistan. Originally, during 1947-58, Pakistan had civilian rule. But the crises of leadership ultimately threw the country to a permanent control by the civil-military bureaucracy. Jinnah's contempt and disdain towards his 'political' colleagues encouraged the bureaucrats in taking decision and formulating policies for the state (Sen 1982:81). The political leaders, who were in power structure, had little support base and very little faith in democracy. The political leaders had a conflict among themselves, throwing the opportunities to the civil-military bureaucracy. This divided and subdivided the political parties and ruled the country according to their wishes. There was no stable government at center or in the province. Before the imposition of martial law in 1958, seven governments were in the center. After the imposition of martial law, the country was under direct control of military bureaucracy from 1958-62 and again civil-military bureaucracy till the breakdown of Pakistan. The civil-military had little faith in democracy and had taken all the decisions to rule the country. Gloomy picture of civilian rule was drawn and civil-military bureaucracy had ruled the country.

During the period of 1947-53, the power elite had compared of the civilians comprising of lawyers, petty official, rich peasants, small traders and businessmen (Burki 1980:17) and from 1953-58, they were the businessmen and landlords of West Pakistan and professional middle class in the East Pakistan. When the military took over power in October 1958, the social base of power had changed and it was like a "marriage a partnership between the army and the civil service". During 1958-68, of the seventeen ministers, six were civil servants, three were military officer, five were landlords, two were industrialist and one was a journalist. They were in-charge of important ministries like finance, agriculture, commerce, industries, and

economic affairs. The provincial Governorships were held by the civil-military bureaucracy. Among the Governors four were from army and three were civil servants, one a big landlord and one a lawyer (Ahmed 1980:40). Of the nine Governors, seven were from West Pakistan.

The National Economic Council, Planning Commission, Industrial Development Corporation, Water and Power Development Corporation were controlled by civil-military bureaucracy. They occupied the key post of these institutions. In 1960s, the Board of Directors of 36 central and provincial corporations were controlled by 48.3 per cent civil-bureaucrats, 30.9 per cent businessmen, 21.4 per cent professionals and 0.4 per cent land-lords (Anisuzzaman1971: 13 quoting Islam 1988:20). To understand the extent of power of these bureaucrats, we have to identify the socio-economic status of these groups, which had given them an advantageous position to dominate in the power structure. 1961 census shows that only 19.2 per cent were literate. A minimum of a bachelor's degree was required to sit for the civil services examinations. During 1950-66, among the applicants, only 2.50 per cent were able to enter the civil service of Pakistan and 67 per cent of them had master's degree; some of them had foreign degrees. The occupational and income levels of the parents of the civil servants revealed that in 1960s, 64 per cent were the sons of civil-military officers, 13 per cent were the sons of land owners, six per cent were the sons of businessmen and 13 per cent were the sons of professionals (Papanek 1967:79). The income level also reveals that 40 per cent of the CSP came from higher income group i.e. earning more than Rs. 1000 and above (Braibanti1966; Ahmed 1980). The socio-economic background of the parents of military bureaucracy also shows the same picture. Most of them who had attained education

from 'cadet college', their parents were from civil-military bureaucracy, and 83 per cent came from those families whose monthly incomes were more than 1500 (ibid.).

It is necessary to mention that most of these politicians, civil-military bureaucrats were from West Pakistan. There was hardly any representation from East Pakistan in the key decision making institutions. The latter's representation was only 6.5 per cent in 1956 and 42 per cent in 1950-68 in the civil service of Pakistan; in the armed forces the number was even less. East Pakistan's representation never went beyond eight per cent in 1964 (Ahmed 1980:68). The representation in the post of Director of key corporations never went beyond 20 per cent in case of East Pakistanis (ibid.: 70). Of the 280 member of the 33 commissions formed during the Martial law period for the purposes of suggesting substantial policy proposals. East Pakistan had only 27 per cent representation.

It is clear from all these facts and figures that civil military bureaucracy was the source of all power. Similar socio-economic and regional background made them cohesive and helped them to maintain their 'coterie' interest. This made them rule the country till the breakdown of Pakistan.

During the beginning periods after independence, Pakistan economy had no definite shape. West Pakistan's economy depended fully on land and a few industries while East Pakistan had total peasant based economy. In 1947 Pakistan's economy was described as an 'economic wreck' and like its political system, its economic system also faced many problems. During 1947-58 the state had no clear-cut policy or planning; it tried to secure rapid development without formulating clear-cut economic plans (Islam 1988:34), with Ayub Khan (the military ruler) having come

to power, the economy took a new shape. The whole state machinery got activated for higher economic growth and development. A new environment was created to enhance economic growth. The Planning Commission, National Economic Council and important public organization were setup or reorganized. The new industrial policy was announced which categorically emphasized that the state would provide all possible help and incentives to private enterprises and individuals' initiatives with land, power, transport, tax holidays and cheaper credit and other advantages as best as possible. The monetary policy, export and import policy, investment policy, and agricultural policy, etc. all were directed to enhance private investment. These policy guidelines continued to be followed in all the subsequent plan periods.

The economic policy was, framed as a strategy of 'functional inequality'[2], 'entrepreneurial approach'[3], and single economy for both the Pakistans. The development strategy had relied on private entrepreneurs, encouragement of high degree of inequality of incomes, minimum investment in social welfare and an entrepreneurial approach based on one economy thesis (Ahmed1980: 76). The policy had had tremendous impact over the economy and the society. The structure of economy got diversified and took a new outlook. Industrial output was doubled. In 1949, the share was 12 per cent and it was 24 per cent in 1969-70. Per capita GNP increased from RS. 253 to Rs. 576 in the same period. The share of large manufacturing sector had increased from 1.4 per cent to 8.8 per cent in same period (GOP 1968). Policy was made to divert capital from agriculture to industry. Local entrepreneurs were given the benefits of foreign exchange at a rate below the existing market price, capital with low interest rate, tariff barrier for imported goods, bonus vouchers for exported goods and tax holiday. The new agricultural policy

also provided incentives to big farmers. Subsidies were given for new technology, fertilizer, pesticide, tube-wells, tractors, imported seeds, even low-priced electricity and petrol. Export duty was lowered for cotton and jute. In the period of 1948-49 to 1969-70, the agriculture sector had grown from 89 to 158 showing an increase of 69 per cent (Ahmed 1980:94).

All these policies and strategies were adopted by the civil-military bureaucracy, having a monopoly control over all decisions. They justified the policy and strategy as the best for economic growth, development and national unity. This policy had helped the trader turn industrialist.

This policy also helped to develop disparity between the East and the West Pakistans. The central government decision regarding expenditure (development and revenue), foreign exchange, foreign aid, export and import, subsidies in agriculture and transport etc. made the disparity more acute. This was reflected in a general way in the economy and the society of the Pakistans. The average annual growth rate in East Pakistan was 0-. 2 per cent in the first decade and 5.4 per cent in the second where as, in at the same period, West Pakistan had 3.6 per cent and 7.2 per cent respectively. The per capita income in East Pakistan was 287 in 1949-50 to 331 in 1969-70, while West Pakistan had RS. 338 and RS. 533 respectively. In 1949-50, the disparity was 19 per cent rising to 61 per cent in 1969-70 (Ahmed 1980:118-119). Regarding the expenditure pattern, East Pakistan's share was 33 per cent (1950-70 period), and in case of development it was only 30 per cent in the same period. (Sobhan 1993: 100). From 1948-49 to 1968-69, US$ 6489 millions foreign aid was disbursed to Pakistan and East Pakistan's share was only 30 per cent (ibid. 130). The import and export policy also favored West Pakistan. So there were huge

imbalance and disparity between the two wings. The disparity situation got worse when an estimated US$311 million per year got transferred from East Pakistan to West Pakistan.

This economic policy had given great advantage to the few who were able to consolidate wealth in their hands. It was revealed in 1968 that only 20 families controlled 66 per cent of total industrial assets, 70 per cent of total insurance fund and 80 per cent of bank assets. (Holiday 1968 April, quoting Moniruzzaman 1982:84). Top 5 per cent shared 20 per cent of the personal income and the bottom 30 per cent shared 25 per cent (Bergan 1967:174 quoting ibid. 84)

Foreign aid had played significant role in Pakistan's economy from 1949-50 to 1969-70. US$ 7640 millions loans were promised to her, of which $6439 million was disbursed. In the same period she also received US$1.4 billion as grants. The disbursed loan, amount was diverted to project aid including technical assistance (51 per cent), non-project and commodity aid (30 per cent) and food aid (19 per cent) (Muhith 1979). From her initial days, she wanted wide range of development activities including setting up of large manufacturing industries and effecting infrastructural development such as building, roads, railways etc. Foreign aid was virtually unavoidable for her development activities. Most of the imports and 67 per cent development expenditure were met by foreign aids. The agriculture and even the priorities industrial sector were deprived of foreign aid. While the continuous inflow of external financial support totally neglected the agricultural sector, it had placed the industrial growth at the top priority. In consequence the rich became richer and businessmen turned to the industrialists which contributing to unequal distribution of wealth and widespread disparity in the society. The donor agencies

and countries had used their capital and technical resource in formulating policy; they wielded political influence also. All these were done in the name of free enterprise, free world, fighting for development and prosperous life. Policy planners had hope of a sustained growth but functionally it was not possible, since dependency had increased in an alarming rate. Pakistan had hardly anything of her own. Donor countries wanted as Gardezi argued, that Pakistan developed a dependent capitalist structure (1998; 1991). The global political economy made her more and more dependent on foreign aids.

Bangladesh Period

Since independence, Bangladesh has experimented with different types of systems-political systems, in particular. The tenure of Sheikh Mujibur Rahman (Mujib) was marked for civilian supremacy in the political arena and 'nationalization' and 'state capitalism' in economic arena, Ziaur Rahman's (Zia) as civil-military domination in politics and disinvestment in the economic field. H.M. Ershad's was a military dominated government marked by denationalization and privatization in the economic arena. Begum Khaleda Zia (Khaleda) had headed a civilian dominated government and propagated economic liberalism and Sheikh Hasina Wejed (Hasina) is now running the government with full civilian control and economic liberalism. Each government has its distinct character both in economic as well as political aspects.

The Mujib Regime (1972-75)

After independence, the country started with fragile political and economic systems. Within a short span of time, Awami League (AL) established it authority and built political and economic institutions. It was able to hold the new nation together and

create national political community (Jahan 1972), Major changes were made in the state machinery. Political elite became the power elite and was given higher positions in the different steps of the state structure. These elites comprised of rich farmers, traders and small industrialists, professionals and the intellectuals and the lower echelon of the civil service[4] also. The political dominance was mostly effected by the activists and the supporters of AL. The government also took necessary steps to subordinate bureaucracy and the military to retain political control (Kochanek 1993:52). The major decision making authority lay with Mujib himself. All the powers with regard to his cabinet, parliament, planning commission and public sector corporation were vested with Mujib. He executed the powers without accountability or answering questions. He was aided by his secretariat where important posts were occupied by non-bureaucrats and highly political men (Rahman1974). In addition to his secretariat, he was aided by his cabinet members, comprised of 23 members of whom 13 were lawyers, four businessmen, four politicians, one college teacher, one landlord and one ex-army personnel (Sen 1987)

During AL regime, Members of Parliament (MP) were also having a role in key decision making. Their socio-economic background demonstrates that 26.6 per cent were lawyers, 23.7 per cent businessmen, 17.6 per cent surplus farmers, 15.2 per cent professionals, 12.7 per cent politicians. Seventy per cent had completed college and university education and 27.3 per cent had post-graduation degree. 32.2 per cent had less than T.K. 20,000 annually, 32 per cent had less than TK 30,000, 25 per cent had less than TK 50,000 and rest had above TK 50,000. The family background of these MPs indicates that fathers of 35 per cent of them were farmers.

18 per cent land lords, 14 per cent in services, 14 per cent in businessmen, 7 per cent from teaching and 5 per cent lawyers (Jahan 1976).

The planning commission also was a key decision making body, which had emerged with a new shape. It was given the serious responsibility of plan making and formulating policies for the implementation of the plans (Islam 1988:62). It was composed of ten divisions. (Islam 1977:142) and almost all the key positions were given to the members of the university faculties (Islam 1988:63) who were closest to AL (Islam 1977:45;Kochanek 1993:76). A few held key positions in the public sector corporations, enjoying a dominate role in decision making. Most of them were professionals and had good relation with AL. Of the 44 chief executives, 35 were political personnel with professional or managerial background, five civil bureaucrats, four military bureaucrats. Subsequently the number raised from 44 to 76 of which 44 were from the professional class, 25 from government service and four retired army officers (Islam1988: 63 quoting Sobhan and Ahmed 1980:535).

The social background of the business executives showed that they were the descendents of those employed in high positions in the government, and the semi-government (38.85 per cent) or self employed in business firms (15.15 per cent). Only 4.54 per cent had a rural or agricultural background (Habibullah 1976 quoting Mannan 1990). Even when BAKSAL[5] was created, political leaders had dominated in the decision making process. The 15 members Executives Committee and 115 members Central Committee were dominated by the politicians, only 21 were from other professions. On June 1975, Mujib issued a presidential order, creating 61 districts. The majority of the district Governors were chosen from AL.

The AL regime took necessary steps to control the civil-military bureaucracy. The constitutional and reformative measures were adopted to curtail the power and privileges of bureaucracy, which they enjoyed last 24 years. Out of 180 Bengali CSP, 53 were fired from job. Defence expenditure as a percentage of total expenditure was curtailed from 56 per cent in Pakistani days to 7 per cent in 1974-75 (Islam 1988:59). The regime was reluctant to establish a well-equipped military.

Thus, from analysis, above it is clear that in every sphere of state power there was civilian domination. They were either AL activist or supporters. Much data is not possible to generate because there is little or no comprehensive study on each dominant group. The socio-economic and demographic status of parliamentarians indicates that they had higher education and income and belonged to the upper stratum of the society. The cabinet members held key posts in public enterprises, and memberships in the executive and the central committees of AL. The members of planning commission were drawn from university faculties, who had higher education, income and higher social background. The domination pattern of these groups in the state apparatus had got reflected in the policy mechanism.

After independence, the new government had taken different steps both institutional and organizational to give a new direction to the various sectors of economy. The strategy followed 'command' economy. But the state did not follow very strict principles of socialism because these were wide spectrum of political and economic ideologies embraced within the ruling party. So during the three and a half years of AL rule, there were diverse policy dimensions in the economic sector

The state adopted 'inward looking' (Salim 1998, Alam 1994) economic policies, where the public sector played the leading role. This provided the base of the

industrial policy, which helped to nationalize a total of 725 industrial units with 92 per cent of the total industrial fixed assets, compared to 53 units and 34 per cent of the fixed assets, held by the state sector in 1960-70. (Bayes et.al. 1998: 91; Kochnek1993: 80). Ten Corporations were set up to manage and control the nationalized enterprises, like small, cottage and handloom industries. The private sector was left to the foreign enterprises. The nationalization policy limited the flourishing of the private sector. Private sector investment per unit was allowed with fixed assets of up to TK 2.5 millions. These units allowed reinvesting of profits up to TK. 3.5 millions. Beside, the private sector investments were not exclusively their preserve the government had the right to nationalize. The new units however, could be guaranteed against nationalization for a period of ten years. So by controlling all activities in the economic sphere, Bangladesh government was able to maintain "command economy". The government allowed private and foreign investments only with public sector collaboration and minority equity participation. The private sector was allowed a five year tax holiday and a 60 per cent exemption from taxes on the money reinvested in the industry or in government bonds (Kochanek 1993:81). Later on, the investment limit was raised up to TK 30 million "Partnership between domestic and foreign capital was permitted, and public sector development was confined to 18 sectors with the remainder open to private capital" (Islam 1979:248; Sobhan and Ahmed 1980 quoting Kochanek 1993:88). Prior permission was needed before private investments. The moratorium on nationalization was also extended from ten to fifteen years and fair and equitable compensation was guaranteed. (Islam 1979:248). For the promotion of small

industry, the government had set up Bangladesh Small Industries Corporation and provided all type of financial and technical assistance to the small entrepreneur.

In the field of agriculture, the state made legislation to control the land-holding sizes. Each family was allowed to retain a maximum of 100 *bighas* (One *bigha* is equal to one third of an acre) of land; families who had less than 25 *bighas* were exempted from land revenue. But the holder were to pay development tax, relief tax etc. Those who had more then 25 *bighas* were asked to submit their accounts of land and the provision of fine was enacted for those who failed to submit land accounts. Those who hold more than 100 *bighas* were asked to surrender excess land to the government. No family was allowed to hold more than 100 bighas. These rules were relaxed on tea, rubber, coffee, industrial and cooperative society etc. (Alim 1979;Siddiqui 1988). Policy provision was made to provide land to the landless families. The rights of land owner to their diluvial land was taken away and the state was made the sole disburser of these lands (Mukherji1976) A Consumer Supplies Corporation was established to procure food grains from the surplus producing farmers and from surplus producing areas and then distributed to the landless peasants and in the deficit areas (Rahim 1975 quoting Islam 1988:97). In order to mobilize savings and ensure redistribution of incomes, rural cooperatives were also made (Islam 1988:97). The state provided huge subsidies on the agricultural inputs.

In the trade and business sectors, also the state played a dominant role. It controlled both domestic and foreign (90 per cent) trades. A trading corporation of Bangladesh was established to control the import business. The private sector played a dominant role in domestic trade. Public sector manufactures and imports were marketed by

private dealers and retailers, (Islam 1988:104) though imports were controlled by the government through imposing high tariffs. From 1972-76, Bangladesh had imported US$ 3383 millions, and exported only US $1439.8 millions, (Hossain et. al 1998). The foreign exchange was strictly controlled by the state.

During Mujib's regime, the state was promised US$ 4267 millions foreign assistance but only US$ 2984 was disbursed. Nearly 52 per cent was as grants (GOB. 1998:133)

The regime could be regarded as a case of economic under-development because of the policies mentioned above. The agricultural and industrial output was below the benchmark level of 1969-70. It was 94 per cent and 87 per cent respectively (Islam1988: 153). The average annual GDP growth rate was 5.1 per cent during 1973-75 period. The prices of essential commodities had increased by 300 per cent in 1973 and by 700-800 per cent in 1974 (Moniruzzaman1982: 128). The entire economy was functioning at a rate well below the rate of the pre-liberation period (Kochanek1993: 273). The per capita real income was TK.635 (In 1973 price). Average GDP was TK. 79423 in current price. Gross domestic investment, as a percentage GDP of was 6.7 per cent. Budget deficit, as percent of GDP, was 8.4. The inflation was 41.9 per cent (B.B.S, various years)

During this time, groups of people were able to acquire substantial capital under state patronage through primitive accumulation. It was estimated that in the period of 72-76, an amount of the TK.10,000 millions was concentrated in the hands of a few whose average GDP was TK 55,000 millions (The Holiday, Sept 9. 1977 quoting Alam 1994). The nine business families used the nationalized banks at their will in 1972-75 period (BBS 1981: 345 quoting ibid.). The state disfavored the

flourishing of the capitalist class and civil-militants bureaucracy, while encouraging the prosperity of the small industrialist, importers, wholesalers, contractors. The state provided all round support. The nationalization policy had given an opportunity of material gain to this class who had extracted state capital with the help of state machinery. The demand to raise the ceiling on private investment indicated their extraction and prosperity. The regime, aiming to establish socialism, established state capitalism instead.

The discussion above reveals that the nature of the dominance, the group identity of the dominant groups, their socio-economic background etc. led to a kind of economy which was their very expectation. The civilian dominance in decision making had prevailed all over the period. The state tried to control the economy through public sector. But the policies pursued by the leadership failed to either establish socialism or generate economic growth. Only a section of people had become wealthy by the indirect patronage of the state.

The Zia Regime (1975-82)

After the assassination of Mujib and overthrowal of his government in 1975, the nature of dominance and decision making changed significantly. New groups emerged to dominate in the state apparatus; hence in the decision making process also. The civil-military bureaucratic elite again came to the forefront, consolidated its position, occupied important portfolios and dominated in all decision making processes.

After a coup and a counter coup, though Ziaur Rahman emerged as a voice of authority and source of power (Saeed 1995), the country was under military rule, controlled by a civilian president. The president was assisted by 17 advisors, of

whom six were civil-military bureaucrats, four educationists, four technocrats , two politicians and one lawyer (Asian year book 1978:13 quoting Alam 1996:46). At that time, the president himself was at the top of the power structure. He was the Chief Martial Law Administrator,, assisted by the Deputy Chief Martial Law Administrators and the president's advisors. On November 30, 1976 and April 20, 1977, Zia emerged as Chief Martial Law Administrator and as the President respectively. All the structures of state power were brought under the direct control of the President. The major decision making authority lay with the office of the president, his secretariat, council of minister and the secretariat. Apart from this, the National Economic Council, the Planning Commission and Public Corporation, also played important roles in the decision-making processes. All the offices of decision making were controlled and dominated by civil-military bureaucracy. It was observed that up to June 1978, the President-cum-Chief Martial Law Administrator was assisted by 31 members advisory council, in which 13 were civil-military bureaucrats, and 11 technocrats, five were non-political civilians, recruited from business and other professions (Ahmed 1995.117). After the withdrawal of the martial law, the cabinet structure remained the same. There were only quantitative changes, no qualitative change. The civil-military bureaucrats remained dominant, playing pivotal roles in decision making. In 1981, there were 24 full ministers in the cabinet and of them, 11 were civil-military bureaucrats, six technocrats, four businessmen, two lawyers and one landlord (Islam 1988: 123). Most import portfolios were given to the civil-military bureaucrats. The socio-demographic character of the 25 civil servants shows that 100 per cent had M.A. degree, four had M.A from foreign university, four had Ph. D degree, 64 per cent had attended

English medium schools. Fathers of the 32 per cent were landlords and surplus farmers, 40 per cent in government services, 12 per cent in business, and 16 per cent in the professional class. (Ahmed 1980:173). New pay scales were introduced which raised their salaries and other fringe benefits.

It is difficult to generate data from the military bureaucracy. But other auxiliary factors indicate that they had good education, income and social background. Their number increased from 52,000 in 1975-76 to 77000 in 1980-81. Defence budget increased from TK 710 millions in 1975-76 to 252 millions in 1980-81 (Moniruzzaman 1988 quoting Kochanek 1993:62). Some of them had completed higher training in UK. U.S.A. and FRG etc. The military bureaucrats were provided better position in the civil bureaucracy, during the Zia regime. Six out of 20 secretaries, 14 out of 20 superintendents of police, 10 out of 20 top public sector corporation director and some 32 diplomatic posts were filled up by military personnel (Hossain n.d: quoting Kochanek: 1993:58)

The civil military bureaucrats became dominant in the chief policy making and policy implementation institutions. The National Economic Council was revived. It was made highest policy making and decision making institution in the field of development planning. The main body of NEC executive committee is comprised with five member civil-military bureaucrats (BBS 1980:8 quoting Islam 1988:124). The planning commission, which is entrusted with the functions of preparing national plans and programs according to the direction of NEC, consisted of eight members. Chairman and deputy Chairman were civilian bureaucrats (Islam 1988:124), who exclusively controlled the preparation of plan documents. The civil bureaucrats dominated the public sector corporations also. Among them, 11 were

former CSPs, 10 military officers, two police officers. six EPCSs and the rest nine belonged to other services of the former central government of Pakistan (Islam 1988:124) The President's secretariat and the central secretariat were the hub of administration and policy making, and they were dominated by civil-military bureaucratic elites.

Though political leaders had a low profile in the policy-making bodies, but the socio-economic and professional data indicate that they had also better position. In 1981, 33.5 per cent members of the central committee of BNP were businessmen, 31.2 per cent professionals, 11.8 per cent agriculturists, 11.7 per cent teachers, 6.5 per cent bureaucrats (Islam: 1988:127). The socio-demography of parliament members also indicated that they were from the higher echelons of the society. Their occupational backgrounds indicated that 27.7 per cent were businessmen and industrialists, 23.8 per cent lawyers, 13.4 per cent agriculturists, 12.7 per cent technocrats, 12.2 per cent civil-military bureaucrats, 45 per cent had post graduate degrees, and 32 per cent were graduates (Alam 1993). Forty three per cent of them had monthly income above TK 5000, 23 per cent had land holdings of over 25 acres, and 60 per cent had more than 10 acres. (Hussain 1985 cited Rahman 1989). The Members of Parliament had had higher educational standard. Statistics shows that 44.70 per cent had post-graduation, 32.10 per cent had graduation degrees; the rest had studied upto higher secondary education or less (Alam1996).

Zia always preferred and favored civil-military bureaucrats. Political leader had comparatively minimum participation (40 per cent) as ministers. This created frustration among the civilian MPs who were keen to get involved in decision-making (Ahmed 1995:118). It was a rule of civil-military oligarchy.

In 1975, there was a change in the state power structure, the state followed different types of economic policies for growth and development. The major thrust of economic policies was disinvestment from the public sector and encouragement private-sector-led growth.

The industrial policy, announced in December 1975, gave immense opportunity to the private sector to flourish for the first time in Bangladesh. The investment ceiling was raised from TK. 30 millions to TK. 100 millions, and by the end of 1978, the ceiling was finally withdrawn. The investment corporation of Bangladesh (ICB) was set up inorder to provide bridging finance and under writing facilities to the private sector. The Dhaka Stock Exchange was revived to reactivate and to mobilize private savings for industrial investment. Different types of incentives were also provided for industrial investment. The state as a whole, got activised for industrial development. The government financial institutions offered liberal credit facilities to the private sector industries. Nationalization was withdrawn and compensation was ensured in case of nationalization. Though high emphasis was given for private investment but it was tightly controlled and regulated by the state (Kochanek 1993:274).

As a part of general economic policies, the government chalked out guidelines to hand over public sector industries to the private sector. The Pakistani abandoned industries were sold by tender. The industries of Bangladeshi owner were reverted back to its original owners. As a result, in 1975-82, 362 abandoned units were sold off to the private sector. (Kochanek 1993:92) The government relaxed the restrictions on foreign investments, by raising the ceiling on foreign equity

participation in selected areas. EPZ was established to encourage the foreign investors.

In the field of agriculture, the government took necessary steps like liberal credit, new technology, easy access to seed, fertilizer etc. to the farmers. A massive program of cannel digging was lunched. A self-sustaining movement was also lunched for rural development. But, land revenue was imposed again for the medium size (25 *bighas*) families. The subsidies on agricultural inputs were gradually withdrawn. The private agricultural entrepreneurs were given facilities for agricultural plantation (tea, rubber, shrimp cultivation etc (Mannan1990). The monopoly over the fertilizer distribution system of Bangladesh Agricultural Development Corporation (BADC), a public sector corporation was abolished in favour of private marketing.

In the field of trade and business, private sector was allowed a leading role. 'The import and export policy was formulated to encourage the private sector'(Alam 1994a: 140). Income tax was reduced, special awards were also introduced for the successful exporters. The performance license scheme was introduced to provide more incentives to the exporters. In 1975-82, the volume of export and import increased to almost double compared to AL regime. The controlling of foreign exchange was not strictly maintained. Wage Earner's scheme was started to facilitate exchange earning (Salim 1998).

During Zia regime, the state was promised US$ 8267 millions, but only US$ 6012 millions was disbursed of which 50 per cent was in the form of grants. (GOB 1998:133).

The policy followed by Zia regime was impressive for the economy compared to the earlier regime. The over all GDP growth was 5.5 per cent. The per capita income increased from TK 652 in 1973 to TK 772 in 1980 at 1972-73 price. Investment as a percentage of GDP increased from 6.70 per cent in 1972-75 to 13.45 per cent in 1975-81. The total investment increased to TK 5445 in 1981 at current price. Private sector investment increased from TK 82 millions to TK 1200 millions in the period 1973-79 (Alam 1994a). The price of essential commodities had gone down compared to 1973-74. But the general price index increased by 628 per cent in 1980-81 at 1969-70 price level (GOB: 1985) Industrial growth rate was 4.9 per cent per annum in 1975-81. Average GDP in the regime was Tk.171047. The gross domestic savings were 2.2 per cent and the inflation was 9.5 per cent. Infact, during this regime the political economy of strengthened its base, which was quite different from Mujib's regime.

The Ershad Regime (1982-90)

Following the assassination of Zia, Justice Abdus Sattar (Sattar) was elected President. He attempted to control the military interference. But, Ershad, the chief of army staff, demanded a permanent role for the military in decision making. Justice Satter refused, the situation got aggravated and Ershad seized state power in a bloodless coup. He was able to create 'an authoritarian, military-bureauratic state dominated by an all powerful president supported by military' (Kochanek, 1993:60). His regime can be called all-powerful military oligarchy.

The number in the armed forces was increased from 77000 in 1982-83 to 110,000 in 1990-91 (IISS quoting Kochanek 1993:61). Defence budget was enhanced from TK 3406 million to TK 11450 millions(SIPRI yearbooks). One account shows that in

1988 there were 56 army officers in the civil administration, which excluded the ministry of Foreign Affairs. In the 36 government corporations, 29 posts of Director General or Chairman were occupied by military personnel (Rahman 1989) Another source shows that 28 senior posts in the Secretariat, 14 Chairman Director General post in public sector corporations, and one third of diplomatic posts were occupied by military personnel. At the political level 40 percent of the ministerial posts were held by the military. Attempts were made to place military officers in all district councils and reservation of 10 percent of government jobs for military personnel. (Kochanek 1993:63). The core military personnel number were 400. They were repatriated from Pakistan, belonged to ranks above Major. They were mostly from the middle or the lower middle class and had family ties with urban bureaucrats. business groups and professionals (ibid: 61). Most of them were trained in Pakistani military academy; some had trainings in USA, U.K. and FRG, In their early days. they had served under General Ayub Khan and were quite comfortable with the idea of military governments (ibid:61).

The President was omnipotent with his powers. All the executive power was vested with the President. Ershad 'was the head of the government, head of the armed forces and the chief executive.' He had the powers to appoint or dismiss the ministers and judges. His secretariat became the most powerful organ of the government (Holiday, June 22,1990, quoting Kochanek) and the most impost posts were occupied by military personnel. Political leaders had minimal role in the decision making process though theoretically the Council of Ministers were the highest decision making body. Within nine years of his rule, it got shaped and reshaped sixty-three times (from 1982 to 1990). The number of ministers grew from

eleven in 1982 to thirty eight in 1989 (Dhaka Courier 4-10 May, 1989. quoting Kochanek 1993:65). After assuming power in 1982, he was aided by a Council of Members among whom seven were military bureaucrats, three civil bureaucrats, two technocrats and four lawyers. (Haq 1983 quoting Rahman 1989). After the parliamentary election, the share of military bureaucrats was higher. Occupational background of the members shows that 48.8 per cent were attached to party politics, 16.3 per cent to military, 9.3 per cent to bureaucracy. 11.6 per cent to business and industry, 7 per cent to journalism, and the rest 7 per cent were technocrats. (GOB 1986, Alam 1993). Most of the important posts were given to the military. Another study shows that in 1988, out of eighty full, deputy and state ministers, 45 belonged to political parties and 13 to military, nine civil bureaucrats, seven intellectuals and six businessmen. (Rahman 1985) quition Rahman 1989). In May 1988, 13 of the 35 members of his cabinet were military personnel (Moniruzzana 1991, quoting Kochanek 1993: 223). The Council of Minister were just in name. Ershad and his 'mini cabinet' did most of the decision-making (Kochanak 1993:65).

There is no rigorous study of the parliament members during Ershad regime; but it was seen that businessmen, civil-military bureaucrats were in large numbers. Even at the level of party (Jatiya party) structure, most of the executive members were from the civil-military bureaucracy. Institutional mechanisms of checks and balances had hardly any meaning or justification. His patrimonial attitude and activities were reflected in every sphere of state. No decision could be taken without his consent.

Ershad and his military oligarchy wielded all power and authority. The regime survived by the active support of the army and distribution of patronage until it collapsed due to mass upheaval.

After assuming power Ershad had given priority to the economy and development. To accelerate the growth he pursued a policy of denationalization and privatization. The regime announced New Industrial Policy (NIP) in 1982 and Revised Industrial Policy (RIP) in 1986 inorder to put the main thrust of economic development into action.

The NIP had made significant changes in the development of the industrial sector in Bangladesh. Its major thrust was industrialization through the private sector leadership. The policy called for denationalization of the public sector units, liberalizing control over the private sector, improving efficiency and profitability in the public sector, promoting export oriented industries and encouraging efficient and economic import substitutions. It also emphasized upon a balance in the development and proliferation of industries in the country. Public sector activities were restricted to only six basic and strategic industries. (Humphrey 1992; Salim 1998). To promote the policy objectives, different promotional and incentives measures were introduced such as relaxation in administrative procedures, monetary benefits, credit facilities etc. Necessary directions were given to the nationalized commercial banks (NCBs) and development finance institutions (DFI) to restructure or to modify the terms of debt servicing.

The announcement of RIP gave another momentum to the development of industrial sector, particularly the private sector. It further extended and strengthened the promotional and incentive measures of NIP. It emphasized on privatization by

offering 49 per cent of shares in public sector enterprises to the private buyers. Fifteen per cent shares were reserved for the employees of the enterprises concerned. The 'concurrent list'[6] was dropped while 'reserved list'[7] was increased from six to seven. A 'priority list'[8] of six categories and 'discouraged list'[9] of twelve were introduced.

As a part of these policies, the government denationalized former Bangladeshi-owned jute and textile mills and privatized public sector enterprises. As a result, 609 industrial enterprises, 465 commercial business units and two Banks had been divested, denationalized or privatized, of which 222 (by mid 1980s) were under NIP and RIP of this regime (Hamphrey 1992:91)

To accelerate foreign investment, NIP and RIP broadened the existing incentive facilities, simplified administrative procedure and identified 84 industries for foreign investment. Special zones (Export Processing Zone (EPZ)) were established to attract foreign investment.

In the field of agriculture, another law was enacted in 1984, which again give limited of land ceiling up to sixty *bighas* (20 acres) per family. A person or family acquiring more than the ceiling permits gets compensation for the excess land surrendered to the government. It gives protection to the rural household in the course of possible eviction due to the non-payment of rent or tax. This law gives due rights to the sharecroppers. It provides for a share contract for five years and ensures two-thirds shares for the sharecropper if he arranges his own seed and fertilizer etc. If the seed and the fertilizer are supplied by the landowner, then owner will share the two-thirds (Hussain1995). The Ershad government also introduced a graduated land tax system in 1983 (Hussain and Chowdhary 1994:47).

Private sector was asked to play a pivotal role in trade and business. Government machinery was entrusted to provide maximum acceleration to the private sector. Import and export systems were liberlized. Imports could be carried out through a "letter of credit". To encourage exports, export performance benefit, duty draw back, subsidised export finance, income tax rebate on insurance premiums, bonded ware house system etc. were offered to investors (Salim 1998; Alam 1994a: 153). The volume of both export and import had increased. In export, the volume was $ 686 in 1982-83 which had increased to US$ 1524millions in 1990. The import was of US$ 2309 millions, which increased to US$ 3759 millions in the same period respectively.

The regime had devalued the Taka several times in response to the internal and external pressures. The nominal exchange rate was depreciated, and dual exchange rate prevailed. So the state control was limited. During Ershad regime, the state was promised US$15408 millions but was disbursed US$ 13465 millions, of which 47 per cent was grants (GOB 1998:133). The average GDP growth rate was 3.7 and GDP was TK.542175 (1982-90). The economy got known for low saving rate, poor domestic resource mobilization, and low rate of export growth etc. (Rahman 1992).

It is needful to mention that this regime introduced structural adjustment policies. The macro-economic performances in 1980s was discouraging (Rahman 1992). Market oriented environment was developed which had made relaxation of state control. The total economy structure was not impressive and performance remained sluggish.

The state under Ershad was dominated by military bureaucrats, who controlled the major decision making process. In the economy, denationalization and privatization

along with the leading role of the private sector were the main thrusts of the regime. The political economy of the regime had shaped the policy outline.

Table 1:1 Macroeconomic Indicators over the Periods

(TK in Million)

Items	1972-73	1979-80	1989-90	1994-95	1996-97 (P)
GDP (at current prices	49,853	196,050	737,571	1170,261	1402,580
Investment	1,50P	29,976	94,427	194,651	243,686
National Saving	-1,383	7,755	42,628	153,245	205,171
Overall Fiscal Deficit	4,656	19,412	58,100	79,700	74,800
Rate of Inflation (per cent change in CPI)	47.40	18.85	9.33	5.22	3.91
Real GDP growth rate	-.20	1.50	6.63	4.44	5.65

(P) : Preliminary.

Source: BBS 1998, Salim 1998

The Begum Khaleda Zia Regime (1991-96)

After nine years of autocratic rule of General Ershad, Bangladesh Nationalist Party (BNP) led by Khaleda Zia swept in power through a free and fair election of February in 1991. A new leadership emerged, hence the decision making process also changed. The structure of government also changed. Following the re-introduction of parliamentary system, the Prime Minister became the chief executive power in the government. Begum Khaleda Zia was a powerful Prime Minister. We can call it "prime ministerial government" rather than cabinet government. She exercised widespread power and absolute discretion. But she took decisions in consultation with senior cabinet member (Ahmed1994); she was assisted by 22

cabinet ministers, 16 state ministers and eight deputy ministers. Important ministries were given to those who had previous experience of governance. The professional category indicate that politicians, civil-military bureaucrats, businessmen and industrialists, lawyers had equal number (4) or equal percentage 18.2 per cent of representation, bureaucrats had nine per cent, landlord had 9 per cent, technocrat and professionals had only 4.5 per cent each. All of them had post graduation degrees except one, who had a Ph.D degree; and three were Bar-at-law (Compiled from Ministers lists). The army and businessmen had good representations compare to the previous regimes cabinets. These two classes are emerging as a dominant force in the Bangladesh society. BNP constitutency had strong support bases of the business community, the army and the civil bureaucrats. After the 1991 election, the parliamentarians regained power. They were able to control and regulate the government's decision making process. The opposition had 47.57 per cent of total MPs who, by their big presence played catalyst's role in the decision making process. If we look into their professional background, then we find that the businessmen and the industrialists comprised 53 per cent, and 6 per cent were ex-army officers who later on turned businessmen and industrialists, lawyers 19 per cent, landlords four per cent, ex-civil bureaucrats two per cent, professionals (doctors, teachers, journalist) 14 per cent, full time politicians two per cent and others only one per cent. The BNP parliamentary party indicates that 57 per cent of the members were businessmen and industrialists, nine per cent ex-army officers now all businessmen and industrialists, 18 per cent lawyers, 2 per cent landlords, 3 per cent ex-civil bureaucrats, 6 per cent professionals (doctors, teachers) and 2 per cent politician. Eighty four per cent of the MPs had graduation and post graduation

degrees, 50 per cent were of 46 years and above and 68 per cent had no legislative experience (Moniruzzaman 1992) at all. Various parliamentary standing committees were made with parliamentarians only as chairmen. This was another way of influencing the policy making process.

The army appearing to maintain a low profile had good relation with the government. The defence budget was increased from TK 11450 millions in 1990 to TK 18080 millions in 1995. Unlike the Mujib government, the civilian government of Khaledia Zia did not cut down on any financial benefits and privileges of the army.

This regime, believed in the notion of liberalism and free market economy, thus ushering in a new era of 'market economy' in the history of Bangladesh. High priority was given to macro-economic stability and economic growth, downsizing the role of the government, and attempts to reduce expenditure and increase taxes etc. The new industrial policy of 1991 prioritized private sector development. The NIP of 1991 had withdrawn the 'discourage list'. It introduced some regulatory measures to stop environmental degradation and promote public health. All sectors of industries except the 'reserved list' were open for private sector. Even telecommunication, electricity generation and transmission were dropped from 'reserved list' (Salim1998). Different policy initiatives were taken to boost private sector development, such as easy credit facility, tax holiday and removal of earlier bans and controls etc. 'Privatization Board' was established to oversee the divestment process. Law was passed to enable SOEs be turned into public limited companies. Twelve SOEs were privatized. Even the government introduced golden handshake policy to reduce the burden of loss in the public sector enterprises.

Foreign private investment was highly encouraged. The restriction on equity participation was withdrawn for the foreigners and foreign private capital was allowed to move without any control.

In agriculture, fertilizer and seed distribution was done by private sector participation. Subsidies were withdrawn and private sector was allowed to import fertilizer. It was stated that '*Khas*' land would be distributed to the landless.

Private sector played an important role in trade and business. Import and export policies were liberalized. Tariff rate was reduced. The share of import items increased by almost cent per cent by 1994. Exporters were given proportional income tax rebates on export earnings; the volume of both export and import had increased. The volume of import increased from US$ 3470 millions in 1990-91 to US$ 5700 millions in 1994-95 and the volume of export from US$ 1993 millions to US$ 3500 millions in the same year. In 1992, exchange rate was unified. Even Taka had been made convertible on current account to relax foreign exchange control. During this regime, the government was promised US$ 8491millions but it was disbursed US$ 8028 millions, of which 49 per cent was grant.

The average GDP growth rate was 4.2. and the economy had made significant mark in lowering the rate of inflation, building up of external reserves, and also in better handling of the budgetary process. There were high savings. The average GDP was TK.107,1358. Much progress was made by 1994 but that could not be maintained in the subsequent years.

The ruling principle of the regime was the notion of civilian government with an all-powerful Prime Minister. The economy was driven by market forces. The political economy shaped its policy structure.

The Sheikh Hasina Regime (1996-)

After twenty-one years in the Opposition, the Awami League (AL) assumed state power in 1996, led by Sheikh Hasina Wajed. The AL of 1996 had changed from its earlier policy position i.e. of the days of 1966-75. A new leadership emerged with a different outlook. Hence the nature of dominance in the decision making process got also changed.

The new government came to power in coalition with Jatiya Party and JSD (Rab). They were included, initially for forming government and finally to establish a 'Consensus' government. But all decision are taken and power rests in its hands for all practical purposes by AL. Hasina, as the Prime Minister is all-powerful and has personalized and centralized the power-structure (Kochanek1998). She has been exercising widespread power discretion. Though she also consults her senior cabinet members. She is aided by 18 cabinet ministers, 15 state ministers and two deputy ministers as on December, 1997. Their socio-economic background is not different from those in the cabinet of the earlier leaders. 50 per cent of the cabinet members are politicians, 11 per cent ex-civil bureaucrats, 11 per cent ex-army bureaucrats, 17 per cent lawyers, 5.5 per cent landlords and 5.5 per cent professionals. Important portfolios have been given to those who were in the government during 1972-75 and who worked as advisers of the party and particularly to Hasina. Most of them have graduation and post graduation degrees and a few have foreign degrees also. The Cabinet Ministers are the sons of landlords, petty businessmen, government servants and lawyers, etc. The dominant positions are held by the politicians who were with the party since long before independence. The new emerging groups like the bureaucrats, armymen, businessmen have been playing an important role in the

decision making process. Prime Minister Hasina is 'powerful' and 'more than equal' no doubt, but she takes her important cabinet colleagues into confidence.

In the Parliament, AL has 147 members and the other parties have 153 members (in the general category). But AL has majority because women members, who have got elected from the constituencies reserved for them. Since there is no study of the socio-economic status of parliament members, it is difficult to analyze their dominance in the decision making process. A general observation indicate that there is no change from the past, viz: that the businessmen and the industrialists, ex-army, and ex-bureaucrats dominate in general. Of those who won from AL ticket in 1991 election, 50 per cent were businessmen and industrialists, 24 per cent lawyers, six per cent landlords, 10 per cent in teaching, two per cent civil-military bureaucrats and 8 per cent professionals (Moniruzzaman1992).

The chairman of NEC is the Prime Minister and the executive committee of NEC is composed of the cabinet ministers. All are civilians. The planning commission is also dominated by the civilians. The sector corporations are headed and controlled by civilians who are government nominees. Most of them are AL activists, or active supporter or have good links with the AL leadership.

The regime is following liberalism and free market economy, high priority has been given to the economic growth and policies are being made to accelerate economic reforms.

The regime's industrial policy is same as of the previous government. It is giving all sorts of supports and incentives to the private sector, regarded as "an engine of growth". Policies to make state owned enterprises (SOEs) profitable by improving

efficiency and productivity have been adopted. Priorities are given for uniform development of industries at the district and the thana levels.

High priority is given to foreign investment. The multi-nationals are allowed to invest in all sectors except in five on the grounds of strategy. New export processing zones (EPZ) are being established to boost private investments. Even industrial park are being established in the private sector.

In the field of agriculture, the government believes that wherever necessary, requisite subsidies should be provided to boost agricultural growth. New export and import policy 1998 also been has announced. This has further reduced import control and provided incentive for export. Import policy has been relaxed for importing capital machinery and petroleum products in the private sector, with a few exceptions, like raw materials and fabrics for the garments industry. The rate of import duty has gone down to 40 per cent. The exporters have been given more incentives than by the earlier government. Export credit is given to the exporter for 270 days per year. He also gets, bonded warehouse facility, and has to deposit 40 per cent of his export earning to get foreign exchange etc. Tariff rate has been also reduced and a package of fiscal measures to mobilize additional revenue has been announced.

During the last two years the average GDP growth rate is 5.5 (95-97). The GDP of agricultural sector has declined to 28.9 per cent and has increased to 17.5 per cent in the industrial sector. The GNP per capita is US$ 260.

In conclusion, we can say that there is a civilian government with an all-powerful Prime Minister. The economy is controlled by the market-driven forces. The political economy of the regime is thus shaping it policy formulations.

Foreign Aids and Development Policy

Following independence, Bangladesh relations with the world community is shaped by economic considerations. It is a donar-dovee relation. She has been promised US$ 38094 millions in the period of 1971-97 but disbursed US$ 31971 millions, of which 49 per cent is grant (GOB 1998: 133). The aid comprised of food aid, project aid and non-project aid.

Bangladesh is a dependent developing country. She needs aid for her very survival and then for her development. Food for the poorest members of the population also come from these international aids. (EIU 1999). So the increased reliance on aid has become unavoidable.

Bangladesh has been taking aid on both bilateral and multilateral basis. The government is pursued or even pressurized to follow a strategy of GDP growth by massive industrialization, privatization, decontrol, liberalization and finally, by reducing reliance on foreign aid. The donor agencies prioritize different aspects and each imposes its own regulatory mechanism, which may or may not correspond to the local necessities, capabilities, and the realities. The donor ties the domestic goods and services with their aids. It neglects agriculture, which is still a major part of GDP growth in such countries. Donor policy of industrialization and privatization ultimately helps the rich and the powerful to be come more rich and more powerful. They provide aid in the name of free enterprise, free world, freedom, fighting against poverty and making a better and prosperous world. But all these hardly makes any sense in a country like Bangladesh, though a few people are becoming more and more affluent through foreign aids. The conditions of the

general population are becoming worse to worst, thus strengthening social inequality.

Bangladesh' dependence the western world is mainly for technology, and resources. She appears to be dependent even on matters of politics, economics, plans and nation buildings. Bangladesh is so dependent on the donor that she is even told what is good for her, and what should be her priority area. She is even told what values she should cherish. She is helpless and crippled as if she has nothing of her own. The government get its legitimacy and the right to run with democratic practices or not from the donors who are giving policy agenda and even areas of priority. Every sphere of state machinery is controlled by the donor community. So it can be said that Bangladesh is for the donor, by the donor, of the donor. She is in an awfully dismal state.

Conclusion

Following independence, some policies were guided by pre-liberation commitments rather than by exclusive policy compulsions (Chowdury1996). During the 1972-75 period, the decision making process was dominated by the civilians. Almost the entire industrial sector, was controlled by the state. Private sector had very minimal role. But changes in the power structure i.e. the political scenario brought in changes in the economic sector also. The quasi-presidential rule of Zia and the military autocratic rule of Ershad offered opportunities to the civil-military bureaucrats and the pure military bureaucrats, respectively to dominate in decision making. The disinvestment policy of Zia and the denationalization and privatization policy of Ershad had opened up the path for the private sector to flourish. Private sector has been offered a leading role. The SAP shaped the policy guidelines of the

governments. But, the mass uprising of 1990 had, once again, opened up avenues for the democratic practices to consolidate in Bangladesh. The governments of Khaleda Zia along with the present government of Sheikh Hasina allowed civilian supremacy. The acceptance of micro-economic reforms, by both the governments, has opened up the economy to the private sector and the foreign investor. The donor communities are heavily influencing the policy options of the government, as well as the economy in practice. The journey of political economy had started with one party dominance in the political arena and state dominance in the economic arena Now it is almost bi-party system in the political arena and free market economy in the economic arena. This was necessary to adopt to the world environment of political economy

NOTES

1. Iftehharuzzaman (1995) discussed the parton-client relation in the context of Japan's role in South Asia and Bangladesh in "Japan's role in South Asia and Bangladesh" in *BIISS Journal* Vol. 16 no.1 and also Mannan. M (1990) "The State at the formation of dependent bourgeoisie in Bangladesh" in *South Asia Journal* Vol.3&4.

2. Functioning inequality- The notion that economic inequality is the precondition for economic growth. This type of inequality was admitted by the Pakistan's economist and foreign adviser on the grounds that it would lead to faster growth and which makes possible to improve the status of lower income groups.

3. Entrepreneurial approach – High priority was given for private initiatives and private investment. The state authority asked the private initiatives to invest for new industry.

4. The outcome of 1970 election of National and Provincial assembly shows that 29.5 per cent belongs to lawyers, 27 per cent businessmen, 4.5 per cent landlords,2.6 per cent services, 9.3 per cent teachers, 7.5 per cent doctors, 5.9 per cent politicians and it also revealed that 64 per cent had college graduation (73 per cent had completed college and university) and their annual income was also more than moderate, 50 per cent had below TK20,000, 24 per cent had below TK 30,000, 16 per cent had below TK 50,000. (Jahan R 1980: PP 150-154). Sen (1987) also shows that 75 members elected from East Pakistan to National assembly, 31 was lawyers, 23 businessmen and industrialists, 12 landlords, and rest belong to other

category. Barua (1978) indicates that during Mujib regime, the AL leaders came mostly from surplus and middle class farming families with career in the district and *mafussil* (rural) towns as lawyers, *mukhters* and teachers in a private college (p-29).

5. BAKSAL: Bangladesh Krishak Sramik Awami League (Bangladesh Peasants' workers' and people league. It was created to consolidate power in the hands of Mujib and his party. Constitution was amended and allowed only one party (Baksal) and Mujib was made chief of the party.

6. The concurrent lists comprised of following sectors: jute textile, cotton textile, sugar, paper and newsprint minerals and oils and gas, cement, petrochemicals, heavy and basic chemicals pharmaceuticals, shipping and equipment and appliances for telecommunication. Both public and private sector were allowed to investment. The remaining were opened up for private sector.

7. The reserved lists listed seven strategic industries. They were arms and ammunition, atomic energy, air transportation and railways, telecommunications, electricity generation and distribution, mechanized forest extraction and currency printing. All these were kept exclusively under public sector.

8. Priority list was made on the basis of priority among concurrent lists to boost up private sector.

9. Discourage list was made for twelve industries such as deep sea trawling, white sugar etc. It was introduced for environmental reasons and serious over capacity.

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CHAPTER 2

DETERMINANTS OF HEALTH AND DISEASES

I. Determinants of Health

The health of a population is determined by different socio-economic, locational and cultural factors in a society. Differences in socio-economic factors also have different effects on health. They are the by-products of the society's internal and external factors that have been greatly influenced by factors like food, water, sanitation, housing, income, education, pattern of health care facility, foreign aid, technology, and policy guidelines etc.

Bangladesh is a small developing country. It is one of the most densely populated and poorest countries of the world. The internal and external factors that influences the state of health of the population are discussed below-

1) Economic 2) Food and nutritional 3) Social 4) Environmental

5) Health care facilities and 6) International factors etc.

Economic Factors

Income plays an important role in improving the health status of a population. Income depends on the economic activities of an individual. It is observed that there are 56 million labor forces in Bangladesh of whom 1.40 million are unemployed. In every household there are 1.48 persons earning and the income per earner is Taka 2950, But per capita income is Taka 830. In the urban areas the major sources of income are business and commerce and professional wages and it accounts for 70 per cent. In the rural areas, agricultural wages are the major source of income and it accounts for 63.1 per cent. The income pattern and the employment and unemployment situations tell us that a large section of the population is unable to

buy their food, clothing, shelter etc. Hence poor health dominates the society, in general.

The development of health status largely depends on government allocations for the health sector. It is observed that those countries which have a larger share in expenditure on the health sector, have a better status of health than those who spend less. In Bangladesh, health sector is not in the priority list partly due to limited resource and partly due to government's lack of commitment. It is observed that in the health sector the allocation of total outlay was 4.48 per cent in 1973-78, which declined to 3.72 per cent in 80-85; it further declined to 3.05 per cent in 1990-95 and 3.17 per cent in 97-2002. (MOHFW1996; GOB 1998). The allocation pattern suggests low prioritization of health. The utilization pattern of the allocation also indicates low priorities. The rate of utilization was 66.83 per cent in 1973-78 and 77 per cent in 95-97 period. The share of GDP spent has increased from 0.56 per cent in 1980-81 to 0.61 per cent in 1987-88 and 0.86 per cent in 1994-95. The per capita public spending also increased from Tk. 14.4 to Tk. 35.2 and Tk. 84.7 in the same period, respectively (Begum and Sen1997). An analysis of revenue budget for 1975-76 to 1994-95 shows that the share of pay and allowances was 50 per cent in 1975-80 which increased to 65 per cent in 1990-95 and at the same period the share of medical and surgical facilities has decreased. The share was 20.4 per cent and 16.5 per cent respectively (ibid.). A study reveals that 34 per cent of the money spent on health comes from the government, 64 per cent from households and private sector and 1 per cent from the NGOs (MOHFW 1998). Various steps have been taken to reduce government expenditure in the health sector, by making amenities user-fee and cost-sharing. Government policy documents also reveal that it is encouraging

private sector and NGOs to participate in the health sector. It indicates that government lacks the commitment for the development of health of its population. Household expenditure survey of 1995-96 shows that top 5 per cent household income per month is Taka 20615 and bottom 5 per cent income per month is TK 774. The average income per household is TK. 4366 per month and expenditure is TK 4096 in which the expenditure on food is TK. 3224 (BBS 1998a). The per capita health expenditure is TK 530 (Rabbani et.al 1997:9). Though the economic condition has improved, (from 52.3 per cent below the poverty line in 1983-84 to 49.7 per cent in 1991-92 and 49.7 per cent in 1995-96 according to head count index) yet the overall situation is not better. The increasing cost of food items aggravate the situation; inflation increased by 5.6 per cent in 1997-98. Hence, people are not able to buy their required food items and it has adverse impact on the health status of population.

Food and Nutrition

Food plays an important role in determing the health status of the population. The availability, accessibility and intake capacity of food affect health. The availability of food depends on the production stock and also import capability of the government. The accessibility and intake capacity depend on the individual's purchasing power. In Bangladesh, the production of food grains increased from 9.70 million tons in 1960-61 to 18.70 million tons in 1989-90 and 19.30 million in 1992-93. Total food grain production increased by 92.8 per cent in three decades (1960-90). But at the same period the population increased by 93.8 per cent (Alam1997: 277). During 1990-95 period, the average food availability (Production + Stock + Import) was 18752.60 thousand tons, but at the same time the requirement was

19515.40 thousand tons (@ 465 gm per person) (WFP 1996). So there was a shortage of food. The annual growth rate of agriculture was only 1 per cent compared to 4.9 per cent in 1973-78 period. The per capita availability of food grains declined to 14.98 oz/day in1994 - 95 from 16.36 oz /day in 1990-91. The per capita food intake in rural Bangladesh declined from 537 gms in 1962-64 to 523 gms in 1975-76, 488 gms in 1981-82 and 452 gms in 1995-96 (INSF 1996). This clearly shows that there is an acute shortage of food.

Nutritional status is the most important indicator of health status. The nutritional status depends on availability, accessibility and intake capacity of food, along with hygienic practices, education and income etc. In Bangladesh, nutritional problem is severe. Poverty, unhygienic living conditions, unemployment, landlessness, illiteracy, all these aggravate the situation. A survey on nutrition shows that the protein consumption declined by at least 15 per cent per capita during the last three decades. The average protein intake declined from 57.50 gms in 1964 to 46.36 gms in 1996 in rural areas and at the same period, in urban areas, it was 47 gms and 50.56 gms respectively. The per capita calorie intake in a day is 1892 in rural areas and in 1779 in urban areas which is much less than the minimum requirement of 2039 kilo calorie per capita per day. The per capita intake of vitamin A is 1668 IU and vitamin C is 32.80 mg. This consumption does not comply with all age groups and all status. The vulnerable section of the population like the pregnant women, lactating mothers, children below ten years, are the real sufferers of malnutrition. Fifty five per cent of under-five children suffer from various degrees of protein energy malnutrition. The female headed households have higher malnutrition levels than male headed households. Fifty per cent of newborn babies had less than 2500

gm weight. About 69 per cent of the population are suffering from iodine deficiency disorder. It was found in 1981-82 that 74 per cent of adult women and 73 per cent of "under five" children were anemic. It was also found that 1.7 per cent of "one to six" years children had night blindness. All these indicate that there is a severe problem of nutrition.

Social Factors

Education is one of the important factors that influences the health of a population. The literacy rate of the seven years and above is 47.30 per cent of which 50.60 per cent are male and 41.50 per cent are female (BBS 1998). Education plays an important role in reducing morbidity, mortality and fertility. It grows consciousness among the population about the ill effects of food habit, health behavior and self-medication etc. Lack of education keeps people away from basic health information. A large number of diseases can be prevented with little or no medical intervention if the population have basic education. Study shows that mothers with education have low IMR, MMR, and deliveries with the help of trained health personnel. A few years basic schooling can make a crucial difference to an individual's ability to cope with the living environment and to use the services effectively as much as to his/her awareness about nutrition and hygiene requirements (Philips1994: 28). Female education plays a major role in determining size and nutrition of the family and health care utilization (ibid.). Health awareness not only prevents illness but also promotes good health. It promotes life expectancy, nutrition level, child spacing, breast-feeding and immunization. Education makes an individual aware and a group about health needs and activates them for their needs.

It is also observed that different social factors like the availability of electricity, clothes and even entertainment facilities also help in promoting the health status of a population. In Bangladesh, it is observed that 65 per cent in urban households and 9.3 per cent in rural households can avail of electricity facility. The per capita consumption of cloth is 1026 meter per annum. The condition of poorer section is dismal. They are hardly able to maintain the minimum requirements of cloth; this causes personal hygiene problems.

Equal opportunity and equal distribution of health facilities among all ages, and sex, ethnicity is an important indicator in determining health status of a nation. In Bangladesh, equal opportunity has not been so far ensured by the state. The children and the women are the worst sufferers. The women and children have less access to the qualified doctors though women-specific development expenditure in health and family planning, in the revised annual development programs, have increased from 5.30 per cent in 1980-81 to 8.79 per cent in 1989-90 to 48.40 per cent in 1993-94 (GOB, Different years quoting Khandker 1996:439). Yet, there is no improvement on the health status of women. A study shows that women did not seek treatment because of lack of funds (63.6 per cent) and thought of such expenses as unnecessary (30.6 per cent) (khan1996: 256). It reveals that the social dynamics do not ensure equitable distribution between men and women.

Environmental Factors

Housing pattern and domestic environment are important in improving health status of the population. Studies shows that better housing and domestic environment ensure lesser chances of diseases spreading, and higher life expectancy at birth. In Bangladesh, 5.6 persons live in each household, of which 0.9 person is sick

(B.B.S1996). Most people do not have adequate housing facilities. Average land owned per household is 1.2 acre. Average availability of bed room per household is 1.5 and per capita bed room space is 41.8 square feet (BBS 1996). The occupancy rate of a bed room is 3.3 persons. The roof material of a house consists of 39.93 per cent CIS/wood, 38.16 per cent hamp/hay/bamboo, 17.42 per cent tile and 5.49 per cent cement. The wall material is 46.35 per cent hay/bamboo/leaf, 23.48 per cent mud/unbrunt bricks. 18.81 per cent CIS/brick/wood, 11.36 per cent brick/cement. (BBS 1998a) So it can be easily understood that most people live in very unhygienic and crowded accommodations.. Due to such patterns of living, numerous communicable and skin diseases are general features in most of the households. Another study shows that about 43 per cent of the rural people live in houses of grooves of bamboo or leaf. On the other hand, 5 per cent of urban population live in slums where most of the houses are made of bamboo/leaf. The houses made of hemp/hay/bamboo/leaf, have mud floors which are unhygienic, often causing worm infestation. And, most of the houses do not maintain ventilation. There is an alarming shortage of fresh air and sunlight. Hence cough, cold, fever are commonly observed among these residents. (Ahmed 1997)

Safe water plays a crucial role in maintaining and promoting improved health status of the population. Bangladesh has made special effort for safe water. Tube wells were regarded as a major source of safe water for drinking purposes inspite of the discovery of arsenic in ground water. There are 0.9 million public and 1.3 millions private tube wells. According to a national statistics. near about 97 per cent households have access to safe drinking water and 39 per cent households have an access to pure water for household purpose (B.B.S1996). So others use both safe and

unsafe water for drinking and domestic purposes safe as it was in recent past. The presence of arsenic in drinking water has emerged as a serious threat to public health. It was first detected in 1993. A recent study has confirmed that almost sixty-four districts are contaminated by arsenic (BBC 1999) Another study reveals that the water of all the tubewells of 53 per cent villages are contaminated by arsenic (Chowdhury et.al. 1998). The government of Bangladesh, development partners and international communities have undertaken appropriate steps to address the situation in the immediate and long term perspectives. Awareness campaigns are on and deep tube wells have been installed as for immediate solutions.

Sanitation is an important tool in improving and promoting health status of the population. The sanitary conditions in Bangladesh is not good enough. Only 44 per cent of population have access to sanitary latrine. It is also observed that only 47.80 per cent of the population are using soap, soil and ash after defecation (BBS and UNICEF 1998). Personal hygiene is important for health status. Yet only 20 per cent of mothers wash their hands with soap after defecation; 60 per cent wash with soil or ash and another 25 per cent do not use anything other that water. This shows that personal hygiene situation is in a poor state. People do not even wash hands before eating. The washing of clothes and utensils are also not done hygienically. It is observed that 75 per cent of illnesses are due to lack of safe drinking water and the prevalence of insanitary practices (Ali 1992). Hence various bacteria borne diseases are prevalent among this group of people. Health and demographic surveys indicate that about 58 per cent of people use field canals for excreta disposal. It was also observed that 77 per cent of the total investment in water supply and sanitation over

the period of 1981-90 was in urban areas only. But the share of urban slums was very low (quoting Ahmed and Shuaib 1995).

Environment plays an important role in promoting health status of the population. Though there are some improvements in the level of general environmental quality and awareness, it is not yet satisfactory. The government has taken necessary steps to promote the health of the people. Acts have been enacted and new ones are about to be made or even implemented. The solid and water wastes are the major sources of environmental degradation and therefore constitute health hazards. In the rural areas there is no system to manage solid and water wastes. In the urban areas, local government authorities, and water and sewerage agencies are working for wastage management. But their activities are very limited and they are able to cover a small area. Recently it has surfaced that Dhaka city gets flooded with lead poison highest in the world. Government has not yet take in any initiative to control this. Solid, water and air wastage management to control the diseases is in a poor state.

Health Care Facilities

The availability of and accessibility to health care service facility is the most important input in improving and promoting health status of the population. Bangladesh has been able to create 4200 union sub centers and union health and family welfare centers, 390 thana health complexes, 34786 beds, 13 government medical colleges, three dental colleges and eight private medical colleges. It is observed that government is able to provide health care facilities up to 93 per cent at the union levels and 94 per cent at the thana levels. But these institutional facilities lack different types of other facilities such as laboratory, x-ray machine, blood bank, and even health personnel. Some of the USC/UHFWC and THCs lack furniture also.

But, significant improvement has been made in health man power development. There are one physician for 4572 people, one bed for 3151, the doctor-nurse ratio is 2:1. There are 21,000 Health assistants and 23,300 family welfare assistants (DGHS1998). There is still shortage of health manpower when compared to international standard. There is a huge shortage of mid level health personnel. There is a shortage of medicine. Inadequate attention from the doctors and above all their non-availability are the most crucial problems. A survey shows that 50 per cent of the outreach center are not functional, 60 per cent of the health facilities are without health personnel and/or supplies (Ahmed 1995) Another survey shows that 63 per cent had inadequate physical facilities, 60 per cent had inadequate personnel, 80 per cent faced a shortage of vaccines or supplies of medicines (Ahmed1997).

The access to the health care facilities has been made limited by several factors like inadequate health facility, high cost of care, low education level, low income, long waiting time for treatment and distance of health care centres from home etc. A study shows that 15 per cent of illnesses remained untreated and though among those who received treatment, 85 per cent received allopathic treatment. Ninety per cent of the poorer households fall in the category of untreated illness. The educated persons have better accessibility to qualified doctors and other health facilities. The illiterates usually consult non-qualified doctors (Rahman and Ali 1996) It is also observed that the average waiting time for treatment is 36 minutes the average time to reach health facility is one hour and the average distance is 2.30 miles. But, the average contact time at OPD is only 3 minutes (Khan 1994). This clearly indicates the acute limitedness of accessibility.

The equitable distribution of health facilities and health personnel also helps to improve the health status of the population. It is observed that better health facilities are concentrated in city centers or urban areas. A study shows that almost all the households in the metro area (Dhaka city) live within two kilometer radius of a general hospital or clinic (Khan 1996), where the average distances is five kilometers for about ninty per cent of the population (DAS et.al. 1991:72). It indicates that there is a high concentration of hospitals and clinics in urban areas. The study also shows that the urban hospitals have no problems with regard to the health personnel. But the USC/UHFWC and THC always face the shortage of doctors. The health personnel are not evenly distributed between rural and urban areas.

The distribution pattern is top-down approach, hierarchical in nature. The super-specialized facilities are clearly located at the most important administrative level. It indicates rural-urban disparity in the provision of health care. One third of the sanctioned post are vacant in rural hospitals. The annual development program of 1994-95 indicates that 57 per cent of total investment in health sector would be spent on construction of hospitals and training institutions of which 51 per cent will be spent at the tertiary level. This clearly indicates urban bias. According to health information unit (HIU) in 1990 there were 19,699 hospital beds for urban areas and 13345 beds for rural areas (Das et.al 1991), which further indicates urban bias.

Handing of delivery cases is an important indicator in determining women's position in the society. Only 17.9 per cent of deliveries are conducted by trained personnel (B.B.S. & UNICEF 1998) and the percentage of institutional delivery is

only 6.2 in urban and only 3.8 per cent in the rural areas (ibid.). It indicates that the government is unable to provide equitable health care among the population.

In Bangladesh percentage of elderly population is eight. They have old age problems and diseases are more common. The prevalence of morbidity among elderly population is 297 per 1000 population. The government has not made any special provision to look after the health of the aged. The children below five years constitute near about 13 per cent. There are some provisions for the children but it is still below the requirements. All these reveal that there is a lack of equitable distribution among different age groups and genders.

The availability and accessibility to drug also influences health, In Bangladesh there are 709 drug companies of which 34.41 per cent is unani, 28.77 per cent is allopathic, 26.93 per cent ayurvedic and 9.87 per cent homeopathic and biochemic. In the allopathic sector there are 204 private(local), eight multinational and two public sector companies producing worth medicines Tk 128.64 billionsin 1996 Tk 137.59 billionsin 1997, but the share of the local companies (private and public) have been 75 per cent and 76 per cent, respectively (Drug Administration 1997). In 1997, the national market of allopathic medicine consisted of about Tk 137.59 billions for 122 millions population and per capita availability was of Tk 123 approximately. The average general expenditure per patient for medicine is Tk 540. It indicates that there is a shortage of medicines. Though government imports "finished drugs", but per capita availability of "finished drugs" is of Tk five to six only. The annual per capita drug expenditure in Bangladesh was only US$ 2 in 1990 (Pallance, Pagany and Forstner 1992) So, there is a net shortage of drugs. The population had limited access to modern drugs with 30 to 85 per cent of the

population being benefited, depending on the situation. (WHO1984; Patel 1983 quoting Reich 1994). In the rural areas, the price of medicines is higher than in the urban areas. The government has shown poor performance in drug regulation which is clear from the fact that 95 per cent of consumption takes place directly from the pharmacy purchases. There is even over prescription of medicines. It was reported that a three years old girl with shigellosis, was prescribed 16 different medications. A study shows that government is able to provide only 10 per cent medicines to the patients who seek primary health care.

International Factors

Foreign assistance also determines the health status of the population. Different bilateral and multinational donors are investing a large share of money in the health sector. The share of foreign aid is increasing over the years. The proportion of foreign aid was 14 per cent in 1975-80, which had increased 25 per cent in 1980-84 and 43.3 per cent in 1984-88 (Khan1997: 20). The share for development allocation during 1988-90 was US$ 73.89 millions(ibid.). (Das et.al. 1991:57) During 1988-90, donor communities had allocated US$73'89 millions (ibid:59). During 1990-95, the share of project aid (foreign aid) in development allocation further increased to 87 per cent (MOHFW1996). Another document shows that in the period of 1990-96, US $ 4709.41 millions was disbursed by different donors community such as IDA, CIDA, KFW, NORAD, OAD, SIDA, GTZ, EEC, Australia and the Netherlands in the health and family planning sectors. Till the duration of the Fourth Health and Population Project the donor communities had disbursed US $ 970.9 millions (MOHFW 1996:1-2). It reveals that foreign aid played an important role in the development of health status of the Bangladesh is. The country is dependent not

only for money but also for technology, servicing of sophisticated modern medical instruments, experts, etc. the donor community, chalks out the policy guidelines also.

Conclusion

There are problems with food availability and accessibility, nutrition, sanitation, potable water, housing, education, income, environment, health service system and drugs, etc. All these accentuate the health problems. This is why there is a poor state of health in Bangladesh.

II. Major Diseases in Bangladesh

We just discussed that the status of health is in a poor state because the inputs of health are in a poor state. The morbidity per 1000 population is166. In the urban areas it is 151 and in the rural areas it is 172, while it is 156 for men and 177 for women. The morbidity rate for elderly person is 297/1000 and 266/1000 for children of 1-4 years. The crude death rate is 8.5/1000; it is 9.2 for rural areas and 6.9 for urban areas (B.B.S 1996). The disease profile of the country (based on hospital records at the district levels and below) indicates that mainly ten diseases cause the highest mortality. These are diarrhoeal disease, intestinal worm infestation, skin disease, peptic ulcer, acute respiratory infection (ARI), anemia, micro-nutrient deficiency diseases, pyrexia of unknown origin (PUO), eye disease and injuries (DGHS1998: 76). A study conducted by the Institute of Epidemiology, Disease Control and Research (IEDCR) in 1993, found that the prevalence of morbidity is 4.5 per cent. The study reveals that diarrhoea and dysentry, ARI, peptic ulcer, viral fever and malaria are the major diseases which are the major causes of morbidity.

Understanding the severity of the disease related problems, the government of Bangladesh has taken necessary measures to reduce the prevalence of morbidity rate among the population. Different programs have been implemented to arrest the diseases, which are more prevalent and endemic among the population.

Diarrhoeal Disease

The prevalence of diarrhoeal disease among the population is 14.28 per cent. The highest rate of morbidity is between mid-February to mid May. It is a water brone disease. It occurs due to use of unsafe water for drinking and household purposes, not using sanitary latrine, unhygienic practices and nutritional deficiency etc. The children under five years are the worst sufferers from diarrhoea. The prevalence of diarrhoea is 16.90 per cent for boys and 15.70 per cent for girls among this age group. Only 19.10 per cent seek help from government facilities and 45.80 per cent go to the unqualified practitioners (B.B.S.& Unicef 1998). Different organizations are working to arrest the diarrhoeal disease. These organizations are government, development partners, non-governmental and voluntary organizations etc. They have taken initiatives like installation of tube-wells, and sanitary latrines, educating the people, imparting knowledge about hygienic practices, encouraging breast feeding, providing oral dehydration saline, and nutrient supplements, etc.

Worm Infestation

The prevalence of worm infestation is 12.30 per cent. There are no observable trends of reduction. BBS survey indicates that out of 292 cases of worm infestations, 14 per cent were in those households who had access to safe drinking water and sanitary latrines, and 80 per cent in those which had access only to safe drinking water. The disease occur due to huge food loss and other environment factors, such as, lack of

sanitary facilities, defecation practices, over population with high proportion of children etc. (Khan 1997). The government is educating people in health practices to arrest the disease.

Expanded Program on Immunization

Under the banner of EPI, three doses of diphtheria, pertussis and tetanus (DPT), three doses of oral polio vaccine (OPV), one dose vaccine for measles for children under one year, one dose BCG (Tuberculosis) for children under two years and two doses of tetanus toxoid (TT) for pregnant women have been administered since 1979. The programme has been undertaken to reduce the morbidity and mortality of infants and mothers. According to BBS (1996) survey the prevalence of morbidity is 14.7 per cent per 1000, and 8.4 per 1000 in "under one year" "and "one to four year" respectively. The proportional morbidity of immunizable disease is measles 1 per cent, poliomyelitis 0.3 per cent, whooping cough 0.4 per cent, Diphtheria 0.1 per cent and Tuberculosis 0.5 per cent. Different organizations such as government, NGOs, donor agencies and private sector are working to make the EPI programme a success. The share of allocation of GOB for EPI has increased from 27.22 per cent in 1980-85 (1st phase) to 42.19 per cent in 95-2000 (4th phase). The total amount of allocation for routine EPI increased from Tk. 46.42 million to Tk 4103.58 million in the same period. The service of EPI has extended up to the village level. The program has been able to transform the government programs into people's programs (DGHS1997). It was estimated that the death of 1.2 million children has been prevented since 1985 (DGHS1998). The morbidity of children and pregnant women from EPI diseases has been greatly reduced by successful implementation of the programs. The success rate can be attributed from table no. 2.1. The percentages

of infants reaching their first birth day and getting fully immunized against diphtheria, tetanus, whooping cough, polio, measles and BCG (TB) and of women during pregnancy are shown on the table that the success rate of DPT_3, OPV_3 measles, BCG and TT_2 are 66, 66, 59, 88 and 72, respectively in 1996 (DGHS 1997:41)

Table 2:1 Success Rate of EPI and TT

Figure in percentage

Year	DPT_3	OPV_3	Measles	BCG	TT_2+
1991	60	60	53	86	78
1994	74	74	71	95	80
1996	66	66	59	88	72

Source: Coverage evaluation survey1991-94 and 1995-96. Routine reports cited in DGHS1997: 41

The reported coverage of EPI for children under one year and TT of women are BCG 100 per cent, DPT 3 97 per cent, OPV_3 97 per cent, Measles 96 per cent, TT_2-90 per cent. The percentages of the immunized children of 12-23 months with DPT_1 and OPV_1 were 83.7 per cent, DPT_2 and OPV_2 79.6 per cent, DPT_3 and OPV_3 75.9 per cent, Measles 73.9 per cent, BCG 71.1 per cent, all vaccination 65.4 per cent (B.B.S.1996).

The success of EPI programmes has been a great impetus to the government to formulate and execute policy network; the community has been inspired to change their health-seeking behavior.

Acute Respiratory Infection (ARI)

The prevalence of morbidity due to ARI in "under five years" children is 7 to 9 times per year. 40 per cent to 60 per cent of out door visits and 30 per cent to 40 per

cent pediatric admissions are due to ARI associated illnesses. Thirty-three per cent of deaths under five years are also caused by ARI. (DGHS1997: 49) Pneumonia is caused by ARI and the number one cause of mortality in all the years between 1993-96 (DGHS1998: 96). The disease is caused by malnutrition, low birth weight, indoor air pollution, exposure to cold and behavioral factors that influence care from the mother (Khan 1997). Training and capacity building amongst the doctors, and the health workers to identify, the disease, and then treat and refer ARI cases is important. Communication, information, education to increase public awareness and knowledge about care taking is also essential. The government and NGOs are working to control and reduce morbidity and mortality due to ARI.

Malaria

The prevalence of morbidity due to malaria has increased, over time, from 1.67 per cent in 1982 to 6.03 per cent in 1992 and then, to 10 per cent in 1994. It decreased to 8.8 per cent in 1996. Annual parasite incidence (under surveillance) increased from 0.52/1000 in 1982 to 1.43/1000 in 1994. *Parasitic falciparum* also increased from 40.74 per cent in 1982 to 48.64 per cent in 1994 and to 53.84 per cent in 1996 (DGHS1998: 91) The number of deaths was 35 in 1994 and 183 in 1995. (B.B.S 1998:592-93) A new strategy has been implemented to control malaria disease, which includes early diagnosis and prompt treatment, recognition of treatment failure, and management of severe and complicated cases in hospitals (DGHS1997: 45). Necessary steps have been taken to control its outbreak in the epidemic prone areas.

Tuberculosis

The prevalence of "smear positive tuberculosis" cases in Bangladesh is estimated to be 111/100,000 population. The annual incidence of any form of TB is 246/ 100,000 population. The survey of 1997 gives an estimation of 2.27 per cent annual risk of TB infection for the year 1996. It has also estimated that more than 50 per cent of the adult population has been exposed to *mycobacterium tuberculosis*. After the inception of registrations, the number has increased from 45,786 in 1994 to 69,885 in 1996. Of the reported pulmonary cases, 51.90 per cent were smear positive (DGHS1998: 92). To control TB, rigorous programmes have been initiated since 1993. The national tuberculosis program (NTP) was combined with leprosy control activities and also integrated with the general health services. There are 4 TB hospitals, 8 segregation hospitals, and 44 TB clinics. Training was provided to 800 doctors, for effective implementation of NTP (DGHS1998: 92). In the period November 1993 to December 1996, the programme achieved "successful treatment rate" of 78.80 per cent in new pulmonary smear positive patients. But, an estimated 52,000 deaths occurred due to TB infection. Government and NGOs are working hard to arrest TB. Information, education and communication activities to control TB are strengthening.

Leprosy

The prevalence of leprosy is 3.5 per 10,000 population (estimated) with a registered prevalence of 1.15 per 10,000 population. The prevalence of leprosy has declined from 13 per 10,000 population in 1992 to 3.5 per 10,000 in 1997 (DGHS1998: 93). To control leprosy, different initiatives were taken such as training of 29000 health workers, including 1000 doctors, introduction of multi-drug therapy (MDT) Units,

strengthening of information, education, communication activities, detection of cases, etc. (DGHS 1997:44). The government and NGOs are working in 56.60 per cent and 43.20 per cent units of MDT facility. The success rate of MDT is 100 per cent. (DGHS 1998: 94)

Kala-Azar Control Programme

In 1995 there were about 40,000 cases nationally. It was also estimated that 20 million people in 27 districts and 88 thanas are at risk. The incidence rate is one per 1000 in the affected areas (DGHS1998: 90). To control the Kala-Azar, an emergency action plan was initiated in 1994-95 in 22 thanas of 11 districts with a population of 5 millions (DGHS1997). Direct Agglutination Test (DAT) laboratories for sero diagnosis were established in 5 districts in 1996 and 6813 cases were detected in this period. Early diagnosis and prompt treatment along with information, education and communication programmes have strengthened the control of Kala-Azar.

In addition to the above-mentioned disease control programmes, there are ongoing have programs to control filaria, cancer, HIV/AIDS and STD, goiter, viral hepatitis, and cardio-vascular disease, etc.

It is observed that out of the top ten causes of death, six of them are preventable. It is also seen that out of the top ten causes of morbidity, all of them are preventable. Many morbidity and mortality cases can be averted if necessary steps are taken by the individual, the community and the government at the right time and in the right manner.

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CHAPTER 3

HEALTH CARE PATTERN IN BANGLADESH

I. Health Services System in Bangladesh

Health services system does not merely confine to providing health care, but it also includes a network of institutions for training, education, research and evaluation. It strengthens the former by providing trained personnel who perform different activities through an organizational structure of medical technology, which is available and accessible to a population.

The health services system of Bangladesh is comprised of three major sectors: 1) public, 2) private and, 3) NGO cum Voluntary sector. In terms of size and network the public sector is the largest sector. It has large organizational set up and manpower. The private sector is scattered all over the country. Qualified practitioners of Allopathy working in the private sector are concentrated in the urban and the affluent areas. NGOs and voluntary organizations (VO) are spread all over the country including the rural areas. The NGO activities are mainly limited to their group members and run more or less on profit motive, while VO activities are not confined to any particular group. Rather, they work for the entire population and work without a profit motive.

Health Care Delivery System

The health care delivery system has a network from village level to national level. The structure is based on top-down approach. All the decisions regarding manpower development, development of facilities, resource allocation, policy formulation etc. are mainly done at the central level. The lower level organizations do not have a say

in the decision making process. They mainly carry out decisions taken at the higher level. The health care delivery system is structured in the following way.

National level: At the national level, there are national specialized institutions. They provide wide range of services, such as medicine, cardiology, nephorlogy, neuro-surgery, cardiac surgery, opthalmology, dentistry, mental disease, cancer, orthopaedics, diabetes etc. These institutions are Bangabundhu Sheikh Mujib Medical University (BSMMU), Institute of Rehabilitation and Hospital for the Disabled (RIHD), National Institute of Opthalmology (NIO), Institute of Disease of Chest and Hospital (IDCH), Institute of Cardiovascular Disease (ICVD), Infectious Disease Hospital (IDH), Institute for Cancer Research and Hospital (ICRH) etc. These institutions have a bed capacity varying from 50 to 600 on an average. The Institute of Post Graduate Medicine and Research (IPGMR) was established during late 1960s. It was renamed as a BSMMU in 1998 without any change in major infrastructure. It was a more politically motivated decision; the development of health facilities was secondary. It has a bed capacity of 600. There is no free beds. RIHD was established in 1972 as a temporary arrangement and later on in early 1980s shifted to a new building. It has 450 beds of which 290 are free-beds. IDCH was established in mid 1970s and has a bed capacity of 500 of which 340 are free-beds. NIO was established in 1978 and has a bed capacity of 100 of which 60 are free-beds. ICVD was established in 1976 and has a bed capacity of 250 of which 200 are free-beds. IDCH, Dhaka was established during early 1960s. It has a bed capacity of 100 of which 60 are free-beds. ICRH was established in early 1980s and has a bed capacity of 50. All are free-beds. The institute of mental health was established in late 1976 and has a bed capacity of 50. All are free-beds. The mental

hospital, at Pabna was established during early 1960s and has a bed capacity of 400 of which 280 are free-beds. The Dental College and Hospital was established in early 1970s and has a bed capacity of 20 all are free beds. The BSMMU covers a wide range of health care facilities while the others have only specialized type of health care facilities. These institutions provide both in-patient and out-patient services. These institutes are meant to follow-up the cases referred by various medical colleges hospitals and other hospitals. Unfortunately the referral system hardly works in Bangladesh. It has been observed that there are more free-beds than paying beds (Table 3:1). It is not easy to get admitted for in-patient care. Those who can manage to use some influence or are ready to adopt extra-procedural ways, may be able to avail of the facility. Even, if the members of the poorer section get admitted to these hospitals, it is difficult for them to bear the expenses of the services. This given us an impression that the medical services in Bangladesh are mostly available to the affluent and the elites of the society who can avail these facilities.

Table 3:1 No. of free beds at Different Level of Health Facilities

Level	Total Beds	Free beds
National Level	2575	1375
Regional Level	7012	4774
District Level	4450	4440
Thana and below level	12292[1]	12292
Total	26329	22854

Note : *Narayanganj 200 beded hospital has 190 free-beds.

[1] THC data is calculated for 390 THCs & 8 RHC

Source: Compiled from DGHS 1998 and GOB 1998.

Regional level: At the regional level, the medical colleges and hospitals provide a wide range of specialized and better laboratory facilities for the treatment of complicated cases. These institutes are required to take-up the cases referred to by the thana and district hospitals. There are 13 public medical colleges and hospitals with bed capacities varying from 250-1050. Dhaka Medical College was established in 1946, in Chittagong in 1957, in Rajshahi in 1958, Sir Salimullah in 1962, in Sylhet and in Mymensingh in 1962, in Barisal in 1968, in Rangpur in 1969, and in Dinajpur, Bogra, Khulna, Faridpur and Comilla in 1992. The Dhaka medical college has 1050 bed capacity of which 580 are free beds. Chittagong has 996 beds of which 546 are free beds. Salimullah has 600 beds of which 428 are free beds. Rajshahi has 500 beds of which 292 are free beds. Rangpur has 650 beds of which 448 are free beds. Mymensingh has 650 beds of which 428 are free beds. Sylhet has 500 beds of which 328 are free beds. Barisal has 650 beds of which 475 are free beds. Faridpur, Comilla, and Khulana, has a bed capacity of 250 each with 182, 190 and 184 free beds, respectively. It is as difficult to get admitted in these hospitals as it is in the national hospitals. Hence the higher income groups are more benefited by the services. In addition to these medical colleges and hospitals, there are a few regional hospitals viz: Leprosy hospitals at Sylhet and Nilphamari. These two hospitals together have a total bed capacity of 130, Infectious disease hospitals at Rajshahi, Khulna, Chittagong and Sylhet together have a total bed capacity of 180, TB hospitals at Rajshahi, Khulana, Chittagong, and Sylhet hold altogether 406 beds. TB segregation hospitals at Bogra, Pabna, Jessore, Barisal, Brahmanbaria, Feni and Rangpur cater to the needs with a total bed capacity of 160. The bed facility of these

infectious, leprosy, tuberculosis hospitals are free of cost. These hospitals, anyway, provide only specialized care for particular disease.

District level: At the district level, there are 59 hospitals, established over a period of time. Thirteen district hospitals and 38 sub-divisional hospitals together had a bed capacity of 2204 during the period of 1972-73. The number of district hospitals has cumulatively increased in the following years 37 in 1978, 43 in 1983 and 59 in 1984. Presently these hospitals have a bed capacity of 50 to 150. Of the total number of district hospitals presently existing in the country are 43 hospitals with a bed capacity of 50 each, 14 hospitals have 100 beds each and two hospitals have 150 each. This must be mentioned here that Narayanganj has one more hospital beside the district hospital, which has 200 bed capacity. It has 10 beds which are available on payment. These hospitals provide both in-patient and out-patient services. The district hospitals are expected to take up the cases referred to by THCs for further treatment. They provide specialist, laboratory and diagnostic services. The bed facility of these hospitals are available at free of cost. But this does not necessarily provide the poorer section an easy access to the services of the district hospitals. Admission for in-patient care is also tough. The poor are neglected while the upper sections are mostly benefited by the services. Besides district hospitals, there are 24 school health clinics, 44 TB clinics and 72 urban dispensaries at district level. They only provide out-patient services.

Table 3:2 Level of Care, Health Facility, and Population Covered

Locational Level of Health Care	Administrative Unit	Health Facility	Population covered
National level of health care	National/Capital	Highly Specialized Facility (50-600 bed capacity each)	Nation as a whole
Regional level of health care	Division or District	Teaching Hospitals (12) (250-1450 bed each)	10-25 million
District level of health care	District (64)	District Hospital (59) (50-150 bed capacity each)	1-2 million
Than and below level of health care	Thana (460) Rural Thana (397)	Thana Health Complex (390) (31 bed capacity each)	200,000-450,000
	Union (4403)	USC/UHFWC 4200	21,000
	Word (13209)	Community based FWA/HA	7,000
	Villages 58000 (approximately)	Traditional Birth Attendants (7BA) & Village Health Volunteers (1,10,000 out reach sites)	1000-1500

Source : DGHS 1998 with some modification

***Thana level** (Police station as well as lower administrative tier below district)*: At the thana level, there are 390 health complexes (THC) with a bed capacity of 31 in each, of which 6 are reserved for maternal health. There are 160 rural health centres, which had been upgraded to thana health complex in 1972-73. The number of THC has increased at an impressive rate from 253 in 1978 to 280 in 1981, to 344 in 1984 to 382 in 1995 and 390 in 1997. These complexes provide both in-patient and out-patient services. In addition to general services, they also provide specialist care in medicine, surgery, gynaecology, MCH and dentistry. It is entrusted to provide primary health care services. There are two health complexes at Char Jabbar and Dohazzari with 31 bed capacity of each. In addition there are 14 rural health centres with bed capacity of 10 each. THCs are designed to work as referral institutions for USC/UHFWC.

***Union level** (Lower administrative unit below thana and ward) :* There are 4200 union level sub-centres (USC) / Union health and family welfare centres (UHFWC). It is the smallest and most peripheral health family planning and MCH care unit. This center provides out-patient service for simple injuries and ailments. It has no surgical or bed facilities.

Ward level: At the ward level (lowest administrative unit with a population of 7000) there are health workers who provide doorstep services. A health worker visits each household for a period of four to eight weeks. They provide domiciliary services.

Village level: At the village level, there are satellite clinics, aiming at providing health care delivery system. There are near about 1,10,000 outreach sites known as satellite clinics. A satellite clinic is held in the house of a local influential person once in a month. The patients are motivated to go to the clinic. These clinics provide EPI, MCH, ORT services and educate people about health, nutrition, sanitation and personal hygiene and also monitor communicable diseases. These satellite clinics are held with the joint efforts of a health assistant (HA) and a family welfare assistant (FWA) who are assigned specifically for the ward. The village health volunteers also help in organizing the clinics. The HA is more concerned with health education, monitoring communicable diseases, participation in EPI, distribution of ORS, etc., while FWA is more concerned with MCH, nutrition, family planning etc.

In addition to Directorate of health services, there are a few hospitals under different ministries. Under the Directorate of Family Welfare, there are 96 maternity centres with total bed capacity of 748, nine railway hospitals with 476 beds, 19 jail hospitals

with 1003 beds, 20 police hospitals with 768 beds and one Madakashakti (addiction center) with 50 beds.

Health delivery system are provided by NGOs, VOs and private sectors too. There are around 425 NGOs who are working in the health sector. They are providing services both in rural and urban areas. They operate community level clinics in the country. They provide services through their health workers. They charge money from their group members as well as others. For example, in 1996, BRAC, a renowned NGO in Bangladesh, charged TK. 10 as a consultation fee for the BRAC families and TK. 20 for non-BRAC families. Voluntary Health Services Society (VHSS), an umbrella association of NGOs, is the confluence of as many as 131 NGOs including international (15), national (20) and local (96) groups. Local NGOs are covering 13078 villages while national and international groups are incharge of 9088 and 3132 villages respectively (Ahmed, 1997). A few hospitals are run and managed by voluntary organizations, such as BIRDEM by Diabetic Association, Eye Hospital by Lions Club, Holy Family Hospital by Red Crescent Society and Kumudini Hospital by Kumudini Trust. Each hospital has their own fee structure. There are also hospitals which are run by individuals, groups and societies / associations such as Al-Raze hospital (Dhaka), Metropolitan hospital (Chittagong), Ibne Sina hospital (Dhaka). Hospitals apart, there are large number of clinics. Though most of these clinics have only outdoor facilities, some of them have indoor facilities also.

A large number of private practitioners, both qualified and non-qualified, make health provide at the doorsteps of the people. Though no systematic study of their distribution by area is available. Causal visitors would notice that qualified

practitioners are more available and concentrated more at city centres or economically affluent areas where they get more fees. In contrast unqualified practitioners are commonly seen at rural and economically backward areas.

Education and Training

There are wide ranges of educational facilities existing in Bangladesh. The educational institutions offer various types of degrees to the different categories of health personnel.

Medical education: The medical institutions offer various opportunities ranging from training programs to courses for post-graduate degrees.

Post graduate degree: There are seven institutes such as BSMMU, ICVD, RIHD, NIO, IDCH, Bangladesh College of Physicians and Surgeons (BCPS), National Institute of Preventive and Social Medicine (NIPSOM). These institutes offer degrees as well as diploma. All these institutes are located at Dhaka. BCPS is the highest academic body, which offer FCPS degree.

Graduate Degree: There are thirteen and eight medical colleges in public and private sector respectively. These colleges have an affiliation with different universities who offer Bachelor of Medicine and Bachelor of Surgery (MBBS). The public sector colleges have student intake capacity of 50-150 but the total intake capacity is 1450. The private sector has intake capacity of 30 to 50. In addition to medical colleges, there are one dental college in Dhaka and two other dental colleges attached to Chittagong and Rajshahi medical colleges with a cumulative intake capacity of 130 students per year. The out-turn capacity of 13 medical colleges is 1200 and of dental colleges this is 60 only. There is no study about the socio-economic background of medical students. But a general observation says that

from early 1980s, most of the students are from urban areas and are they educated from reputed schools and colleges and their parents have a moderate income. The fees of public medical colleges are nominal. The state provides subsidy to them. But the fee at private medical colleges is much higher which only the upper middle class of the society can afford. Paying capacity of the students is the most important precondition for admissions in the private medical colleges. Marks obtained in the examination is the criterion for admission in public medical colleges, where sixty per cent of the seats are in the open category while thirty per cent are reserved for female candidates. Five per cent of the seats are reserved for the tribals and five per cent for the children of freedom fighters. In the open category students are selected from district based quota.

Para-Medical Education

Two institutes in Dhaka and Rajshahi, known as Institute of Health Technology, were established in early 1960s and early 1970s, respectively. They offer wide range of specializations. The students get trainings to become Laboratory Technicians, Radiographers, Pharmacists, Sanitary Inspectors, and Dentists. The colleges offer graduation degree. The intake capacities of these institutions are 250-300 and out-turn is near about 200 (table no 3:3). Apart from these, there are eight training schools at Bogra, Serajganj, Kushtiya, Bagerhat, Faridpur, Tangail, Comilla and Noakhali, offering "medical assistant course". It is a diploma course, offered by Bangladesh Medical and Dental Council (BMDC). Four of these schools were established in 1976 and another four in 1980. The intake capacity of these school are 400-500 and out- turn is near about 300 (Table no. 3: 3)

Table 3:3 Outturn of Doctors, Nurses, Dentist, Medical Technologists, and Midwives

Personnel	1973	1978	1983	1988	1993	1996
Doctors	518	761	1408	1077	1036	1039
Dentist	31	27	28	50	56	46
Postgraduate Doctors	n.a.	53	143	279	335	362x
Medical Technologists	70	96	85	153	162	131
Nurses	n.a.	467	653	390	1195	1052
Midwives	n.a.	205	522	n.a.	n.a.	n.a.

Note : 'x' indicates other than column source; n.a. indicates not available

Source : BBS, Statistical year books various years; DGHS1998

Nursing Education

There is one college of Nursing and thirty-eight Nursing Institutes. The former offers a two-year course leading to B.Sc. degrees in Nursing or Public Health. The nursing diploma holders are eligible for admission. On the other hand, the Nursing institutes offer four-years training program offering diploma to those who seek nursing as a career. The Nursing college is situated in Dhaka and was established in 1976-77. Graduation degree is offered by the affiliating university while diploma is offered by Bangladesh Nursing Council. Among the nursing institutes, eight are attached to eight medical college hospitals, at Dhaka, Mitford, Mymensingh, Chittagong, Sylhet, Rajshahi, Rangpur and Barisal, a total intake capacity of 475 students. Eighteen nursing institutes are attached to eighteen new district hospitals with a total students intake capacity of 360 and twelve are attached to twelve general hospitals of old districts with a total students intake capacity of 300. The total out turn of nurses is 900 per year.

Research

A large number of institutions are actively engaged in health research. They are doing clinical as well as non-clinical research. Some of them are in public sector and others are in private sector. The public sector institutions are Dhaka University, Bangladesh Medical Research Council (BMRC), BSMMU, ICVD, NIPSOM, Bangladesh Institute of Development Studies (BIDS), and ICRH, Institute of Public Health (IPH), Institute of Public Health Nutrition (IPHN), Institute of Epidemiology, Disease Control and Research (IEDCR). BMRC is the pioneering institution in medical research. It not only guides research activities but also provides funds to individuals and other research organizations for the purposes of research. These institutes were established over a period of time. For example, NIPSOM was established in 1976, IPH in early 1950s, IPHN in 1979, IEDCR in 1980, BMRC in 1974, DU in 1921, BIDS in 1971. BIRDEM, established in1976, and National Hospital established in early 1950s are in the private sector. The pioneering non-government organizations are Bangladesh Rural Advancement Committee (BRAC, 1972), Proshika (1976), Association for Social Advancement (ASA, 1978), Gonoshathya Kendra (people health center, 1972), Grameen Bank (1982) etc. International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B, 1978), is an important international organization.

Health Personnel

There are different types of health personnel, who make the health systems more effective in providing health services. Without their joint effort, health service worth its name is not possible.

Table 3:4 Pattern of Health Care Growth in Bangladesh

Year/Facilities/Personnel	1973	1978	1983	1988	1993	1996
Total Hospitals	308	424	724	875	903	933
Government hospitals	302	388	560	608	611	645
Private Hospitals	6	36	164	267	272	288
Total Beds	12311	19538	2557	33334	35280	37527
Beds in Public	10449	16853	20286	26871	27637	29502
Beds in Private	1862	2685	4771	6463	7643	8025
Total Medical Colleges	8	8	9	9	17	19
Private M.C					3	6
Postgraduate Medical Institutes	1	3	6	6	6	6
District Hospitals	13	37	43	59	57	60
THCs	160	253	319	352	372	381
USCs	1275	1275	1275	1275	1362	1362
UHFWCs	n.a	n.a	n.a	1050x	n.a	2794
Medical Assistant Training Schools	n.a	n.a	8	8	8	8
Para medical Institutes	1	2	2	2	2	2
Nursing Training Institutes	5	n.a	n.a	38	38	38
Maternity Institutes	93	91	96	96	96	96
Registered Doctors	5001	7035	11496	18030	21004	27425
Registered Dental Surgeons	310	407	437	555	732	937
Registered Nurses	765	2011	5164	7390	9655	13830
Registered Midwives	764	1041	3424	6556	7713	11200
Registered LHVs	n.a	413	758	1795x	3459x	n.a

Note : x indicates other than column sources or column year; n.a. indicates not available

Source : BBS Statistical year book, various years First Five Year Plan, GOB 1973, DGHS 1998

The health service needs a variety of expertise to support and manage a wide range of services. The cumulative number of registered Doctors was 26535, Dentists 938, Nurses 15408, Midwives 13211, Medical Assistants 2254, Pharmacists 2752, Radiographers 674, Sanitary Inspectors 491, Health Inspector 1400, Medical Technologist 1311 (1997). There were 78,928 staff positions of different categories sanctioned under the revenue head of DGHS and 72,333 were filled in June 1996. (DGHS 1998). There are also 21,000 health assistants and 23600 family welfare assistants. No study is available on the socio-economic background of these kinds of health personnel. The common perception is that most of the doctors and the dentists are from the upper middle class while most of the nurses and para-medical and other mid-level health personnel are from the lower middle class. In 1997 the doctor: patient ratio was 1:4548, nurse doctor ratio is 1:2. This figure is less than both global and regional average. The global figure for doctor population ratio, in 1990, was 1:3980.

Administration of Health Services System

The administration of health services follows the general administrative pattern of the country. The ministry of health and family welfare (MOHFW) formulates national strategy and policy and decides upon the targets for achieving the goals and objectives of health. The ministry (integrated at the ministry level) is headed by a Cabinet Minister. The Minister is assisted by a state /deputy Ministers. There is a public service bureaucrat, a secretary who performs overall duties. The secretary is assisted by a additional secretary, joint secretaries, deputy secretaries and assistant secretaries. The ministry is divided into two implementation directorates, viz: the directorate general of health services (DGHS) and the directorate of family planning

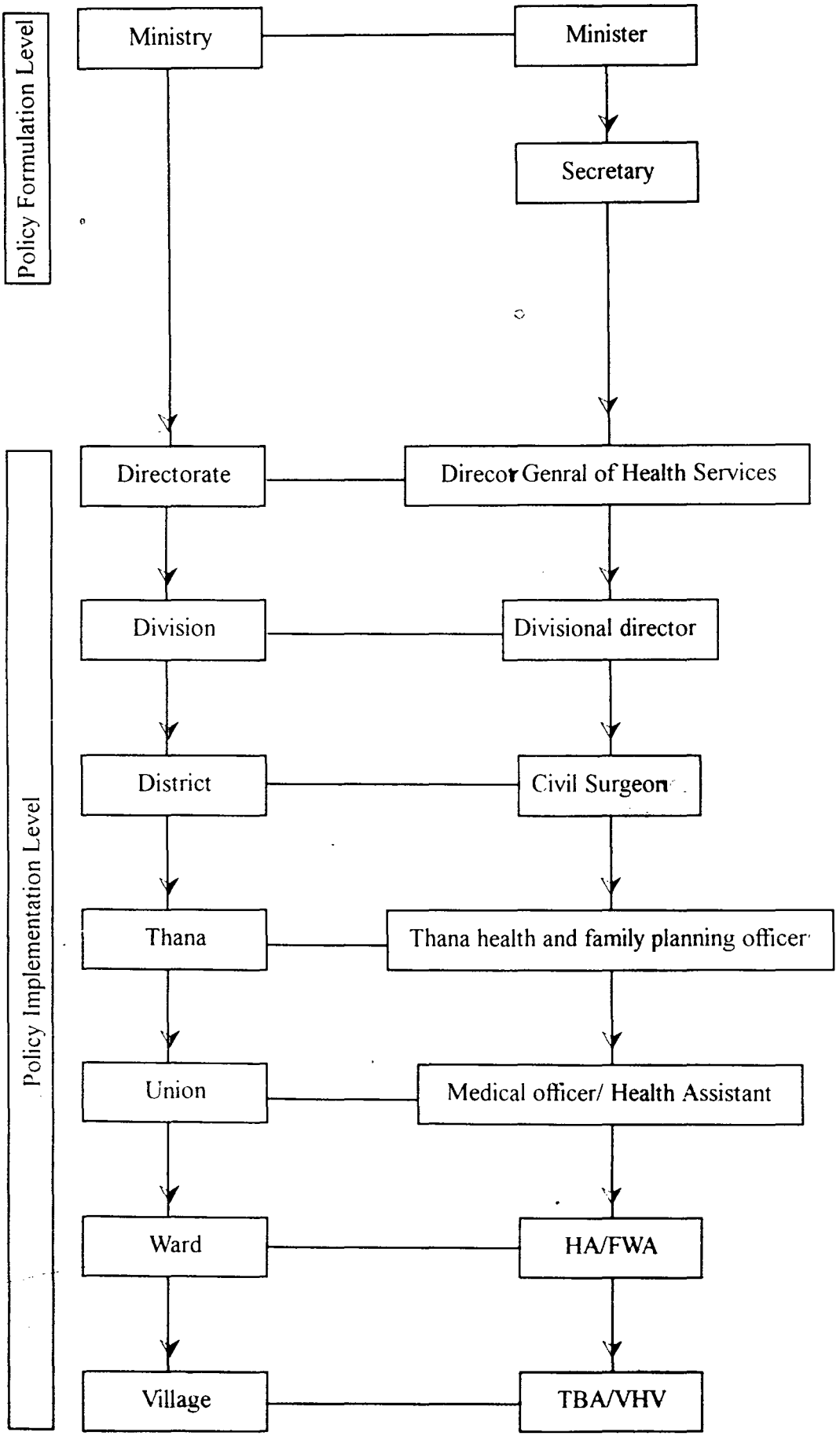
(DGFP). The directorate general of health services provides technical assistance to the ministry and is also incharge of implementing all health program. The Director General is the head of the health services. He/she is assisted by the Additional Director General and the directors, the deputy directors, and the assistant directors. All of them are part of the Central administration.

At the divisional level, there are five divisional directorates. The Director or the head of the division, supervises, monitors and coordinates all the health activities in all the districts under the division. He/she is assisted by two assistant directors, one for administration and the other for disease control. A divisional office has a total of fifty health personnel and staff, including the Director. Important health personneis are the Assistant Director (Nursing) and the Entomologist.

At the district level, the Civil Surgeon is the head of the district. He is assisted by one deputy civil surgeon and one medical officer in category I and one medical officer in category II and III districts, respectively. He is the authority on health in that district. He supervises and monitors all domiciliary and institutional activities in the district except those related to the medical colleges and the attached hospitals if there is one. A Civil Surgeon's office has 26 to 41 staff in charge of health and auxiliary depending on the category of the district. The important personnel are Superintendent of Drugs, Entomologist, Sanitary Inspector, Health Education Officer, EPI Supervisor, etc. In the district hospitals there are 11 doctors, 3 technicians, 3 pharmacists, 13 nurses, one record-keeper, etc. The numbers, of course, vary according to the bed capacity of the hospital.

Figure 1

Administration of Health Services



At the thana level, the Thana Health and Family Planning Officer (THFPO) is in charge of health and family planning and its administration in the thana. It is the health complex (THC) and the health administrative center of the thana. The THFPO also supervises and monitors all other health activities at the thana level. There are four junior consultants (one each in surgery, gynecology, medicine, and anaesthesia), one dental surgeon, one resident medical officer, and one medical officer in the THC. There are also 2 pharmacists, 2 laboratory technicians, one radiographer, one dental technician, five senior staff nurses, one mechanic and various auxiliary personnel. The THFPO is also assisted by the health inspector, the sanitary inspector and other non-medical functionaries. The union sub center / union health and family welfare center is in complete charge of health at the union level. Till today, 1500 USC/UHFWC are in operation, with one medical officer, one medical assistant, one pharmacist, one family welfare visitor and one MLSS. The other units have all other personnel mentioned above except the medical officer. At the ward level, which is the lowest administrative unit, we find one health assistant and one family welfare assistant. They have the responsibilities of providing health care at the door-steps of the population. They are also to look after the local sanitary needs. They are also incharge of ensuring, hygienic practices among the people. At the village level, traditional birth attendants (TBAs) and village health volunteers (VHVs) take care of village health needs. Usually TBA helps in delivery cases and VHV educate people about basic minimum health and hygiene.

The administration of the general health services system, is quite different from the administration of BSMMU, post graduate medical institutes, medical colleges, para medical and nursing colleges and institutes. Each has its own setup and style.

BSMMU administration is headed by a Vice-Chancellor, who is assisted by a Pro-Vice-Chancellor, Registrar, Deputy Registrar and Assistant Registrar. The Executive Council formulates all policies related to administration while the Academic Council chalks out policies for academic purposes. The post-graduate institutes are administered by a Director, who is assisted by a Deputy Director and senior professional staff.

The medical colleges are administered by the principals, assisted by the vice-principals. There are academic councils who look after all academic matters. The hospitals attached to the medical colleges are separately administered by a Director, assisted by a Medical Superintendent and other supporting staff. The administration of para medical institutes, medical training schools, and colleges of nursing, are in the hands of Directors/ Principals, who are assisted by other administrative staff. The institutes are supervised and controlled jointly by the Directorate of Health Services and the Ministry. The medical colleges, and other degree offering institutions are administered by the Directorate, the affiliating university, the Ministry and the Bangladesh Medical and Dental Council (BMDC), as the case may be. The medical, colleges for example, are controlled by the Directorate and the Ministry, degree is offered by the affiliating university, but the academic standard is supervised by the BMDC. The non-degree offering institutes also are administered jointly by the Directorate and the Ministry. The Directorate of Nursing control and supervise the nursing institutes and colleges but, the degree of nursing is conferred by the affiliating university.

NGO Sector

The administration of the NGOs is run by their executive councils/governing bodies. Each NGO has its own set of rules and personnel to implement those. In addition, they have to follow also government rules in running the administration. But in reality, the executive head, like the managing director of Grameen Bank, is the absolute authority and wields power similar to the executive director of BRAC. BIRDEM is run by the executive body of the Diabetic Association which is elected by the members of the society. Kumudini hospital is run by the Kumudini trust.

Level of health care

The health care delivery system of Bangladesh is based on Primary Health Care (PHC) concept. There are various levels of health care, viz: primary, secondary and tertiary.

(1) Primary health care

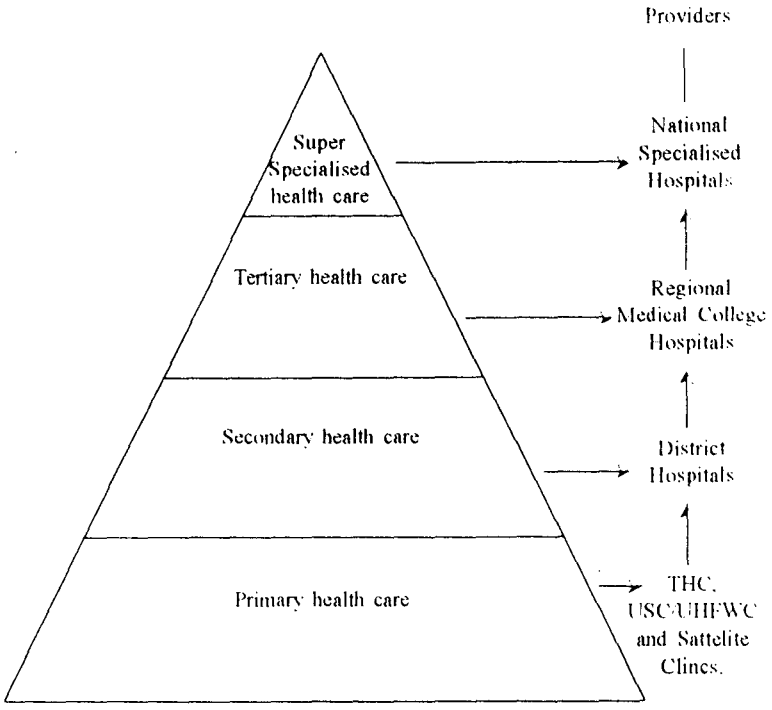
(a) *First contact with health care:* It is the beginning of health care. Contact is established at the community level in both village/ward areas. TBAs and VHVs had covered a population of 1000-1500 with their health care facilities. HAs and FWAs had covered a population of 7000 with similar motives.

(b) *First health facility*: This is the first contact level where a patient gets the first ever institutional facility. This contact happens at the union level where USC/ UHFWC is situated. It cover a population of 21,000.

(c) *First referral level*: This is the first level of contact for health facilities, where cases are referred to higher/better institutions. It is provided by THC at thana level and covers a population of 200,000-450,000.

Figure 2

Levels of Health Care



(2) ***Secondary health care:*** This is referral health facility at a secondary level of contact. It is provided by the hospitals at the district level. It cover 1-2 millions population.

(3) ***Tertiary health care***: This is the third stage of referral facility, available at the regional level and provided by the medical college hospitals. It covers 10-15 million population.

(4) ***Super-specialized health care***: This is health facilities at the national and therefore, the top level, available mostly in Dhaka, the capital of Bangladesh.

II. Health Policies and Programs

Policies are like guidelines to the government to initiate and implement programs. Policies get dictated by the political priorities, and shaped by the political commitments of the ruling elite/party. Allocation of resources, are done accordingly. Success or failure of a policy can be measured by the performance of a government

and the implementation of that particular policy in the desired manner. Hence, a 'good' policy does not necessarily mean the achievement of the expected or targeted results. These depend upon the nature and commitment of the implementing authority. Other socio-political and economic dynamics of the society can very well influence the nature, directions and the implementations of the policies and plans.

Pakistan Era

In the very beginning of its inception, Pakistan had followed the policy enunciated in the Bhore Committee (1946) recommendations. These were a) No individual can be denied adequate medical care because of his/her inability to pay for it. b) The health services when fully developed should provide for all types of medical consultants, and laboratory and institutional facilities. c) Preventive programs should be given special emphasis from the beginning d) The rural population should be provided with medical relief and preventive measures for a comprehensive health care as soon as possible e) The health services should be located at places as close to the people as possible; only this can provide and ensure maximum benefits to the communities. The ministry of health should be responsible to a some one who enjoys the confidence of the people and are able to secure their cooperation (GOB 1946a).

During the British rule, medical services were initially supported by the army and the British civilians. It was made available to the "native" gentry who constituted a tiny fraction of the total population, in the latter part of their rule. Public health services were provided only when there used to be massive out breaks of epidemics. The missionaries, the philanthropic institutions and the private practitioners were active on such occasions, but the services provided were limited in both input and

outreach. The Committee had recommended both short-term and long- term measures to provide comprehensive services to the population. It emphasized upon some primary conditions on which depended healthy living. These were suitable housing, sanitation, safe drinking water supply, elimination of unemployment, a living wage for all workers, improvement in agricultural and industrial production, and the development of communication network especially in the rural areas. (GOI 1946b). This inter-sectoral approach to health service development required the coordination of all spheres of the development activities at both local and higher levels.

The Bhore Committee recommended an integrated health services system having proper infrastructure for rural and urban health care, along with effective preliminary and referral systems. It also emphasized upon an inter-sectoral approach to the health care services development. This involved viewing health services in the context of socio-economic requirements and developments.

In has early days Pakistan faced all types of problems like the absence of proper health personnel, medical technology, hospitals and even pharmaceuticals. So, she had to trudge along a rather difficult path in order to provide a relatively better health care system with more qualified health personnel. It was no easy task to ensure a minimum level of health status to the people.

During this period it was observed that there was not only shortage of health personnel and health facilities, but also acute shortage of other health inputs, such as food shortage, inadequate nutrition, insanitary condition. The problem of unhygienic practices was also acute. All these contributed to the prevalence of ill health, epidemics and a high rate of morbidity and mortality. So when the government

wanted to improve the health status of the population, the major thrust was to maximize child survival rate at birth and to increase life expectancy at birth. The major policies, to attain these goals were proposed during the Pakistan regime. The basis of this long-term program of 20 years were as follows. a) To ensure the availabilities of the most essential health services to all members of the community. b) Development of an integrated health service with greater emphasis on public health. c) Development of a comprehensive and regionalised health care pattern. d) Special health program for children, mothers and the industrial workers. e) Active participation of the local communities in the formulation and implementation of the health programs. f) Even distribution of the health personnel, and the hospital beds in both rural and urban areas. (GOP: 1965)

The government had prioritized the establishment of different types of medical institutions for offering different types of medical education and training. The government also tried to educate the people about their own health. Schemes were launched on the basis of Bhore Committee Recommendations in 1961 to set up one rural health center with three sub-centers in order to provide comprehensive health care for every 50,000 population.

A Medical Reform Commission was set up in 1960 to provide suggestions for the improvement in health administration and medical services The commission was also entrusted with the responsibility of providing suggestion on medical and para-medical trainings and education, and also medical research. The Commission recommended for effective referral system from the rural centres to the medical college hospitals. The internship was proposed through rural centers to medical colleges hospital. Policies were proposed to emphasize on preventive medicines and

to open up a full department on preventive medicine. Policy was recommended for the improvement and expansion of facilities for the training of para medical personnel. The Committee recommend research on trachoma, cholera, diarrhoea, TB and diseases caused by malnutrition.

It is observed that activities were prioritized to preventive health. Initially the government had sprayed D.D.T. in the malaria endemic regions to eradicate malaria. A countrywide malaria eradication program was launched with the assistance of WHO. By 1961, a phased program of fourteen years was lunched to eradicate malaria totally. Different phases, such as, preparatory, attack, consolidation and maintenance, were adopted for effective control and administration. There was a high incidence of TB. B.C.G. vaccination program was launched to arrest TB from early 1950s to mid 1960s. Hospitals and dispensaries were established with this aim. But, gradually clinics started getting preference over hospitals for both diagnosis and domiciliary treatment. Small pox vaccination program also was launched. It was endemic in East Pakistan. The entire population of East Pakistan was vaccinated against small pox resulting in decrease from about 79000 cases in 1958 to only 50 cases in 1964. There were 100,000 cases of leprosy in East Pakistan. Leprosy hospitals and clinics were established to control leprosy.

Policies were undertaken to arrest water-borne diseases also. Safe water supply and better sewerage facility were given highest priority in both rural and urban areas. During 1955-60 Rs. 368 millionswas allocated. Policies were undertaken to install tubewells in all over the country. But little success had come out in this regard.

Health facilities were minimum during Pakistan regime. The government took initiatives to enhance the health facilities. Medical

colleges and hospitals were established. Postgraduate studies institutions were also set up. Policies were undertaken to expand health amenities facility at the district and the sub-divisional levels and to setup rural dispensaries. Institutes were built for the training of mid-level health personnel.

Attention was paid for adequate health manpower grooming at all levels viz: doctors, nurses, paramedical and other health personnel. Twelve medical colleges were able to produce more than 1000 doctors each year. Due emphasis was given for the development of mid-level health services and more out-turn of mid level health personnel. But all these were in papers. There was a shortage of those personnel.

Policy was chalked out for medical research. A public health research institute was established to conduct research on western and indigenous systems of medicines, nutrition and different diseases etc. Most of the research was clinical in nature. There were hardly any research activities.

There were separate administrative systems for preventive and curative health cares. Policy was made to integrate them. A comprehensive long-term (20 years) goal was proposed by the government to cover the entire population. The Third Plan was made with the specific goal of achieving within twenty years. The major goals were to (a) increase the survival rate of a child, (b) life expectancy and above all, (c) to ensure those facilities with which one can enjoy good health throughout his/her lifetime. To regulate the indigenous and homeopathic medical practitioner, in order to eliminate unauthorized practices, was found necessary.

The government officially acknowledged in early 1960s its inability to provide health care services efficiently to the vast majority of the population. It recognized a very important fact that it was not merely its responsibility to provide an efficient

health service: The entire society has a responsibility and duties. So it asked the philanthropists, welfare agencies and private practitioners to join in the venture to provide a satisfactory level of health care to the people. The government asked the private sector also to participate in this process. It offered incentives for private sector development with free land, land tax exemption, and reduced duties /taxes on the equipments. Rs. 50 millions and 40 millions were allocated for health during the Second and Third Five-Year Plans, respectively.

During the Pakistan era, Rupees 2007.2 millions had been allocated in the 1955-70 development budget. The share of the Centre was 186.76 millions of West Pakistan 848.25 millions and of East Pakistan 927.19 millions.

By 1966 there were 12 medical colleges, 469 hospitals, 200 rural health centers, 19 nursing training centers, 2136 dispensaries, 766 MCH centres, 98 TB clinics, 33184 beds, 17477 doctors, 4002 nurses, 1169 LHV, (Jahan 1977). The doctor: population ratio was 1:7300 and nurse population ratio was 1:34000, bed: population ratio was 1:3300, LHV: population ratio was 1:110,000 in 1965. The CBR was 55/1000, CDR was 29/1000, IMR was 155/1000, and MMR was 30/1000 in 1965. (GOP 1965: 249).

Table 3:5 Disparity between East and West Pakistan in 1966

Location	Medical Colleges	Hospitals	Beds	MCW Centres	Doctors	Nurses
Pakistan	12	469	33184	766	17477	4002
West Pakistan	6	393	26200	711	10488	3438
East Pakistan	6	76	6984	53	6989	564

Source: Jahan 1977

Differences in the availability of health services between the East and the West Pakistans were glaring. There were six medical colleges, 76 hospitals, 55 MCH welfare centres, 6984 beds, 6989 doctors, and 564 nurses in East Pakistan in 1966. At the same time the figure in West Pakistan was 6,393, 711, 26200, 10488, 3438 respectively. The growth rate of hospitals in East Pakistan was 7 per cent in 1959-66. In the same period, it was 16.27 per cent in West Pakistan. The growth rate of beds was 56.17 per cent in East Pakistan, and 15.61 per cent in West Pakistan and of the doctors it was 38.12 per cent in East Pakistan and 86.79 per cent in West Pakistan (GOP 1968). During the Pakistani colonial rule, much had not improved. The condition of East Pakistan was more than worse. The nature of the colonial ruler hardly wanted the development of its colony, viz: East Pakistan. Hence status of health was poor in the then East Pakistan.

Bangladesh Era

Following independence, Bangladesh has been pursuing health policies to achieve and promote universal standard of health for the people. During the early days of independence it had limited health intelligence and resources. The colonial rule of the Pakistani days made the health sector handicapped like the other sectors. Most of the development activities were done only in West Pakistan. But there has been no national health policy even in independent Bangladesh. All the governments emphasized on the development of the health sector through ambitious development plans. The improvement of health status through reducing morbidity, and mortality has been prioritized. A country health program was undertaken in 1973 focusing on selected health logistics problems.

Mujib Regime(1972-75)

The regime recognized health as a fundamental right. This recognition has been included in the Constitution of Bangladesh in Articles 15 and 18. The article 15 mandates that "it shall be a fundamental responsibility of the state to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a views to securing to its citizens. a) the provision of the basic necessities of life, including food, clothing, shelter education and medical care". Article 18 also mandates that it is the primary responsibility of the state to improve the nutritional status of the people and the development of public health. It further stipulates that it is the responsibility of the state to provide health care facility with developments in nutrition and public health.

The success of a health program largely depends on the simultaneous and coordinated efforts on the part of the allied sectors i.e. environmental cleanliness, sanitation, potable water, hygienic night-soil disposal, food and agriculture, transport and communication and, above all, education and social welfare. The regime had wisely prioritized inter-sectoral cooperation and coordination. The major policies followed were a) To ensure reasonable health care to all. b) To create a health infrastructure in the rural areas for providing integrated and comprehensive health services. c) Integration between health and family planning programs. d) Specialized health programs for infants, children and mothers. e) Improvement in the quality of the existing health facilities. f) To ensure inter-sectoral cooperation and coordination. (GOB 1973)

The health care delivery system was reorganized accordingly. During the Pakistani period, preventive health care was provided by the District Councils (local government bodies) while curative care was provided by public health departments (Ministry of Health). Following liberation, services were integrated and unified under the Directorate of Health. In the preventive health program, control and eradication of communicable disease was given priority. Public health laboratory services were set up to produce anti-serum and toxids, infusion fluids etc. All these were done to strengthen preventive health care. But in practice, curative care got higher priority.

Policies were proposed to provide integrated and comprehensive health care to the rural population. This service was proliferated through community level, union sub-centres and thana health complexes. Hence integration was possible between preventive and curative services. A comprehensive health service became possible through community, home, and family cares, out-patient, and in-patient cares, physical and social rehabilitations etc.

It was also proposed to integrate malaria, TB, leprosy, smallpox and cholera programs. The idea behind was that a primary health worker would be able to work simultaneously for immunization, collection of slides for malaria and sputum for TB, supply of anti-malarial, anti-TB, anti-leprosy drugs to the confirmed cases for domiciliary treatment, and anti-epidemic programs. He had to also maintain family health and family planning cards.

Thana health complexes (THC), union sub centres (USC) were entrusted to provide integrated and comprehensive health services to the population. There were 356 rural thanas and 3698 unions. Policy was to establish one THC at each thana level

and one USC at each union level. At the thana level, a 25 bedded hospital was proposed. There was an MCH clinic attached to each THC. The MCH clinic had six maternity beds. In addition there was a clinical/pathological diagnostic laboratory. It was also proposed to convert THC into 50 bedded hospitals as part of a scheme to upgrade the existing district and sub-divisional hospitals with 100 beds. One post-graduate institute and one medical college, 600 bedded TB hospitals, 500 bedded hospitals for infectious disease, 400 bedded for children, 400 bedded hospitals for mental patients, 100 bedded hospitals for cancer and 100 bedded for causality were proposed to be setup at the divisional level.

Safeguarding the health of the industrial workers was also proposed in the priority list. Industrial units were asked to create health environments at work places, to protect against industrial health hazard, periodic check up of the workers and if necessary, also of their family members. Endeavours were there to coordinate between general health services and industrial health programs. The industrial units were asked to recruit proper manpower and employ proper equipments and follow the existing rules to ensure health facilities.

The regime had given priority to the development of health manpower. Necessary measures were taken to increase the existing intake capacity of students in the medical colleges. The graduate doctors would be provided adequate and intensive training to fill up the gap for specialists in both curative and preventive medicine. Due emphasis was given to create a new health cadre known as "health assistant" who were entrusted to take care of simpler cases only. The service would minimize the shortage of doctors. The utmost priority was given to promote nurses. Through

crash program. The regime emphasised for the development of para-medical personnel to reduce shortage of staff.

The regime tried to make the best use of available manpower. The development activities gone importance to the necessity of the state not of the individuals. The postgraduate training of doctors was instituted strictly on the basis of actual requirement and priority. One year service in the rural area under the national health program, which was made compulsory for all doctors, nurses, and paramedical, medical assistants.

The regime took some regulatory mechanism to promote essential drugs. A regulatory mechanism was set up to control the quality and restrict the licensing of licenses for pharmaceutical production. Financial incentives were provided to the manufacturers of essential drugs. Domestic production was given priority along with imports for non-available drugs and supplies.

The government proposed a comprehensive health insurance scheme where the government and the employer were asked to pay and the employee would only receive the service. It was proposed to implement the scheme in a phased manner- starting with specific categories of employee and eventually reaching at cent per cent coverage. The government also planned to open up polyclinics at urban areas where the service was to be provided on payment. It was suggested that the government would provide buildings, equipment. These clinics would be managed by a 'Board'.

Administrative decentralization was prioritized to take care of administrative and financial powers and responsibilities. The Government proposed to set up a National Health Council. The government representatives, National medical and public health

association and other representatives were its members with. The Minister of health as the Chairperson. The council was entrusted with power to formulate national policies and programs. During the period from 1972-73 to 1974-75, Taka 109.18 millions was allocated to the Council of which 55 per cent was earmarked for development expenditure. The regime had made some development, yet it was far from expectation.

There were 980 sanitary inspectors, 1500 compounders/pharmacists, 270 lab-technicians, 10 radiographers/x-ray technicians, 20 physiotherapy technicians, 20 Dental technicians, 800 lady health visitors in 1972-73. (GOB 1973). The bed : population ratio was 1: 6250, doctor population ratio was 1:10,714. doctor nurse ratio 2:1 in 1973. During 1975, there were 6243 registered doctors, 327 dentists, 1214 registered nurses, 739 registered midwives, more than 300 hospitals, 17572 beds, eight medical colleges and one post graduate institute. Altogether 43 TB clinics, 95 maternity and child welfare centers were set up by 1975. At the same period IMR was 140/1000, MMR was 30/1000, CBR was 49/1000, CDR was 17/1000 and life expectancy at birth was 50.7 years. It was observed that there was a shortage of health personnel as well as health facilities. Much had not improved in this regime. The status of health of the population continued to be in a dismal state.

Zia Regime (1975-82)

The regime had taken sincere initiative to promote the health status of the population. It had carried out all on going programs of the earlier regime and introduced new one to increase the availability of health service. The influence of global policy also driven the government to take necessary policy initiatives to attain of all people to lead socially and economically productive life.

During the regime, health sector got priority. It was placed at the 10th point's in Zia's 19-point program (Appendix-1). Program categorically stated about medical care. Country's second health program exercise was done in 1977 focussing comprehensively on health care facilities and needs. The government had signed Alma Ata declaration in 1978 and accepted primary health care as the key approach to attain the Health for All (HFA) by 2000. The government prepared a country paper in 1980 to attain HFA. The major aspects of the health policy of the regime were : (a)To ensure minimum medical care for every body and health for all by 2000 A.D. (b) To strengthen health manpower development program especially for middle and field level workers. (c) To expand hospitals and clinics in publics sector as well as private sector on priority basis. (d) To encourage development of the traditional system of medicine. (GOB 1978)

The regime continued all on going preventive programs such as malaria eradication, EPI, smallpox eradication etc. Malaria eradication was integrated with general health services in 1977. The expanded program of immunization was launched in 1979. The smallpox eradication program was also launched.

The regime took decision to bring the general masses into the net of health care facility. There were very few health care facility available in the country especially in rural areas. Health services often not available for care even general ailments and injuries. The Government took steps to provide services from partially completed thana health complex and sub-centers and upgraded few district and sub-divisional hospitals. These facilities were created in important places at industrial areas or sub-divisional centres. Different institutes were set up such as ICVD, NIPSOM, NIO, IMH, IPHN IEDCR etc. to enlarge the scope. The international

center for diarrhoeal disease research, Bangladesh was also set up by the same regime.

The regime took part in the development of health facilities and more out-turn of health personnel at all levels, prioritized at the middle level, to reduce the shortage of health personnel. The medical colleges of Barisal, Rangpur and Sylhet were made fully operational. Same attempts made for post-graduate training of doctors, medical assistants and nurses. Eight medical training schools and five nurse's training institutes were established. The College of Nursing was also established by the regime. The number of nurses intake capacity was also increased from 150 to 400. The regime took most innovative program of training *of 'Palli Chikitsok'* (village doctor). This program was taken for ensuring easy availability of medical care facilities to rural people. The regime successfully to created more than 5000 *palli chikitsok*.

The regime took initiative to popularize indigenous medicine. New institute was set up in public sector for this purpose and they were bestowed with authority to award degree and diploma. It has greatly encouraged the biomedical research. Unfortunately very little had come out of biomedical research during the regime.

The regime framed policy to integrate health and family planning at thana level and below. The objective of the new system were to reduce worker population ratio, to increase the number of female workers, to reach targeted female population, to under take registration and vital statistics, to make of MCH service, nutrition, immunization, preventive and promotive health education available to each family. The family planning personnel were brought under the control of the officials of the department of health. The family planning personnel did not agree with the

government proposal. This order curtailed their earlier power and privileges. They resorted to various proposing tactics and finally compelled the government to withdraw its order.

Participation of people and local government institution were encouraged in the planning and management of health care institutions. Prevention and promotion of health education and local resource mobilization was entrusted with them. The regime allocated Taka 1018.22 millions from 1975 -76 to 1981-82 for both health and family planning. The share of health and family planning was 718.03 millions and TK. 301.90 millions respectively. The per capita expenditure was Taka 18.28 in the year 1981-82 and the total expenditure as a percentage of GDP was 0.65 per cent at the same period.

The regime actively considered for setting private polyclinics. nursing homes etc. A scheme was undertaken in 1977 to open up the avenue of private sector. Policy was formulated to provide loan at a negligible interest rate (only 3 per cent) to those who wanted to setup private hospital, clinics, nursing homes etc. The aim was to establish 25 to 50 beds polyclinic, residence-cum-clinic, specialized nursing home etc.

There was a visible improvement of health status of the population due to the government intervention. It was observed that in 1981 crude death rate was 12/1000, crude birth rate 34.8/1000, IMR 121.5/1000, life expectancy at birth 54.8, MMR 5.6/1000, child mortality rate 22/1000. Yet it remained for less compare to developed countries. The neighboring countries even had better health status than Bangladesh. Till 1981, there were five postgraduate medical institutes, nine medical colleges including one dental college, two paramedical institutes, 44 TB clinics, 290 THC, 37 district hospitals, 676 hospitals (512 govt. + 164 private), 23792 beds

(4771 private sector) 11,513 doctors, 425 dentists, 3736 registered nurses, 2239 registered midwives, 449 registered LHV, 1400 sanitary inspectors, 5300 pharmacists, 200 radiographers, 1150 lab technicians, 500 medical assistants, 13000 health assistants were made available. There was much development in health infrastructure and manpower development. This was not only much less than developed countries. The country was still lagging behind neighboring countries which had better access and health personnel than Bangladesh.

Ershad Regime(1982-90)

Although there were substantial alterations to health policy after Ershad refine come to power. The basic thrust to improve the health status of the population continued to be the same. Ershad's 18-point program (Appendix-2) also emphasized medical care for everybody. The major policies of the regime were : (a) To bridge the urban-rural disparity and coverage of the health care services with a view to providing minimum medical care to all. (b) To improve health and family planning services in a package to every family with a view to increase welfare. (c) To promote adequate production, distribution of essential drugs, vaccines and other diagnostic and therapeutic agents. (d) To encourage the private sector in the development of health care facilities. (e) To develop health information system for monitoring and development of an affordable health care delivery. (f) To mobilize resources to support expanding health care services. (GOB 1983, 1985)

The regime carried out all on-going programs of the earlier regime and also added a few new one. Soon after assuming power, the regime initiated drug a policy in 1982. The objective to the drug policy was to ensure the availability, to promote local production, to control quality and to improve distribution system. All drugs

came under unified administrative and legislative control. The major recommendations of the drug policy were a) a basic list of 150 essential drugs and a supplementary list of 100 specialized drugs. The basic list was subdivided--12 drugs for village health workers (VHW), 45 drugs for THCs level (inclusive VHWs drugs) and 150 drugs for secondary and tertiary levels (inclusive VHW & THCs level) ; b) The drugs of THCs level were asked to manufacture or sell under generic names only. c) The drug act of 1940 should be revised ; d) the price mechanism was regulated by the government. The policy was highly appreciated by WHO and international consumer groups. International medical journals, such as, *Lancet* and *Tropical Doctor* welcomed the policy it. It was intended that the drug policy would be an integral part of the national health policy. It was a major milestone in the development of health in Bangladesh. Through the policy, the government banned production or sale of as many as 1700 drugs. The policy made marked success to protect local manufactures and restrict foreign firm activity.

The regime had given all inputs to boost private sector development. The medical practice and private clinics and laboratory ordinance of 1982 (Appendix-3) had specified the procedure to set up clinic, laboratory, to recruit personnel required for hospitals/ clinics, and specified various punitive actions in case of violation of rules. It formulated a broad guideline to fix maximum fees for different types of services provided by doctors, clinics and laboratories. The regime also relaxed the restriction to establish private medical college. Provisions were made to provide facility to the self- employed doctors in the peripheral areas. One such provision included long-term loan at low interest. Different medical personnel including the doctors were asked to seek for suitable job placements in private or NGO sector. Private sectors

were encouraged to take active part in development planning, infrastructure building, to set up pharmaceutical industry etc.

During the middle of 1990, an effort was made to launch a new health policy. The government formed two committees for this purpose-one is four member committee, known as health care system improvement (HCSI) committee. Among its members there was Dr. Zafarullah Chowdhury of Gonoshasthaya Kendra (People health Centre). The other committee was headed by the additional secretary of MOHFW to work out a national health and population policy. The committee was comprised of seventeen members from different segments of people such as members of physician's association, experts but no consumer representatives. Finally, the government accepted the proposal of HCSI committee report which proposed a major changes in health care system. (Rich 1994). It was presented in the Parliament in 1990. The main objectives was to ensure preventive and curative health care for the people as a whole. The policy emphasized on (a) provision of health care, sanitation, nutrition and family planning service for the vulnerable groups; (b) accountable management system, (c) decentralized health care system and establishment of health authorities at thana, district and regional levels. The management authority comprised of elected representatives, health personnel, women, freedom fighters, journalist etc. The new policy strictly prohibited on private practice of academicians of graduate and postgraduate institutes and provisions were made to compensate the loss. The policy came into the limelight through Ershad's speech on 25th July, 1990 and subsequently it was presented in Parliament in the next day by the Minister of Health and Family Welfare. Bangladesh Medical Association (BMA) took strong exception of the policy and

reacted sharply. They declared 72 hours nation wide strike in protest against the new policy. BMA demanded immediate withdraw at of the policy. They threatened to paralise the health services through enmass resign on 15th August. The policy seriously affected the privileges, powers and income of the medical professionals (Reich 1993). The senior doctors opposed it because they apprehended that it would substantially reduce income as private practice would be stopped. The junior physicians were made accountable to people's representative, which they could not accept and they also opposed it. As a result of the continuos movement by the professionals and the political parties, the government was overthrown soon. The new heath policy then died before it was born.

The regime proposed to bridge rural - urban gap and to build up health infrastructure through out the country. The regime actively considered for such a structure, which would be able to provide regionalised health care module, and supported by a network of referral system. The medical colleges were proposed as an apex organization. There was an attempt to make each region self-sufficient in primary, secondary and tertiary health care. Effective referral system was proposed for functioning of regionalised health care. According to the proposed policy the patients, would be referred from PHC level to district and then to the medical college hospital. The regional center was proposed to be connected to national level hospitals. This network was designed mainly to help rural people. The on going PHC activities were strengthened through community level to union level. The THCs were provided with diagnostic and treatment facilities. Policies were taken to establish a health post at community level, which would be managed by the community on a cost sharing basis.

Though the EPI program was introduced in 1979, crash program was undertaken by the regime. All the field level workers, their supervisory staff and doctors were involved, mobilized, and made accountable for the implementation of EPI program within the stipulated time frame. There was functional integration between health and family planning at village level in 1985. Satellite clinics (1,10,000) were established to provide EPI, MCH and nutrition services. These clinics were established at the out reach center.

The regime made policy for homeopathic, unani and ayurvedic practitioner ordinance in 1983. It also emphasized on systematic development of these medicines. The regime emphasized more on specialized training. It prioritized crash programs for training of radiographers, dental technicians and lab technicians. Emphasis was given for mid level and lower level personnel training, such as, training for health inspectors, sanitary inspectors, traditional birth attendants etc. Priority was given to build up of mid level institutions. Eight medical assistant training schools were functioning fully. Provision was made for expansion of nurses training institutes, nuclear medicine etc. The regime took special interest in training of health administrators. A number of steps were taken to provide training at public Administration Training Centre (PATC), National Institute of Preventive and Social Medicine (NIPSOM) National Institute of Population Research and Training (NIPORT) and Bangladesh Management Development Centre (BMDC).

People's participation was made essential at every step of the implementation of the policy. It was evident in the plan document, "People need to come up with their problems and resolve those problems within their means.... involvement of people of all walks of life including communities, local government bodies, NGOs and other

voluntary associations of people towards development of health awareness and skill, mobilization of resource and management of PHC program (GOB 1985)". This was done with broader perspectives of self management of health care and participation in health activity.

The regime had allocated Tk 4669.66 millions in health and family planning sector and the share of health was Tk 2940.71 millions. The regime adjusted the structural adjustment policy. The per capita expenditure was Tk 20.31 in 1982-83, which increased to Tk 62.47 in 1990-91. The total expenditure as a percentage of GDP in the health sector was 0.79 and 0.95 respectively at the same period.

It was observed in 1990 that IMR was 94/1000 , MMR 4.77/1000, Life expectancy at birth 55.8 yrs., CBR 33.50/1000, CDR 12/1000, Population growth rate 1.95. There was 875 hospitals, 34786 beds, 353 THCs, 59 district hospitals, 8 medical training schools, 19387 midwives, 96 maternity and child welfare centers, 2700 UHFWCs were available. The population bed ratio was 3200:1, doctor population ratio was 1:5546, nurse population ratio was 1:12549 in the same year. There was a development during the regime. The health status of the people improved. But the improvement was much less compare to developed countries. Even the countries in the neighbourhood had better health status. The regime tried its best to provide better inputs in the development of health facilities.

Begum Zia Regime (1991-96)

Instead of setting aside the going activities of the preceding regime, the government under the leadership of Begum Zia gave special attention in the existing program to make the program success. The major policies of the regime were : (a) To improve the health status of population especially of mothers and children. (b) To consolidate

and strengthen the coverage of primary health care and its supporting services. (c) To improve nutritional status of the population especially mothers and children. (d) To strengthen planning and management capabilities of the health system for maximum utilization of health services. (e) To ensure people's participation in the local level planning to create community awareness about health care. (GOB 1990; MOHFW 1997)

The regime followed different plan of action to improve the health status of the population. The immunization program was intensified covering the entire country. It declared national immunization day to intensify for the program. An intensive program for diarrhoeal disease control system was taken up. Cases detection and epidemic control was decentralized. Diarrhoeal disease cell was established in all medical colleges and ORT at district hospitals was strengthened. As a step to arrest the Diarrhoeal diseases, five centres i.e., Dhaka, Comilla, Jessore, Rangpur and Barisal collectively produced on an average 45 million packets of oral saline annually while essential drug company's and others together produced about 10 million packets per year.

The regime proposed people's participation at all level due emphasis was also proposed for framing health committees, raising health volunteers, setting up health cooperatives at union / village level, integrating existing organization structure with bottom-up planning process, a improving coordination between health related sectors and NGOs and procuring general resource from community through cost sharing.

The regime emphasized on effective referral system in order to develop linkages between the community based services upto the specialized care. The referral

mechanism was initiated by the community health worker to the next higher level and subsequently to other level as per need. It was felt that the referral centres should have requisite physical and service facility to meet the demands of the referred cases.

It was proposed to integrate homeopathy and indigenous systems of medicine with mainstream of Western medicine. The education systems were upgraded to improve the skills of these practitioners. The regime actively considered for establishing a kidney disease institute in Dhaka and Nephrology and Urology unit in all medical colleges. Policy was taken for the development of surveillance system and control strategies for STD/ AIDS. The diagnosis facilities in laboratory was strengthened.

Bangladesh is a disaster prone area. Every year disaster takes a heavy toll of life and causes various health hazards. Necessary improvement has been made disaster management to protect life and to arrest different diseases. A few of them are formation of mobile medical team, supply of water purifying tablets, ORS, IV fluid, bleaching power, essential drugs, logistics, arranging field hospitals, maintaining epidemiological surveillance, training of health personnel, community awareness and participation etc.

The regime prioritized on women and child health. Bangladesh was a signatory in the 'World summit for children', 'International conference on population and development' and 'Women in Development'. As an obligation to international commitments, the country introduced various devices to improve the health status of women and children. It set its target to reduce IMR, MMR, CMR etc. The MCH-FP package approach addressed specifically to women health. This program was an

integral component of health and family planning at community and PHC level. Steps were taken to provide comprehensive service to mother and child.

Policies were taken to provide all incentives and to relax almost all restrictions for the development of private sector development. Private sector was encouraged to undertake different types of programs for the development of manpower, infrastructure, pharmaceuticals etc. Appropriate processes and procedures were institutionalized to ensure complementary and supplementary role of the NGOs. Emphasis was given for effective cooperation and coordination between the government and NGOs. The policy document revealed that where the government itself was unable to provide services, the NGOs and the private sector were asked to provide services. The government acknowledged that it was impossible for them to provide services without cost sharing. Lack of cost sharing led to over use of services by a privileged few. Hence generating resources through cost sharing, health insurance and cooperatives became a necessity. This does not mean that the cost sharing became universal. The objective was to ensure equity among various socio-economic classes. An amount of Tk 1810 millions were kept specially for the investment in the private sector including NGOs for various health development activities. These activities included development of polyclinics, nursing homes, pathological laboratories, x-ray clinics, day care centres, private medical institutions and hospitals etc. The government made provisions such as introduction of user-fee, fees for some laboratory diagnosis etc. to generate resources.

During the regime, the government took special interest to develop private sector. As many as six medical colleges were set up in private sector. A large number of clinics and diagnostic laboratory was also set up.

During this period Tk 6265.9 millions was allocated for health and family planning. The share of health sector was 4321.39 millions. The per capita expenditure increased from Tk. 61.37 in 1991-92 to Tk. 131.57 in 1995-96. The total expenditure as percentage of GDP was 0.82 to 1.23 at the same period.

It was observed that in 1996 CBR 27/1000, CDR 9/1000, population growth rate 1.8, IMR 78/1000, CMR 116/1000, MMR 4/1000, LEB 58.1 years. There were 19 medical colleges (six were in private sector), 33 hospitals, 381 THCs, 37527 beds, 26488 doctors, 937 dentists, 1300 basic nurses, 2254 medical assistants, 1800 lab technicians, 700 radiographers, 675 pharmacists and 4175 USC/UHFWC. Till 1996, 50 per cent population were covered by the essential health care. 13 per cent delivery were attended by trained person. In 1995, the doctor population ratio was 1: 4870, the bed : population ratio was 1:3450, Nurse population ratio was 1:10714. There was an improvement of health status of the population. More health facilities, manpower was available. But these developments were not encouraging enough compare to the average pace of development in the developed countries and the regional countries. The regime had however, tried its best to provide health services to the doorstep of the people.

Sheikh Hasina Regime (1996-)

After coming to power, AL government has taken new initiatives in reforming health sector. The basic tenets of reform has followed the *World Development Report 1993- Investing in health.* There has been a major shift of policy framework. The major policies of the present government are: a) To ensure universal access for the people to essential health care and services. b) To provide one-stop services point with acceptable quality and equity. c) To improve medical nursing and

paramedical education with latest concepts. d)To reduce health disparities between geographic area socio-economic groups. and gender. e)A package of essential services on a pilot basis to meet the major needs of the people with minimum required services. f) To integrate health and family planning services (GOB 1998).

The Government has formulated the health and population sector strategy (HPSS) with a vision to reform the of entire health sector (MOHFW 1998b). The HPSS gives a broad picture of new policy the trusts of the government. Later, a health and population sector program (HPSP) has been formulated with a purpose of giving an understanding of implementation mechanism of the program (MOHFW 1998a).

One important aspect of reform is the introduction of essential service package (ESP). The components of essential service package are reproductive health care, child health care, communicable disease control, limited (simple) curative care and behavior change communication. The Government has been decided not to provide all component of ESP (due to financial constraints) but only limited services on the basis of a client's immediate needs. The package is client oriented and provision is made for one-stop service (MOHFW 1998a, 1998b). For the proper implementation of ESP, various measures have been proposed for the restructuring of MOHFW. They include from central to periphery, requisite human development strategy, sector wide program management, and provision of service delivery. It also includes program sustainability, affordability and quality of services.

The present regime has formed a committee (to formulate the national health policy) on December, 12. 1996, headed by the Minister of Health and Family Welfare. Subsequently, five-sub committees have been made. The twenty-six-member health policy formulation committee submitted the draft policy to Prime Minister on 23rd

July 1998. The main thrust of the policy is (a) to provide the best possible health services to the people particularly to the poor, mother and children (b) to decentralize the health services system for better monitoring, cost sharing and effective management and accountability of health personnel (c) to ensure effective participation of the community, NGO and other private sector provider (d) to follow-up the guiding principles of HPSS and HPSP (MOHFW 1998c). Even though the Government is yet to declare the policy, it has begun to implement the policy guidelines of HPSS and HPSP. The major goals of HPSS is client-centered reproductive health approach. In addition, it talks about a) increasing quality, equity of access and efficiency in services b) focusing on essential package of services, specially which is meant for public good, such as non-excludable and important externalities, c) expanding health services through partnership d) implementing cost recovery mechanism to ensure equity etc. (MOHFW 1998b). The main purpose of HPSP is client centered provision and client utilization of ESP and selected services. HPSP has given a broad idea about implementation process of ESP. A high level committee on organization and management has proposed to initiate restructuring of health and family welfare sector (MOHFW 1997a). This has not been implement fully. A pilot program has been taken by the government. After successful completion of the pilot program, the government will implement the program all over the country.

The Sheikh Hasina regime is emphasising on decentralization, local level planning, management of health services and community participation. Community is entrusted to look all programs in of all aspects of health services including program planning, monitoring and supervision, cost sharing, provision of service, quality

control, information, education and communication etc. They will work close collaboration with the government in partnership basis for the achievement of common goal of the sector. This will ensure sustainability of the process. Delegation of authority to the district councils and thana parishads for the management of district hospital and thana health complexes become the policy for better management, and emergency response. It is also felt that decentralization will grow a sense of ownership in the community. This will help to take decision and share the cost, which will ultimately lead to rational and sustainable health system.

The urban primary health care has been ignored since long. On the other hand, there is a huge migration from rural area to urban area. Even the condition of urban slum is in a bad shape. Policy has been taken to strengthen primary health care program to provide adequate quality health services to urban population and more particularly to the slum dwellers.

The new health policy sounds for improve program management and service delivery. It has been assumed that function, responsibility, accountability of individuals and organizations, will enhance an efficient management system. Priority is made to promote new generation health managers to bring efficiency in management.

New effort has been made to improve indigenous and homeopathy system of medicine. The development of education, training and research is carried out in such a way so that it can play a complementary role to Western system of medicine.

The policy document also reveals greater participation of private sector and NGOs in health sector. All out mechanism has been set to boost private sector. All service delivery system will soon go to private providers which will become operative

shortly. The government itself wants to limit its role in providing services. It wants its activities limited only in policy formulation, monitoring and control. The Government investment will remain restricted to those areas where the private / NGO sectors are not capable to invest and to provide health facilities. Even provision has been made (the details of surface which will in near future) for public sector doctor for practicing in government hospitals beyond their office hours on specified fees.

Policy has been made to look after women's health. Efforts have been made to ensure access of women, adolescents and children to health facilities. Basic health services are provided at the doorstep of all households. The Government has evolved steps to provide gender friendly services. A strategy will be there to monitor the progress of gender equity through service accessibility. The government has proposed to protect the health of the poor and to provide necessary service to the poor such as to provide acute medical care, nutrition and health education. It is assumed that HPSS has ensured the accessibility of the poor. The services included in ESP are quite comprehensive in nature. It fulfills the most of the needs of the poor.

The above policy analysis of different regimes reveals that Bangladesh has accepted fundamental responsibility bestowed on it by the constitution to provide health care facility. During the Mujib regime, the state followed socialist policy and tried to provide a reasonable health care pattern to the people. The regime proposed to abolish paid services from government hospitals in order to provide equal care and attention like socialist countries. In addition, the regime proposed for paid services polyclinics which will be managed by a Board. The First Awami League

Government under S.K. Mujib's had planned to provide buildings and equipment, so it may be concluded that the regime itself deviated from its ideological stand, hence tried to build a national health care system in the pattern of United Kingdom. The Zia regime had followed the policy of denationalization and privatization. The private sector had started flourishing during Zia's regime. Ershad on the other, had totally opened up the economy to the private sector including the health sector. Khaledia Zia followed the footstep of Ershad and further emerged the private sector. The present regime is following largely the same policy. More so, it has reduced the scope of the state in intervention in the provisioning of health delivery which will in all likelihood strengthen private sector. The state is able to cover only 50 per cent of the population through PHC activities. Now the state expresses its inability to provide health care facility to the entire population, limiting its activities to policy making, monitoring and control and one-stop service to the population. However, emphasis has been made to pay special attention to the poorest, women and children. The state has shifted its focus from comprehensive health care to essential health care and has become less interested and active to promote and provide health services.

III. Health Care Financing Pattern

Health care financing is an important input for the improvement of the health status of a population. This is done by the government departments, the local authorities, the specialized agencies, the public sector corporations, the NGOs, the foreign donors, the private sectors, and even the households and individuals. The flow of funds in the public sector is from the government revenue and the development budget, taken care of by the government and the donors. The flow of funds in the

private sector is from the household expenditures for health care, the non-government donors and firms.

In the pubic sector, district level downwards, the services are free of cost. Both indoor and outdoor services, except the ticket money i.e. the user fee can be availed of without any payment. At the tertiary level, there are both paying and non-paying systems. Even the paying system is subsidized by the government. It has been mentioned earlier that the public sector (MOHFW and other government organizations) financed 34 per cent of total expenditures, while the household and the private sector together, account for 64 per cent, only one per cent is financed by the NGOs. The national health account of 1996-97 shows that the share of MOHFW was 31.4 per cent, of other ministries 2.3 per cent, of the local governments, corporations and autonomous bodies 0.4 per cent, of the donors 2.2 per cent of the non-profit institutions, NGOs and firms 0.7 per cent, of the households 63 per cent. (MOHFW 1998a:4)

The allocation pattern in the health sector indicates the nature and extent of the government's commitment to health and development.

Table1 3:6 Allocation Pattern of Health as a Percentage of National Budget, GDP and Per Capita Expenditures in Different Regimes

Factors	Mujib regime	Zia Regime	Ershad Regime	Khaleda Zia regime
Health allocation as a per cent of national budget allocation (average)	3.90	3.52	3.91	4.21
Health allocation as a per cent of GDP (average)	0.43	0.79	0.83	1.15
Per capita expenditure in Taka (average)	4.22	15.54	40.64	100.27

Source: Compiled from Khan 1997, Statistical year book various issues.

The table no.3.6 shows that allocation as a percentage of total national budget and GDP have increased over the regimes. The per capita expenditure has also increased. But these allocations, independently, are very much less. With this limited allocation of funds and resources, a comprehensive and minimum standard health care is not possible. It can be inferred from the table that the democratic regime of Mujib and Khaleda Zia had allocated more than Zia and Ershad who were military men and ruled the country on the basis of quasi-democratic way. The expenditures in the health sector during the regime of Khaleda Zia was twenty-four times more than that during the Mujib regime, more than six times than during the Zia regime and more than two times than during the Ershad regime. The democratic government are more interested in the developments of the health sector than the military or the dictatorial rulers were.

The government allocation and utilization patterns further indicates government's willingness for health sector development.

Table 3:7 Comparison of Allocations and Utilization Pattern in Health and Family Welfare Sector

TK. in Million

Plans	First Five year plan (1973-78)	Two year plan (1978-80)	Second Five year plan (1980-85)	Third Five year plan (1985-90)	Fourth Five year plan (1990-95)
Total Allocation	44550.00	38610.00	111000.00	250000.00	347000.00
Allocation to					
Health	1477.80	1176.50	4130.00	5500.00	10,600.00
Family Welfare	900.00	1000.00	3100.00	8700.00	15980.00
As a percent of National out lay					
Health	3.32	3.05	3.72	2.20	3.05
Family Welfare	2.02	2.59	2.80	3.48	4.60
Utilization in per cent					
Health	90.47	97.38	90.79	79.63	99.00
Family Welfare	78.94	71.07	122.92	111.73	106.38

Source: MOHFW 1996: 12-13

It is observed from the table no. 3.7 showing the allocation patterns that the rate of allocation increased of 1675.56 per cent for family welfare which mainly meant population control between first five-year plan and fourth five-year plan. The share for health is only 617.28 per cent at the same period. The expenditure pattern had also increased i.e., more than allocation pattern. The figure for family welfare is 2292.65 per cent and for health is only 690.18 per cent. The utilization pattern also indicates the government's fascination for the family welfare sector. All these indicate that the government is more interested in family planning rather than the development in the health sector. The allocation for health sector is almost the same over the plan period but the share for family welfare is increasing. The allocation pattern for health sector does not suggest a high prioritization of the sector.

Table 3:8 Comparison of ADP Allocation to Health and Family Welfare

Tk in Million

Year	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96
Total Allocation to						
Health	1789.80	2162.40	2787.60	3115.80	4100.00	4660.00
Family Welfare	2970.40	3425.00	3511.00	4596.4	5360.00	5200.00
Project Aid to						
Health	653.90	955.20	1489.60	1831.10	2040.00	2300.00
Family Welfare	2093.30	2356.30	2185.30	2993.80	3620.00	3450.05
GOB Taka in						
Health	835.90	1207.20	1298.00	1284.70	2060.00	2360.00
Family Welfare	877.10	1068.70	1325.70	1423.90	1740.00	1817.30

Source: As on Table 3.7

The development activities are done through annual development program (ADP) allocations. The allocation for family welfare has been observed to the always more compared to the allocation for health (Table 3.8). It indicates that the government is more interested to develop family welfare sector than health sector. The donors allocations also paint out to the same trend. The donors communities are more

interested for the development of family welfare sector. They believe in population control rather than the over-all, long overdue development of the population.

Table 3:9 Comparison of Allocation to Health Sector During Fourth and Fifth Plans

TK. in Million

Plans	4th Five Years Plan		5th Five Years Plan	
Programs	Total Allocation	% of Total Allocation	Total Allocation	% of Total Allocation
Primarily level	5671.90	53	34249.84	55.1
Secondary Level	1179.70	11	6227.24	9.9
Tertiary Level	2033.40	19	8718.14	14.2
Manpower Development	1154.00	11	9340.86	14.9
Drug, biological, equipment	422.50	4	3113.62	4.9
Miscellaneous	208.50	2	622.70	0.9
Total	**10670.00**	**100**	**62272.40**	**100.00**

Source: GOB 1990, 1998

The allocation pattern shows that in both the Fourth and the Fifth Plans, more than fifty per cent allocations have been made for the primary level health care, while the share of the secondary (district) and the tertiary (regional and national) levels has been 30 per cent in the Fourth and 24.1 per cent in the Fifth Plan periods. The secondary level has comparatively less allocation than primary and tertiary health care. The tertiary and secondary level health care mostly benefit the urban and the richest people. So it can be concluded that the allocation pattern is biased the non-poor.

Table 3:10 Percentage Distribution of MOHFW Expenditures Pattern

Category	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97
MOHFW Secretariat	12	17	21	n.a.	18	13
Medical College hospital	10	10	9	n.a.	10	11
District hospitals	10	10	8	n.a.	7	10
THCs	33	30	27	n.a.	28	29
Union level	13	8	10	n.a.	12	9
Specialized	12	15	13	n.a.	14	16
Research and Training	9	9	10	n.a.	9	11
Other facilities	1	1	1	n.a.	1	1
Total	**100**	**100**	**100**	n.a.	**100**	**100**

Note : n.a. indicate not available

Source: MOHFW 1998: 13

It is observed from the figures in the table 3:10 that THC and Union level expenditures were the highest. The expenditures for the medical colleges, the district hospitals, and the specialized hospitals were the second largest. There was a decreasing trend of expenditure at the Thana and Lower level facilities. The share of those at the lower levels was 46 per cent in 1991-92, 38 per cent in 1996-97, while the share of the higher levels hospitals was 22 per cent and 26 per cent, respectively. These figures also indicate bias towards non-poor and urban areas. The upper section of the society also gets benefited by the tertiary health care services. The political power favors the most affluent segments of the population.

Table 3:11 Distribution of MSR Funds into Different Types of Facilities

Types of Facilities	% of total
THCs	11.80
UHFWC	5.00
Central Medical Store	20.00
Urban Dispensaries	0.20
School Health Clinic	0.20
District, Medical and Specialized Hospitals	62.80
Total	**100.00**

Source: Begum and Sen 1997:60

The medical and surgical requirements (MSR) allocations are done on the basis of bed capacity of the hospitals. The utilization rate is not considered for MSR allocation. Allocations at different levels for different facilities are also not rational. All medical college and specialized hospitals are allocated TK. 20,000 per bed per year, but TK. 18000 is granted to district level and TK 10,500 to THC level hospitals. For the purposes of allocations to the USC/UHFWC, urban dispensaries and school health clinics facilities available are taken into consideration. The UHFWC get TK 40,000 per year, urban dispensaries get TK 70,000 per year and the school health clinics get TK 70,000 per year. The central medical store gets only 20 per cent of the total fund for buying equipments and machinery. The table shows bias towards tertiary health care. About two-thirds of the health budget is for the secondary and the tertiary sectors while the share of primary health care is only 17 per cent of the MSR fund. The shares of the urban dispensaries and the school health clinics are even worse. (only 2 per cent). The urban and the rich people get more in patient care than the rural and the poor people. So the fact that the relative

benefit goes to the upper segments of the society further indicates the skewed balance of development and political power in favour of the more affluent segments of the society.

The allocation pattern for the hospital diets is not adequate or equitable. At present TK. 30 is allocated per patient per day for three meals. There are allegations of pilferage, wastage and misuse of food, which causes poor quality and insufficient quantity of diet supplied to the patients. The food allocation pattern is same irrespective of the nature of the hospital as its location. Price differences exist between the rural and the urban areas. Different types of food are required for different types of patients. But the authorities do not take that vital fact into consideration. TK 30 is too little to provide three meals a day, the question of quality do not arise in such cases. The poorer patients have no alternatives but to eat the hospital diet, inadequate both in quantity and quality. The non-poor section brings food from outside which is violative of the stipulated hospital rules.

Table 3:12 Proportionate Revenue Expenditure on Health

Figure in percentage

Year	Pay and Allowance	Contingencies and Diet	MSR
1980-81	48	23	28
1983-84	54	23	24
1986-87	66	17	17
1989-90	67	17	15
1992-93	68	15	17
1995-96	69	15	16

Source: DGHS 1998:101

An analysis of the revenue budget shows that the allocations for the pay and the allowance of the officers and the staff are increasing, while that for contingencies,

diet and MSR are going down. It also shows that the health staffs and the officers benefit more than the two- thirds allocations can offer. So the amount left for diet and MSR became even less than what is stipulated. The quality of services are going down pathetically. The figures in the table indicates that the allocations for pays and the allowances was 48 per cent in early 1980, which increased to 65 per cent in mid-1990s, and that, the share for contingence diet and MSR was 23 per cent and 28 per cent, respectively in early 1980s which on the other hand , declined to 15 per cent and 16 per cent, respectively, in the same period. It also indicates that the government is not interested in quality health, services as that can be ensured by diet and MSR in a big way.

Table 3:13 ADP (real) Allocation in Health Sector as a Percentage of Social Sector

Year	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98
Social sector allocation as a per cent of ADP	12.96	12.48	16.39	18.88	23.93	21.02	21.67	23.98
Health as per cent of Social Sector	2.8	2.3	3.1	3.1	3.6	2.7	4.1	4.6

Source: GOB 1998 MOF

The health sector does not seem to enjoy that much priority within the social sector as it is required. The ADP allocation to this sector in early 1990 was only 2.8 per cent, which increased to only 4.6 per cent in late 1990s. The average budgetary allocation was only 3.3 per cent in 1990-98. The share of family welfare on an is in average, is only 4.36 per cent but of education and religion is more than 10 per cent. This proves that the government is less committed to the betterment of the health of the people when compared to its commitment for education and family welfare

Table 3:14 Financing Pattern of MOHFW in 1996-97

Tk. in Million

Provider	Revenue Budget	Development Budget
Medical College hospitals	919.00	1012.00
District hospitals	649.00	1308.00
Specialized Hospitals & Institute	1043.00	1432.00
Subtotal	2611.00	3752.00
Thana and lower level facilities	2846.00	3282.00
Public Administration and others	1211.00	1487.00
Education, Research and Training	382.00	1544.00
Other Public Facilities	92.00	38.00
Total	**7142.00**	**10103.00**

Source: Schwartz 1998

The MOHFW financing pattern shows that there are higher allocations for the secondary and the tertiary level health facilities when compared to that for the primary level in the revenue budget. In the development budget also it is more for secondary and tertiary health care facilities than for primary, thus, clearly indicating that the government favors the tertiary and the secondary sectors.

The power structure of the society and its decision-making machinery favor "higher level" facilities for the higher echelons of the society. Such a policy is relevant to the skewed balance of political power in favor of those who wield the power. The nature of the state and its political economy create such a financing system that the upper strata of the society only get benefited.

IV. The Private Health Care Sector in Bangladesh

The private health care system is an important constituent of Bangladesh's health care system. There is a wide network of private health care facilities. There are various types and forms of organizations to provide the health needs of the higher strata of the population. The presence of private health care system is nothing new in a political economy which is heavily tilted towards privatization. Its existence was noticed from the late nineteenth century.

During the Pakistani rule, the development of private health care system was put in priority as the state had recognized her inability to cover the health needs of the entire population. So the private sector was invited to take a major role in the provision of health care. The state even offered some concession to boost up the private sector development. It provided free land or, at least, helped in the acquisition of land to those organizations and individuals who desired to open hospitals, dispensaries, maternity homes, clinics. The State also offered assistance in the procurement of equipments and drugs and, tax exemptions to those organizations and individuals who provided free services. The private sector was asked to undertake insurance schemes also in the large cities. Thus, within this program, the hospitals and the dispensaries were built for the benefit of the urban middle class.

Following independence during Zia regime in 1977, the private sector had come in the forefront. The government used to give all possible incentives for the development of the private sector. The House Building Finance Corporation (HBFC) was asked to disburse loans to the private sector investor with a very low interest rate. Policy was undertaken to build 25-50 bed polyclinics, residence cum clinics, and nursing homes. So within a short period of time the number of hospitals

increased from 36 in 1978 to 164 in 1981 and the number of beds increased from 2685 to 4771 in the same period in the private sector. Thus, there were 355.56 per cent and 77.69 per cent increase in the number of hospitals and beds, respectively. But in the public sector the corresponding figures were discouraging. The rise in the number of hospitals was only 31.96 per cent and that of beds only 13.78 per cent.

Table 3:15 Comparison and Development of Public and Private Sectors

Years	Public Sector		Private Sectors	
	Hospitals	Beds	Hospitals	Beds
1978	388	16583	36	2685
1981	512	19201	164	4771
1982	544	19136	164	4771
1987	608	26575	267	6463
1990	608	27003	267	6463
1991	610	27111	280	7242
1995	645	29106	288	8025
1996	645	29502	288	8025

Source : B.B.S. Statistical year book various years. Figures are in commutative number

In 1982, the enactments regarding medical practice, private clinics and laboratories (Appendix-3) were framed to boost up private sector development. The number of such institutions had gone up from 164 in 1982 to 267 in 1987. In the same period, the number of public sector hospitals had also risen from 544 to 608. The percentage of increase was 62.80 and 11.76 in private and public sector respectively. The number of beds had increased by 35.46 per cent and 1.61per cent in the two sectors in the same period. All this was possible due to the government commitment toward the development of the private sector. Taka 500 million was made available for the

development of polyclinics, x-ray clinics, pathological laboratories, nursing homes, medical institutions etc. in the private sector. During early 1990's, more emphasis was laid on the development of the private sector. According to B.B.S figures, 37 new hospitals were established. In 1990 to 1995 the number of hospitals went up from 608 to 645 and for the number of beds in the public sector from 27003 to 29106. In the private sector the figures were 267 to 288 for hospitals and 6463 to 8025 for beds in the same period. So the percentage of hospitals in the public and the private sectors increased by 6.09 and 7.87, respectively; for bed it was 7.79 per cent and 24.17 per cent in the same period. From 1978 to 1996 the rate of increase in public sector was 66.24 per cent for hospitals and 77.91 per cent for beds and in the private sector it was 700 per cent for hospitals and 198.22 per cent for beds. So the rate of increase in the private sector was near about 11 times for hospitals and 3 times for beds compared to that in the public sector within a span of nineteen years. During the period 1997, private sector development has been given high priority. Particularly for supplementary efforts in boosting up health care. It was estimated that the private sector will invest Tk 18,682 millions. This amount was in addition to the NGOs and the voluntary organizations investments. It is also estimated that these two (NGO and Voluntary) sectors will invest Tk 6227 millions. So it is expected that the private sector will receive a further boost-up and will establish more private medical colleges, polyclinics, hospitals, nursing homes, x-ray clinics, pathological laboratories etc.

It is observed that most of the health care facilities are concentrated in urban areas It is logical and natural that the development of private sector is based on

profit motive. They locate their enterprises in places where more profit can be earned.

Table 3:16 Number of Private Hospitals and Clinics Registered by Year of Establishment

Years	Total for Bangladesh		Total for Dhaka	
	Hospitals/Clinics	No. of beds	Hospitals/Clinics	No. of beds
1980-85	53	759	28	435
1985-90	103	1985	45	718
1990-95	164	2274	57	865
1995-97	112*	2548	43	410
Total	**432**	**7566**	**173**	**2428**

Notes * the decrease in the numbers is because the figure is only two years.

Source : Khan (1996)

The figures in Table 2 indicate that private sector development between 1980-90 was more than 715 per cent all over Bangladesh. In the capital city the figure was more than 517 per cent for hospitals, since more than 40 per cent facilities are in Dhaka.

Table 3:17 Location of Private Sector (95-96)

	Bangladesh	City Centre* of Medical Colleges (MC)	Dhaka	Non-city of MC
Hospitals	288	205	122	83
Beds	8025	5388	3488	2637

Source: Compiled from B.B.S 1998

*City center of medical colleges indicate the places where medical colleges are located. This figure includes Dhaka city also.

The figure in Table 3:14 indicates that more than 71 per cent of the hospitals are in urban areas and more than 67 per cent of the beds are also in the urban areas, thus

indicating that the private sector is biased in favour of the urban population. There were 450 private laboratories and diagnostic centres by the end of June 1995. Another 395 applied for registration from all over the country and obtained government approval. It is estimated that half of these newly registered centres are located in Dhaka itself. Hence by 1997, Dhaka has 645 laboratories and diagnostic center (Khan 1996). There is no available study about the diagnostic centers and the laboratories. A general observation, tells us that types of facilities developed in those areas where other health facilities were already concentrated. The city centres of the medical colleges had better facilities.

There are eight medical colleges in the private sector, and a few are under processing for government approval. There was only one medical college in the late eighties. The growth rate of medical colleges in the private sector is 700 per cent whereas at the same time, the public sector growth is only 62.50 per cent.

It is widely believed that physicians prefer to locate their practices in the urban areas because the people of urban areas have more income than those of rural areas. They also command a better income-generating process. It is also observed that their fees are more than of their rural counterparts. Thus, physicians earn more in urban areas than in rural areas. There are social factors also which encourage the physicians to settle down and practice in the urban areas. They can avail of urban amenities which are not available in the rural areas. Hence private sector facilities developed in the urban areas only.

The government doctors are the major source of manpower even in the private sector. Rules are hardly followed up. A WHO Report (1992) indicates that the doctors in government service invest more time to private practices. They even

alter official working days and hours to work in the private sector. They are extremely reluctant to work for which they are employed. They are getting salary without offering full level of service the public sector hospitals where they are employed. Most of the medical graduates, that is why, prefer government jobs which give them immense opportunity to practice privately by using the weight of their position. Patients usually prefer senior doctors from government service.

A recent report indicates that there is a informal relation between the physician and diagnostic centres and clinics. A large number of such doctors earn additionally through 'commission', offered by the owners of the diagnostic centres for having referred patients. The referral fee charged by these doctors vary from 20 per cent to 70 per cent, depending on the type of investigation. The diagnostic centers get more patients if they are ready to pay higher 'commissions' to the referring doctors. The number of tests prescribed for the patients is also unscrupulously high. Both the centers and the physicians gain in geometrical proportion as a result of such dishonest, patient-un-friendly practices. The government doctors also get money from the private hospitals for having referred patients to them. In this way private hospitals are getting patients through the government doctors.

The government has fixed the charges of different laboratory tests. But hardly these rules are followed. Different hospitals and different clinics have different rates depending on their locations and reputation. Similar varying rates exist for hospital admission, bed / cabin fare, surgical operations etc. The charges for a dental x-ray e.g. vary from Taka 40 to Taka 65. Same applies to all other tests, etc. It is observed that the average cost of room, operation theater (OT) and surgery has increased by 125 per cent to 200 per cent since 1982.

Table 3:18 Maximum fees for Medical Services as defined by the Medical Practice and Private Clinics and Laboratories Ordinance 1982 and Inflation Adjusted 1995-96 Rates

	1982 fee/charge	1982 fee in 1995-96 prices
CONSULTATION (CPI 1982-83=100;1995-96=263.3)		
Registered medical practitioners in the Service of the Republic		
Professors/associate Prof.	**Tk. 40 (revisit 20)**	**Tk. 105**
Asst. Prof./civil surgeons etc.	**Tk. 30 (revisit 15)**	**Tk. 79**
Others	Tk. 20 (revisit 10)	Tk. 53
Registered Medical practitioners Not in the service of the Republic		
Holders of advanced medical Qualification	Tk. 40 (revisit 20)	Tk. 205
Others	Tk. 20 (revisit 10)	Tk. 53
SURGICAL OPERATIONS (House rent 1982-82=100, 1995-96=297)		
Major operation OT charges	**Tk. 600**	**Tk. 1740**
Anesthesia charge +drug costs	**Tk. 800**	**Tk. 2176**
Operating charge	Tk. 2000	Tk. 5740
Interned. Operation OT charge	Tk. 300	Tk. 870
Anesthesia charge + drug costs	Tk. 400	Tk. 1088
Operating charge	Tk. 1000	Tk. 2870
Minor operation OT charge	Tk. 200	Tk. 580
Anesthesia charge +drug costs	Tk. 250	Tk. 680
Operating charge	Tk. 400	Tk. 1148
Normal Delivery (50 per cent rent, 50 per cent CPI)	Tk. 400	Tk. 1120
LABORATORY TEST80		
Histopathology	Tk. 80	Tk. 224
Pap Smear	Tk. 40	Tk. 112
Fungus	Tk 20	Tk. 56
Fungus culture	Tk. 50	Tk. 140
Blood Sugar	Tk. 20	Tk. 56
Blood Urea	Tk. 25	Tk. 70
Serum uric acid	Tk. 30	Tk. 84
Serum sodium	Tk. 30	Tk. 84
Serum iron	Tk. 60	Tk. 168

Source : 1982 Ordinance and BBS 1996 for constructing price indices cited in Khan 1996

Khan study (1995) shows that total charges have increased three times, but the unit charges have increased by less than 150 per cent Since there is no regulation

ensuring consumer protection, the private sector is ruling over the lives of people according to its desire and the rules of market economy.

It is also observed that the consultation fees have been raised much more than the inflation rate by the physician. During 1982, the fees of the Professors and the Associate Professors was Taka 40, of the Assistant Professors and the Civil Surgeons was Tk 30 and of others TK. 20 ; fees for a revisit was 50 per cent of first visit. If the inflation rate is taken consideration into then their fees should be Tk.105, Tk.79 and Tk.53 respectively. But they are charging Tk. 300 (revisit Tk. 200), Tk. 200 (revisit Tk. 100) and Tk. 100 (revisit Tk. 50), respectively.

The private health care system is expanding day by day. But the expansion process is not systematic. It hardly follow any rules. It is totally driven by profit motive. Most of these hospitals run with open-staff system. They do not have any permanent staff. They take the services of the government health personnel, whenever they need. Only a few have their own manpower (closed staff system) but they are at the junior levels. Their administrative system is also weak. Each has its own set of administrative mechanism. There are no hard and fast rules. The hospitals are run directly by the management cum owner. There are a few exception who follow a set of rules. These rules are based on the government rules such as BIRDEM child hospital etc.

Private hospitals system is expanding encouraged by the ruling socio-economic and political dynamics of the society. The political authorities encourage such expansions. They seem to be more committed to the private sector development. The state provides all incentives, envisaged in her policy. This has been discussed earlier.

According to a household expenditure survey of 1995-96, top five per cent of the households in the urban areas have an income of Taka 38508 and in the rural areas Taka 14404. (BBS 1998). Another top 20 per cent of households in the urban areas have very good income. So they can easily afford the expenses of the medical costs. It is also observed that a modern patient wants immediate cure whatever the nature of disease which ultimately increases the visits number to a doctor. This helps the private sector expansion.

In 1996-97, total health expenditure i.e., all expenditures on the public private, NGO, and voluntary sectors amounted to Tk 54,700 million, which is 3.9 per cent of the GDP. The share of the public sector is only 34 per cent of the total expenditure. The largest single source of health financing is direct payments of the households, which accounts for 63 per cent. (MOHFW 1998:1-2). It is estimated that health expenditure will increase at the rate of eight per cent in real terms and government expenditure will increase only four per cent in real terms. (MOHFW 1998a:83). This increased burden will naturally be on the individual supposed to be beneficiaries. This gives an opportunity to the private sector to generate money from the patients. This facilitates private sector expansion and development, thus commanding a more important position in the health sector.

The nature of service is important for its expansion. The perception about the quality of service in the private sector varies according to the households and the income groups. A survey of two medical colleges, one in the private sector and the other in the public sector, shows that the prescriptions for drugs and the diagnostic tests are almost the same in the both private and public sectors. But in the private sector, the doctors usually devote more time (6.9 minutes) to the patient than in the

public sector (3.2 minutes) for consultation (Khan 1996). The private sector doctors take two times more than his counterpart in the public sector. This gives an impression among the patients that a private practitioner charging more and devoting more time than the public sector doctors. The social images of the private practitioners is highly favourable. Hence the private sector is expanding incessantly.

The outdoors are the major sources of service provision in the public sector. It is found that the number of patients for 1993, 1994, 1995 and 1996 are 54.25 million, 40.57 million, 41.71 million and 37.86 million respectively (DGHS :1998) for all types of public sector hospitals – from the post-graduate to the thana health complex. The figures indicate that outdoor attendance is decreasing. From 1993 to 1996, more than 69.79 per cent has decreased. It is strange that whole the population is increasing by near about two per cent per year, the attendance in the public sector hospitals is decreasing. The causes probably are non-availability of doctors, non- availability of drugs, over-crowding, more waiting time, more distance etc. So people are less interested in visiting the public sector hospitals. Hence once again, the private sector is expanding.

A study shows that in 1994, eight medical colleges generated only 1.41 millions out-patient consultations. This is like less than five patients per day per physician. (265 days of work per year is assumed). It is also estimated that 50 per cent of them are not able to provide services due to other administrative responsibilities, hence per physician consultation remains below 10 per day (Khan 1996). This apathy on the part of the public sector doctors towards their duties and responsibilities ultimately guarantee private sector expansion.

Bangladesh has a big private health care market. From early 1980s it is expanding. The negative role of the state and the consequent demand by the patients make it expanding forever. But, it is still in a infancy state. Most of the facilities are limited. Yet, the private sector is playing an important an role in the provisioning of health care.

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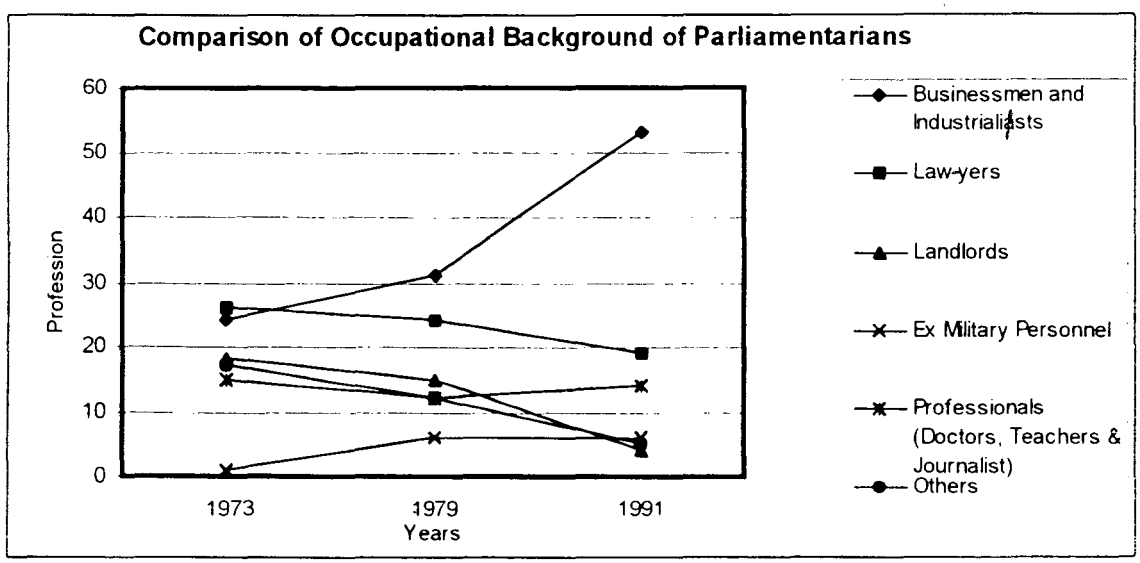
CHAPTER 4

DISCUSSION AND CONCLUSION

Ever since her independence from the yokes of Pakistani's military autocracy Bangladesh, has been governed by the 'coterie' interest of the upper strata of the society whoever may have been the Head of State, or whatever may have been the shift in her political economy. In every sphere of the state administration, they been able to maintain their interest and influence. The social and economic background of this elite and the consequent economic policies pursued by the state encouraged their growth in power.

Graph 4:A



Source: For 1973 election Jahan (1976), 1979 compiled from biography of Parliamentarians, 1991 Moniruzzaman (1992)

The above graph 4:A indicates that businessmen and the industrialists followed by civil-military bureaucrats were the class emerging as most powerful in these days. The positions of the lawyers and the landlords were declining in power, yet, were

they in large numbers, in the ruling class. These upper strata of professionals have been making decision in all respects.

In the field of economy, all incentive for the private sector development were there. So the private sector investment had increased from TK. 1450 millions in 1972-73 to TK. 11022 millions in 1976-77 to TK. 33404 millions in 1986-87 and from TK. 71804 millions in 1992-93 to TK. 157064 millions in 1997-98. In the same period the public sector investment had comparatively gone down. The corresponding figures in the public sector were TK. 2577 millions, Tk. 8456 millions, TK. 34173 millions, TK. 59044 millions, TK. 93443 millions. The share of the private sector allocation in the first five-year plan was TK. 64295, which increased to TK. 1100,582 million on 1996-97 prices during the fifth five-year plan. The increase was from 11.29 per cent to 56.17 per cent in the same plan period (BBS. Statistical Yearbook, Various Issues).

The economic policies of different regime boosted the private sector development, giving enough inputs to the emerging new class of people. They started controlling the economy as well as the polity. The government policy also helped this group to earn a substantial part of the national income. So there is a wide gap in income distribution among the people of Bangladesh. It is observed that during 1985-86, the lowest 20 per cent of the population had only 10 per cent of the national income while the highest 20 per cent owned 37.2 per cent of the national income. The share of the lowest income group declined in 1992 to 4.1 per cent and that of the highest group went up to 38 per cent during the same period (WB 1990, 1995). So it is observed that the shares of household income of the lowest groups are continuously declining, while that of the highest groups are showing an upward trend

permanently. During the early days of independence, there were no billionaires but at present there are at least 300 families of billionaires. The wealth has got concentrated in the hands of a few who, directly or indirectly, have full control over the economy as well as polity. Hence the decision making process is also totally in their hands. The emerging trend of businessmen as Members of Parliament members prove this and also indicate that their emergence is omnipotent. The state thus created a new class of entrepreneurs, who were provided and rewarded with financial and commercial incentives. The economic and political policies of the state had given them the advantageous position for flourishing further.

The economic policies of different regimes have been focusing on the private sector initiatives and the, private sector developments. Mujib had followed the policy of state controlled economy, giving high priority to the public sector development. But the regime itself shifted from its earlier position and the private sector was allowed to investment more and more. Zia too, had indirectly opened up the economy to the private sector. Ershad had boosted the private sector growth directly. Khelada Zia followed the same policy and helped its further development. Sheikh Hasina is no exception. The state is de-emphasizing public sector growth; it is infact, declining. The private sector growth is encouraged with all possible supports and incentives.

Table 4:1 Investment as Percentage of Total Resources

Year	1972-73	1975-76	1984-85	1988-89	1990-91	1995-96	1997-98p*
Total	8.73	11.47	10.81	10.37	9.90	13.74	12.99
Private	3.14	5.02	6.22	5.51	5.01	8.66	8.14
Public	5.59	6.45	4.59	4.86	4.89	5.08	4.85

Note:* Preliminary

Source: BBS, Statistical yearbook various years.

The Table no. 4:1 clearly shows that the private sector investment has increased while the share of public sector has consistently declined. It points out that the regimes have encouraged private sector development, which has affected the public sector adversely. The entire economy is now directed to private sector growth and development. But the structure of the public sector is large in terms of its organization. It has more personnel, more activities. It's activities are evenly distributed all over the country. It provides services for the common people. It emphasizes national interest rather than on narrow personal interests. The public sector role is indirecting industry, public administration, defence, social services, power, gas, water, sanitation, communication etc.

Public Health sector is one of the most important components of social service sector inspite of the dominance of the private sector. It is the major provider of health services in Bangladesh. It still offers more facilities, has more qualified personnel and is evenly spread all over the country, though it has its urban bias in facility development and resource distribution. There were 15706 beds available in the urban areas and the share of the rural areas was 11297 in 1990 (Das et.al 1991). It is also seen that all the specialized and super-specialized hospitals such as BSMMU, ICVD, RIHO, NIO, IDCH, and 13 medical colleges are in the city centers only.

The expenditure pattern also reveals the bias of the government towards the urban residents. The per capita expenditure in the public sector in the urban areas is TK. 118 for in-patient service and TK. 79 for out-patient service. But the corresponding share of the rural areas is TK.41 and TK. 37, respectively. The amount of total expenditure on the medical personnel also indicates to same bias. The share of the

urban areas is TK. 230 and TK 110 is of the rural areas (MOHFW 1998). The manpower distribution is also more urban oriented. There is a shortage of doctors in the union and thana level health centres. The government is not able to provide, even a graduate doctor in all the union level health facilities. There is an over concentration of health personnel in the urban areas. It is observed that there were 359 doctors at IPGMR, 384 in DMC, 253 in Salimullah Medical College in 1990 (Presidential address by Ershad 25th July 1990).

The public health services though meant for the economically backward strata of the society are pro-rich. Overall 17 per cent of total government health subsidies benefit the poorest quintile of the population, while 25 per cent benefits the richest quintile of the population. The per capita public expenditure for the richest (income quintiles) is TK 90 (31 per cent) and for the poorest is TK 39 (13 per cent) for in-patient services. The share for out-patient services is TK 53 (23 per cent) and 43 (18 per cent) respective by for theses two groups. (MOHFW 1998:32)

There is no socio-economic study of the patients who receive specialized or super-specialized care. A general observation shows that those who take in-patient services are mostly from the middle or the upper middle class. The BSMMU has all paying beds. So it is difficult for the general population to get services there. It provides the highest level of health facilities, but only the affluent can reap this benefit. So is the case with many other specialized and medical college hospitals where good number of beds are free. A survey (N.D) shows that 35.6 per cent of the patients could not get admission to public hospitals through the normal procedure (Transparency International). It is also found from the study that 43.5 per cent households agreed that without either money or influence, it is difficult to get

admission to public hospitals. So the influentials and the affluent could get the services of these hospitals whether in the public or the private sector. The poorest, the rural residents and the women receive the least less service or benefit from the government facilities.

Table 4:2 Use of Public Facilities by Level

(in percentage)

Income Group	Hospital Visits	THC Visits	Union level facility visits
Poorest quintile	13	23	26
Second quintile	17	20	19
Third quintile	25	23	21
Fourth quintile	23	20	17
Richest quintile	22	14	17
Residence			
Rural (82 per cent)	65	89	83
Urban (18 per cent)	35	11	17
Gender			
Male (51.3 per cent)	48	53	55
Female (48.7 per cent)	52	47	45

Source: MOHFW. 1998a:102

Table no. 4:2 shows that the richest 20 per cent of the population are much more likely to use hospital services which have become the most expensive avenues to health care. The poorest section has to use the primary level health care facilities- the THCs and union level health facilities where the facilities, all types, are minimal. It shows that 82 per cent of the rural population are eligible to 65 per cent hospital visits, 89 per cent to THC and 83 per cent to union level facilities compared to the small 18 per cent of the urban population who receive 35 per cent, 11 per cent and 17 per cent services, respectively in these places. The condition is worse when in-patient services are considered. The patients from the richest quintile to get admitted for in-patient care enjoy a five times more privilege than the patients from

the poorest quintile. The urban patients are more than twice advantaged the rural patients and the male patients are more likely to get adequate and quality treatment than the female patients (MOHFW: 1998:101).

It has been mentioned earlier that the physicians prefer to locate their practice in the urban areas as these provide better income opportunities, better living facilities and other socio-cultural services. One can not expect all these in the rural areas: 390 THCs and 4200 USC/UHFWC provide health services to the rural people. In 1993, there were 23.50 million outdoor attendance in the hospitals which declined to 15.65 million in 1996; for THCs and for USC, the figures were 24.98 million in 1993 which declined to 17.18 million in 1996 (DGHS 1998). Another study confirms the declining trends in the government services. In 1984, about 20 per cent of the rural patients suffering from acute illnesses were treated in the public sector. This declined to 13 per cent in 1987 and to 12 per cent in 1994 (Begum 1996). This declining trend can be attributed to the non-availability of doctors, and drugs, inadequate attention by the doctors, accompanied by their greed for money, and also too long a distance from home, etc. A minimum of 28.1 per cent mentioned inadequate attention from the doctors, 25.7 per cent talked about the non availability of drugs, 4.9 per cent about the long waiting time, and 9.2 per cent about the very long distance (Khan 1988). The poorer patients are more sufferers from improper medical attention. They are given less attention, less medicine. The people who look affluent get a better deal. The THC personnel shows a preference to the well off and educated persons. They may be related to the elite or known to the doctors (Rahman and Ali 1996:47). So the rural health services are also pro-rich, and pro-elite. It withdraws decent services to the poorer sections of the population.

In the public sector the government has been generally found to emphasize the expansion of the physical infrastructure, like the building of the hospital. Since independence government has built around 650 hospitals buildings, and 4200 USCs/UHFWCs, 72 dispensaries, 96 maternity clinics structures. That is all. Most of these lack in laboratory facilities, required manpower, equipments etc. A survey of 16 THCs, 12 RDs, 100 USCs shows that 63 per cent had inadequate physical facilities, 60 per cent had inadequate personnel, and 80 per cent faced shortage of supplies or vaccines (Ahmed 1997). The government counts the number of buildings constructed while assessing its performance in this sector.

The public health services are gradually tending to have more specialists, rather the than mid level health personnel such a paramedics, nurses and auxiliary health personnel.

Table 4:3 Health Personnel in Different Levels

Health Personnel	1973	1985	1997
Postgraduate Doctors	259	1050	n.a.
Doctors	5001	16000	24981
Dental Surgeon	310	510	1200
Sub-Total	**5570**	**17560**	**26181**
Nurses	765	6500	13830
Medical Assistants	n.a.	3600	2254
Pharmacists	1500	5800	6800
Radiographers	130	350	758
Laboratory Technician	270	1350	1944$_x$
Sanitary Inspector	980	1265	1359$_x$
Dental Technician	20	n.a.	270
Sub-Total	**3665**	**18865**	**26715**

Note: 'x' indicates not column year source; n.a. means not available

Source: Five year plan-different issues and DGHS 1998

It is observed from table no. 4:3 that the state has produced more specialist than mid-level health personnel. During 1973 there were 5570 doctors including dentists. The number had increased to 17560 in 1985 and further to 26181 in 1997. But the number of mid-level health personnel were 3665, 18865 and 26715 respectively, in the same period.

There are six post graduate institutes, 14 medical colleges including one dental college as against two para-medical institutes, eight medical training schools, one college of nursing and 38 nursing institutes. The revenue expenses for medical colleges and other training schools reveal that in 1985-86 to 1989-90, the share of the medical colleges was 3.3 per cent as against 1.2 per cent share of the training schools. During 1990-91 to 1994-95, the share is same for both the sectors (Begum and Sen 1997:65). The manpower development plan and the resource allocations indicate the high preference for full-fledged and specialist doctor. The paramedics and nurses get very little attention.

There was only one postgraduate, eight graduate and one paramedical institutes in early 1970s. At present (1997), there are six post-graduate institutes, fourteen medical colleges and only two paramedical institutes, eight medical training schools, one nursing college, and 38 nursing institutes in the public sector. Every year 1250 postgraduate and graduate doctors are in the profession, but the number of paramedics is less than 200, and that of nurses about 900. The out turn of health technologists paramedics and nurses are below the national requirement. This as discussed extensively above is due to government policy the lop sided boom out of its lack of commitments for the people.

Another major malady of the public health services systems is that these focus on curative care rather than preventive care. The plan documents of the government reveal priority on preventive care, but in practice, all afforts are directed towards curative care. In the initial stages in 1970s, preventive program had been launched to control malaria, small pox and other epidemic diseases. There was uni-purpose program to control these diseases. In the latter part (1977) of the decade, all the uni-purpose (vertical) programs were integrated and the preventive efforts were shifted to childhood diseases only through EPI, and health education. In the 1980s, the preventive health programs became a part of the development programs for health. It is seen from table no. 4:4 that the revenue expenditure on preventive care was around 8 per cent in early 1980s and only 0.14 per cent in early 1990s. But the shares of allocation increased in ADP from 13 per cent in early 1980s to 25 per cent in early 1990s. Inspite of an increasing trend the total of revenue expenses and development allocations together is not more than 8 per cent of the health sector allocation for preventive care. Three-fourths morbidity originated from infectious and parasitic diseases. If the government takes appropriate measures to control the above – mentioned, then only it is possible to prevent them. Lack of appropriate measures like resource allocation for preventive care indicates a relative indifference about preventive care. Hence we see biases for curative cares only.

Table 4:4 Revenue Expenses and ADP Allocation for Preventive Care

(In percentage)

Period	Revenue Expenses	ADP Allocation (revised)
1975-76-1979-80	7.9	n.a.*
1979-80-1984-85	2.7	13.4
1985-86-1989-90	2.2	23.3
1990-91-1994-95	0.14	25.3

Source: Begum and Sen 1997:62 ; Note * n.a. indicates not available.

So from above analysis, it is clear that the public sector health services systems are biased in favour of the rich and the urban elite, stresses, on the construction of buildings than essential medical facilities, favours the service of the specialists and aims more at curative than preventive aspects. Though the public health services systems are expanding in terms of health care facilities and manpower. Yet it is far from a comprehensive, and integrated health services concept and system.

Table 4:5 Development of Health Status Over a Period of Time

Health indicators	1973	1997
Infant Mortality Rate	140/1000	78
Child Mortality Rate	260/1000	116
Maternal Mortality Rate	30/1000	3.6
Crude Birth Rate	47/1000	26.5
Crude Death Rate	17/1000	9
Life Expectancy at Birth (yrs)	45	58
Doctor: Population	1:10714	1:4572
Nurse: Doctor	1: 10	1:2
Bed: Population	1:6250	1:3151

Source : Five Year Plan-Different issues; DGHS 1998

Bangladesh has improved her health status over the period. Table 4:5 shows that during 1973, the IMR was 140/1000, CMR was 260/1000, MMR was 30/1000, CBR was 47/1000, LEB was 45 years, and the doctor population ratio was 1:6250. In 1997, the IMR was 78/1000, MMR was 3.6/1000, CBR was 26.5/1000, CDR was 9/1000, TFR was 3.4/1000, child mortality rate was 116/1000, and life expectancy at birth was 58.1 years. The total population covered by essential health care, was 50 per cent, immunization coverage under one year was 66 per cent, delivery assisted by trained persons was 14 per cent, external care was 40 per cent, diarrhoea control was 70 per cent. Average calorie intake capacity was 1950 K. cal, prevalence of low

birth weight was 25 per cent. There were 390 THCs, 4200 USC/UHFWCs, 290 government hospitals by 1997 (GOB 1998). But these achievements are much lower than those of the neighboring countries, and far below the regional and global averages.

As mentioned in the earlier chapter, poor inputs like the shortage of food, drug, and health facilities and health personnel are the major causes of the poor health status of the Bangladeshis. There are problems with housing, sanitation, safe water, income, employment, education, accessibility to services etc. which aggravate the poor health status of the population. The per capita food intake in 1995-96 was 5 per cent lower than in 1975-76. The per capita nutrient intake has gone down drastically over the years. The per capita intake capacity was 2118 K. calorie in 1962-64 which went down to 1868 in 1995-96. The intake of protein has lowered from 55.31 gm to 49.93 gm, of fat 20.06 gm to 15.95 gm in the same period. (Jahan 1997). When will Bangladesh be meeting their needs fully and satisfactorily like so many regional and global communities?

Table 4:6 Comparison of Daily Per Capita Supply of Calories of Different Countries

Year	1970	1995
Bangladesh	2177	2001
India	2078	2382
Pakistan	2198	2471
Sri Lanka	2229	2302
China	2000	2708
Least developing Countries	2090	2103
World	2337	2702

Source: UNDP 1998

The table no. 4:6 shows that all the neighboring and the world communities have achieved the requirements of calories intake capacity and not, of course,

Bangladesh. On the contrary, her position is further declining. The fact gets further strengthened by the following figures of table 4:7.

Table 4:7 Daily Per Capita Calorie Supply as Percentage of Requirements Among Different Countries

Year/Countries	1967-70	1980	1984-86	1988-90
Bangladesh	91	88	83	94
India	87	86	100	105
Pakistan	92	100	97	101
Sri Lanka	105	102	110	99
Cuba	107	120	124	137
China	89	107	111	112
Sweden	113	119	113	n.a.
U.S.A.	130	139	138	n.a.
U.K.	133	132	128	n.a.

Note: n.a. indicates not available

Source: Column 1,2 & 3 UN 1991 column 4 UNDP 1994

The participation of the labor force has increased from 50.7million in 1989 to 54.6 million in 1995-95. At the same time the number of the unemployed has also increased from 0.6 million to 1.4 million. So the overall employment, and income situation is terribly disheartening. The resources at the household levels are limited. As high as 62 per cent of the house hold expenditure is devoted to purchasing food. The figure is 73 per cent for the landless people. The poorest and the second lowest income groups spend TK 56 and TK 87 per month for health care and this account for 49 per cent of total household expenditures. (BIDS 1995) we also must keep in mind that most of the households have very little resources for access to health care. This has worsened the health situation of Bangladesh.

Table 4:8 GDP Per Capita of Different Countries

(in US$ 1987 price)

Year/Countries	1970	1980	1990	1995
Bangladesh	162	144	179	202
India	245	262	374	425
Pakistan	223	259	350	381
Sri Lanka	247	328	438	512
China	92	138	285	481
Sweden	14389	16903	20018	19521
U.S.A.	14001	16389	19426	20716
U.K.	8463	10161	12899	13445

Source: UNDP 1998: 140-42

The table 4:8 indicates that the people of Bangladesh are hardly able to get remedies for sickness, and ill health. The GDP of Bangladesh is near above 50 per cent less than that of the neighboring countries. The GDPs of the industrialized countries are 70 to 80 times more than of Bangladesh. This poor economic condition leaves very little room in Bangladesh for health care expenses. So the health status is far below than in the developed world.

But, the defence expenditure in Bangladesh is two times more than health expenditure. The expenditure for defence in developed countries is much less than the health expenditure. In 1990-97, the share of health expenditure as a percentage of total expenditure was 5 per cent in Bangladesh, 6 per cent in Sri Lanka, 20 per cent in USA, 14 per cent in U.K., and 11 per cent in the entire world. At the same time the defence expenditures in these countries are 10 per cent, 18 per cent, 16 per cent, 8 per cent, 9 per cent respectively (Table 4:9). Another unfortunate feature is that the government of Bangladesh is less interested in improving the health status of its people compared to the afore-mentioned countries. Since independence, Bangladesh was under direct or indirect military rule for about fifteen years. More

expenditure was incurred for increasing the salaries and the other facilities of the military personnel, etc. Hence there was more defence expenditure compared to expenditure for health care.

Table 4:9 Comparison of Central Government Expenditure in Health and Defence as a Percentage of Total Expenditure in Different Countries

Year	1972		1980		1990		1990-97	
Countries	Health	Defence	Health	Defence	Health	Defence	Health	Defence
Bangladesh	5.0	5.1	6.4	9.4	4.8	10.1	5x	10x
India	n.a.	n.a.	1.6	19.8	1.6	17.0	1	13
Sri Lanka	6.4	3.1	4.9	1.7	5.4	7.4	6	18
U.S.A.	8.6	32.2	10.4	21.2	13.5	22.6	20	16
U.K.	12.2	16.7	13.5	13.8	14.6	12.2	14	8
World	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	11	9

Note : n.a. indicates not available; *: 'x' indicate other than column indicates

Source: Column 1,2,3 from WB various years, Column 4 from UNICEF 1999

The educational status of Bangladesh for below than regional and global average.

Table 4:10 Comparison of Adult Literacy Rate of Different Countries

Year/Countries	1980		1995	
Gender	Male	Female	Male	Female
Bangladesh	41	17	49	26
India	55	25	66	38
Pakistan	38	15	50	24
Sri Lanka	91	80	93	87
Cuba	91	87	96	95
China	79	53	90	73
South Asia	52	24	63	36
Industrialized Countries	98	96	n.a.	n.a.
World	74	56	81	66

Note : n.a. indicates not available

Source: UNICEF (1999) P:106-109.

Table no. 4:10 shows the adult literacy rate. That too is lower in Bangladesh than in the neighboring, and regional countries. The poor status of education leads to poor health. Better health can be attained by learning and awareness, which can happen only if the level of education is universally high.

Table 4:11 Access to Safe Water, Sanitation and Health Care, Iodized Salt

(Figures are in Percentage)

Year	1990-97	1990-97	1985-95	1992-98
Access to	Safe Water	Sanitation	Health Care	Iodized Salt
Bangladesh	95	43	45	78
India	81	29	85	70
Pakistan	79	56	55	19
Sri Lanka	57	63	93	47
Cuba	93	66	98	45
China	67	24	92	83
U.K.	100x	96x	n.a.	n.a.
South Asia	80	33	n.a	65
World	75	44	n.a	66

Note : 'x' indicate other than column source. n.a. means not available indicates

Source: Column 1 and 2, 4 UNICEF 1999 Column 3 UNDP 1998

Bangladesh has made remarkable progress in the supply of safe drinking water compared to her neighboring countries. But the discovery of the presence of arsenic in ground water has caused a big set-back. Most of the districts have been found contaminated by arsenic. It is a rather formidable problem.

In Bangladesh, during 1990-97 period, only 43 per cent people had access to sanitation. Rest of the population used either *Kutcha* or other in-sanitary toilet system. A large number of people are devoid of any toilet facilities at all. This causes a serious threat to public health. It is seen from the figures in table no. 4:11

that those countries have achieved better health status who have better access to sanitation.

It is believed that Bangladesh lags behind the regional and global average because of poverty and the systems not yet fully developed. But 93 per cent and 98 per cent of the people of Sri Lanka and Cuba respectively have access to health care facilities. And, by no standards these two economies can be called developed or rich. It is the policies and the commitments of the governments that really matter not just its economic status or capabilities. On the contrary, healthy, educated and contented people make a country rich and powerful.

When Bangladesh has one doctor for 6670 persons, Cuba has 270 and Sweden has 370. In Bangladesh a single nurse is burdened with the care of 8340 patients. Is that humanly possible? So, nurses do not treat their patients humanily. In the world's most highly populated country viz: China a nurse has to take care of 1460 patients, where as in a poor country like Cuba 160 patients enjoy the good care of a nurse.

Table 4:12 Comparison of Population Per Physician and Nurse

Year	1970		1980		1990	
Personnel	Physician	Nurse	Physician	Nurse	Physician	Nurse
Bangladesh	8540	65810	10940	24450	6670	8340
India	4950	3760	3690	5460	2440	2220
Pakistan	4670	7020	3480	16960	2940	1720
Sri Lanka	5900	1290	7170	1340	7140	1400
Cuba	n.a.	n.a.	710	360	270	160
China	1500	2500	1810	1790	730	1460
Sweden	730	140	490	60	370x	n.a.
U.S.A.	630	160	520	140	420x	n.a.
U.K.	810	240	650	140	n.a.	n a

Note : 'x' indicate other than column indicates, n.a. indicates not available.

Source: Column 1 WB1993, column 2 WB 1984 column 3 UNDP 1994

Table no. 4:12 indicates that though the population: doctor and population: nurse ratios are showing an upward trend, the position of Bangladesh is still for below those countries that have achieved better health status.

The demographic and fertility facts of Bangladesh are not encouraging. They show that the country is far below the global average in these fields also.

Table 4:13 Comparison of Demographic and Fertility Character

Countries/ Year	1980			1990			1997		
B/D/F Factors	**CBR**	**CDR**	**TFR**	**CBR**	**CDR**	**TFR**	**CBR**	**CDR**	**TFR**
Bangladesh	45	18	6	35	14	4.6	27	10	3.2
India	36	14	4.9	30	11	4	25	9	3.1
Pakistan	44	16	6.1	42	12	5.8	36	8	5.1
Sri Lanka	28	7	3.6	20	6	2.1	18	6	2.1
Cuba	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	13	7	1.6
China	21	8	2.9	22	7	2.5	16	7	1.8
Sweden	12	11	1.7	15	12	1.9	12	11	1.8
U.S.A.	16	9	1.9	17	9	1.9	14	9	2
U.K.	14	12	1.8	13	11	1.8	12	11	1.7
South Asia	n.a.	n.a.	n.a.	32	11	4.2	27	9	3.4
World	n.a.	n.a.	n.a.	26	9	3.4	23	9	2.8

Note : CBR: Crude Birth rate per 1000 population; CDR: Crude Death rate per 1000 population ; TFR: Total fertility rate per women; n.a. indicates not available

Source: 1980 figures WB 1982, 1990 figures WB 1992, 1997 figures UNICEF 1999

It is seen from the table no. 4:13 that though there is a decreasing trend in CBR, CDR, TFR all over the world, Bangladesh is still far behind the average of the regional and developed countries. Excess of birth, death and fertility is the chief and almost insurmountable problem with Bangladesh. Its per square kilometer population density is 755. Per capita GNP (US$ 260) and GDP are too low These also cause the poor standard of health in Bangladesh.

The per capita expenditure on health is like this in a few countries of our interest. US$ 7 in Bangladesh, US$ 12 in Pakistan, US$ 18 in Sri Lanka, US$ 11 in China US$ 2343 in Sweden, $ 2765 in U.S.A. (WHO 1995).

In Bangladesh, only 8 per cent of births are attended by trained health personnel. The figure for India was 34 per cent, for Pakistan 18 per cent, Sri Lanka 94 per cent, Cuba 99 per cent, China 89 per cent, Sweden, USA and UK average 1996 to 99 per cent, and for the world 60 per cent in the 1990-97 period. Tetanus preventive injection during pregnancy was found in 86 per cent cases in Bangladesh, 80 per cent in India, 57 per cent in Pakistan, 89 per cent in Sri Lanka, 61 per cent in Cuba, (UNICEF 1999). This indicates that Bangladesh has (i) shortage of health personnel, (ii) women's position is low, and, above all, (iii) the health service system is weak. It is unable to provide adequate services to all and women's mortality rate is also high.

The health status of Bangladesh can be more clearly observed from following tables on IMR, MMR, CDR, (Table nos. 4:14, 4:15, 4:16)

Table 4:14 Comparison of IMR (<1 yrs) of Different Countries

Year/Country	1980	1990	1998
Bangladesh	136	105	79
India	123	92	72
Pakistan	126	103	74
Sri Lanka	44	19	18
Cuba	21	13	9
China	56	29	41
Sweden	7	6	5
U.S.A.	13	9	7
U.K.	12	8	7
South Asia	n.a.	93	n.a.
World	n.a.	52	n.a.

Note : * IMR: Infant mortality rate per 1000 life birth, n.a. indicates not available

Source: Column 1 WB 1982, Column 2 WB 1992, Column 3 WHO 1999

Though the IMR rate is decreasing in Bangladesh, it is still higher than the regional and the global average. Here it is near about 10 time more than in the industrialized countries.

Table 4:15 Comparison of Child (under five) Mortality Rate

The figure is for per 1000 life birth

Year/Country	1980	1990	1997
Bangladesh	211	140	109
India	177	131	108
Pakistan	151	138	136
Sri Lanka	52	23	19
Cuba	26	13	8
China	65	47	47
Sweden	9	6	4
U.S.A.	15	10	8
U.K.	14	9	7
South Asia	174x	135	116
World	117x	94	87

Note: x: indicates other than column sources

Source: Column 1 UNICEF 1997, Column 2 and 3 UNICEF 1999

The child mortality rate is decreasing in Bangladesh but it is still far above global average. The figure for Bangladesh is 15 to 20 times more than in the industrialized countries. The children of Bangladesh under five year suffer usually from underweight (56 per cent), wasting (18 per cent) stunting (55 per cent). Their growth also is stunted due to malnutrition (55 per cent) (Barket 1997). A large number of children die from diarrhoeal diseases. Hence CMR is more compared to other neighboring and developed countries.

Table 4:16 Comparison of MMR (Figures are for per 100,000)

Year/Country	1980	1990	1980-97
Bangladesh	600	850	440
India	500	570	440
Pakistan	600	340	n.a.
Sri Lanka	90	140	60
Cuba	n.a.	95	24
China	44	95	60
Sweden	4	7	5
U.S.A.	9	12	8
U.K.	7	9	7
World	n.a.	430	n.a.

Note : MMR: Maternal Mortality Rate ; n.a. means not available

Source: Column 1 WB 1991 Column 2 WHO 1999 Column 3 UNICEF 1999

The MMR is also decreasing in Bangladesh but the figures in table 4:16 shows that MMR is still far higher. The death rate is mainly due to anemia, lack of immunization against tetanus, and births not attended by trained medical personnel. All these make the mortality rate quite fearsome.

The IMR, MMR, CDR are much higher than the regional and the global averages. Hence the average life expectancy is also lower. It is observed that though life expectancy at birth has been improving over the years it is still much lower than the global and even the regional averages.

Table 4:17 Comparison of LEB of Different Countries

Year/Country	1980	1990	1997
Bangladesh	46	52	58
India	52	59	62
Pakistan	50	56	64
Sri Lanka	66	71	73
Cuba	73	76 x	76
China	64	70	70
Sweden	75	78	78
U.S.A.	74	76	77
U.K.	73	76	77
South Asia	n.a.	58	61
World	n.a.	66	67

Note : n.a. indicates not available; X indicates other than column year

LEB: Life expectancy at birth;

Source: Column 1 WB: 1982; Column 2 WB 1992; Column 3 UNICEF 1999

In conclusion we can say that the health status of the Bangladeshis is in an overall dismal state. They are victims of shortage of food, limited access to income, hence livelihood, limited access to health care, medicines, safe water, sanitation, etc. To top it all is the absence of government commitment.

The figures on health inputs, health status etc. are about the average population where the richest and the poorest are taken into account. If we book into the figures telling us separately about income distribution, urban-rural, male-female divide, then the facts will be more frustrating. There is a wide gap between the rich and the poor, the urban and the rural and, the male and the female in terms of the accessibilities and the benefits

According to Human Development Report, of 1992 the highest 10 per cent of the population of Bangladesh shared 23.7 per cent of income or consumption, but the lowest 10 per cent shared only 4.1 per cent. The figure for the highest 20 per cent

was 37.9 per cent and the lowest 20 per cent was 13.5 per cent (UNDP). According to Household Expenditure Survey 1995-96 the per house income of the top 5 per cent was TK 20615; for the urban areas it was TK 38508, and for the rural areas it was TK.14404. The share of the bottom 5 per cent was TK 774, TK1186 and Tk735 respectively in these categories. (BBS 1998).

There is a wide gap in the income range among the households, Needless to say one earns much more in the urban areas.

Table 4:18 Income Structure in Bangladesh

Fig. in TK.

Unit	National	Rural	Urban
Per Household income	4366	3658	7973
Per earner income	2950	2205	5014
Per capita income	830	697	1504

Source: BBS 1998

The literacy rate for seven years and above was 38.9 per cent for both sexes. In the urban areas it was 59.6 per cent, but in the rural it was 34.6 per cent; 44.3 per cent of the male and 33.4 per cent of the female (table 4:19) population were educated, or at least literate.

Table 4:19 Literacy (7 years and above)

Fig. in Percentage

SEX	National	Rural	Urban
Both Sexes	38.9	34.6	59.6
Male	44.3	39.8	66.1
Female	33.4	29.2	53.2

Source: BBS 1998.

There is a wide gap between the urban and the rural areas with regard to accessibility to safe water and hygienic sanitation. The females, as expected, are disadvantaged in these matters also (Table 4:20)

Table 4:20 Comparison of Urban-Rural Access to Safe Water, Sanitation and Electricity

Fig. in Percentage

Access to	Total	Urban	Rural
Safe water 19 90-97	95	99	95
Sanitation 1990-97	43	83	38
Electricity 1995-96	20.50	72.60	10.30

Source: UNICEF 1999 for row 1 and 2. BBS 1998 for row 3

Similar gaps between the rural and the urban areas and the male and the female are observed with regard to food intake capacity. Though table no. 4:21 shows that the daily per capita calorie intake capacity in rural areas is higher than in the urban areas. The protein and fat intake capacities are more in the urban areas.

Table 4:21 Comparison of Daily Per Capita Nutrient Intake in 1995-96

Nutrients	Total	Urban	Rural
Calorie (K Cal)	1868	1779	1892
Protein (Gm)	46.93	48.99	46.36
Fat (Gm)	15.95	22.50	14.14

Source: Jahan 1997

The inequitable gap between the male and the female with regard to food and nutrition intake is evident from the fact that on an average 60 to 70 per cent women suffer from anemia. A study reveals that 3.9 per cent women faced malnutrition related morbidity; the corresponding figure for men is 1.7 per cent. The land-holding size matters a lot only 3 per cent of those who have 0.51 to 2.5 acre land. suffer from malnutrition related morbidity is while this occurs in only 0.4 per cent of those who have more than 2.5 acre of land (Khan 1997:71-75). Female-headed households have higher malnutrition levels. Iodine deficiency disorder and anemia are more prevalent among women.

Table 4:22 Utilization of Health Care Services for Current Sickness by Sex and Residence

SEX	Per cent Treated	Residence	Per cent Treated
Male	87.10	Rural	83.61
Female	83.00	Urban	92.60
Both Sexes	85.00	National	85.00

Source: Khan 1997:78

The health care utilization pattern shows that male use more than female and urban people use more than the rural. We must also not that even among the urban and the privileged categories, females have less accessibilities to health care, food, nutrition and all other socio-economic benefits, though the rural female is definitely at a disadvantage compared to her urban counterpart (table 4:22). Differences in income also determine utilization pattern. Those who have less than 50 acres of land get only 80.7 per cent sicknesses, treated. while the figure is 89.5 per cent for more than 2.51 acres of land holding household (Khan 1997:80). On an average 38 per cent less is spent on a woman's treatment. If TK. 542 is spent e.g. for women, this TK 878 will be spent on men (average). (Rahman and Ali 1996:76).

IMR is higher in rural areas and with females. The table no. 4:23 shows that mortality rate is more for men and than female but it is move in rural areas then urban areas.

Table 4:23 IMR Difference by Sex and Residence (Per 1000 live birth)

Sex	1996	Residence	1996
Male	68	Rural	69
Female	66	Urban	50
Both Sexes	67	National	67

Source: BBS 1998:151

There is difference of MMR between the rural and the urban areas.

Table 4:24 Difference of MMR by Residence MMR Per 1000 Live Births

Residence	1996
Rural	4.6
Urban	3.8
National	4.4

Source: BBS 1998:151

Table no. 4:24 shows that MMR is much less in the urban areas than in the rural areas. The figure for the urban areas is 3.8/1000 while it is 4.6/1000 for the rural areas.

There is a difference in life expectancy at birth between the rural-urban and male-female. Table no. 4:25 shows urban (male and female) and male (urban-rural) have longer life expectancy than rural (female and male) and female (rural and urban) population.

Table 4:25 Life Expectancy at Birth in 1996

Sex	National	Rural	Urban
Male	59.1	58	61.7
Female	58.6	58.2	60.9
Both Sexes	58.9	58.2	60.9

Source: BBS 1998:152

In conclusion, we can say that those who have better income, have higher status in the society and also better health status. Besides, the urban people and men are better off in all fields. The poor, the rural and the female are always at a disadvantage.

Health service system is pro-rich and pro-urban male because they are the over in the decision making processes. Thus it is of the rich, by the rich and even for the rich.

Following independence, the leaders made lofty for an egalitarian society. But the state machinery was not changed or geared for that. The autocratic state machinery of the Pakistan days continued to work for the vested interests of the new emerging elite. Funds were allocated to build hospitals, but these were initially built in urban areas only on a priority basis not even minimum hospital services were provided to the rural area. Instead of building THCs and USC/UHFWCs which cost much less, hospitals were being constructed in urban areas only. The existing rural hospitals lack minimum facilities but in the urban areas, hospitals have been developing with the latest sophisticated equipments.

The political authority of Bangladesh does not seem to interested in developing the health of the general masses. All their commitments are in mere words. There have been no tangible measures to improve the health of the masses. China, Cuba, and Sri Lanka have achieved satisfactorily though their GDP is not encouraging. The political will of the leaders of these countries have made this possible. Even the state of Kerala (India) has been able to make significant success in health status. with IMR 13, CDR 6, CBR 17.3. The per capita health expenditure was Rs. 73.66 in 1990-91 and 8 per cent of the total expenditure (quoting Kutty. N.D.). The life expectancy for male was 67.23 years and for female is 72.37 years in 1995-96. Political will and commitment are the chief ingredients to attain better health status.

The power structure of the society is interested in producing physicians only because they are the children of the privileged class who enjoy state subsidy for their education and training. The elites get what they need for their better health and better life. The state is less interested in mid-level health personnel. They are unable to provide the kind of sophisticated consultations which the privileged wants. This

class always wants specialists care. Hence more specialized facilities has been developed in the urban areas. The nature of the state, the class character of ruling elite, the relationship among different upper segments of the population and its political economy hardly emphasize on a health services system which will cover all segments of population and area. So the government should change its policies and programs to provide better health care facilities which the country urgently needs for her majority population.

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Appendix - 1

Zia's Nineteen Point Program

1. To preserve the country's independence, integrity and sovereignty at all costs;
2. To reflect he four fundamental principles of the constitution in all spheres of national life;
3. To make the nation self-reliant in every possible way;
4. To ensure the participation of the people at every level of the administration, in development programs and in the maintenance of order;
5. To strengthen the economy by according top priority to agricultural development;
6. To ensure that no one went hungry, by making the country self-sufficient in food;
7. To ensure clothing for everyone, by increasing cloth production;
8. To take all measures to ensure that no one remained homeless;
9. To rid the country of illiteracy;
10. To ensure a minimum level of medical care;
11. To give women their rightful place in society and to organize and inspire the young for building the nation;
12. To give necessary incentives to the private sector for the economic development of the country;
13. To improve workers' conditions and to develop healthy labor management relations in the interests of increased production;
14. To encourage the spirit of public service and nation-building among government employees and to improve their financial situation;
15. To check the population explosion;
16. To establish friendship with all countries on a basis of equality and especially to strengthen relations with Muslim countries;
17. To decentralize the system of administration and develop and strengthen local government;
18. To establish a social order based on justice and free from corruption; and
19. To safeguard the rights of all citizens irrespective of religion, colour and sect and to consolidate nation unity and solidarity.

Appendix - 2

The 18 point Program of President Ershad

1. To achieve rural development;
2. To increase agricultural production in order to achieve self-sufficiency in food;
3. To take steps for further land reforms;
4. To expand the activities of Grameen Bank in rural areas;
5. To increase industrial production;
6. To encourage industries in the private sector and to create atmosphere for investment;
7. To develop cooperative system and cottage industries;
8. To drive away the gap between the rich and the poor through proper distribution of national income;
9. To introduce development and production-oriented educational system;
10. To create opportunities for maximum employment;
11. To ensure minimum medical care for everybody;
12. To take steps for the establishment of Islamic ideology and values in national life;
13. To eliminate corruption;
14. To decentralize the system of administration and to hand over power to the elected representatives;
15. To check population explosion;
16. To transform 'politics' into 'politics of development' and to secure political freedom through economic emancipation;
17. To reconstruct the Judiciary in order to ensure justice at all levels;
18. To ensure the socio-economic rights and status of women.

Appendix –3

The major features of the Medical Practice and Private Clinics and Laboratories Ordinance 1982

1 **Licensing Condition:** A license is required for establishment of a private clinic or hospital. The conditions for the issuance of the license are: a) proper accommodation with hygienic environment, b) at least 80 square feet of floor space for each patient, c) air-conditioned operation theatre, d) essential equipment, e) adequate supply of life-saving and essential medicines, f) required number of physicians and other personnel.

2 **Requisite Health Personnel:** The personnel to bed ratios are defined by the ordinance for the clinics. Each 10 beds, hospital must employ round the clock full time physician, two nurses and one sweeper. These personnel must be present 24 hours a day. Every 10 beds will require full time appointment of at least two physicians, four nurses and two sweepers.

3. **Inspection and Punitive Measures:** The Director General (DG) or any officer authorized by him may inspect the clinic or hospital to see if the provisions of the ordinance are being followed. If the facility is found to be deficient in terms of the requirements of licensing, the owner will be asked to show cause against the cancellation of the license. The hospital or clinic can appeal for review of the case within 30 days from the receipt of the order of cancellation.

4. **Process of Fee Receipt:** Maximum charges and fees for hospital, physician and diagnostic services were set by the ordinance. All registered facilities shall display a list of charges and fees. All private clinics and laboratories are required to issue money receipts in printed form for the charges realized from patients. The clinics and laboratories are also required to preserve the counterfoils of the receipt issued for future inspection.

5. **Regulations for Diagnostic Centers and Laboratories:** A diagnostic laboratory, at the minimum, will need the following personnel: one pathologist, one qualified lab technician, one qualified radiographer (if the service is provided) and other cleaners. The x-ray room will have to be protected from radiation. Directly exposed wall should have a concrete wall of 10 inches. Other three walls should be at least five inches. Lead sheet and apron should be available in the room for use. The regulation will also set the minimum size of the x-ray machine to ensure quality of the picture for diagnostic purposes.