

Governance Challenges in the Health Sector and the Way Out

Executive Summary

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Governance Challenges in the Health Sector and the Way Outs

Research Advisors

Advocate Sultana Kamal

Chairperson, Board of Trustees, TIB

Dr. Iftekharuzzaman

Executive Director, TIB

Dr. Sumaiya Khair

Deputy Executive Director, TIB

Mohammad Rafiqul Hassan

Director, Research and Policy, TIB

Research Supervisor

Shahzada M Akram, *Senior Program Manager, Research and Policy, TIB*

Research and report preparation

Taslima Akter, *Program Manager, Research and Policy, TIB*

Editorial support

Shadhan Kumar Das, *Programme Manager, Research and Policy, TIB*

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For further information

Transparency International Bangladesh
House # 141, Road # 12, Block # E
Banani, Dhaka 1213
Tel: 880-2-8826036
Fax: 880-2-9884811
Web: www.ti-bangladesh.org

Governance Challenges in the Health Sector and the Way Out¹

1.1 The Context and Rationale of the study

Over the past decades the successive governments of Bangladesh have taken various steps to develop the health services. The steps included developing infrastructure, expanding health services down to the grassroots, increasing the number of health professionals and health workforce, introducing modern equipments and establishing specialized institutions. Bangladesh has so far achieved remarkable progress in respect to reduction of crude birth rate, death rate, maternal mortality rate, child mortality rate, fertility rate and increase of life expectancy. As recognitions of such achievements, Bangladesh received an UN award for its remarkable achievements in attaining the Millennium Development Goals particularly for reducing the child mortality rate (MDGs-4), and received the Best Immunization Performance Award by Global Alliance for Vaccines and Immunization (GAVI).

However, despite the above successes, governance challenges in this sector exist that hinder further achievements. According to TIB's National Household Survey (2012), 40.2% of the recipients of health services from public institutions became victims of irregularities and corruption while receiving services. According to this survey the estimated amount of bribes at the national level in this sector was Tk 703 million. News reports on irregularities such as absenteeism of doctors, lack of quality of services, irregularities in getting bed and medicines, active presence of middlemen luring patients to private health facilities, financial corruption of the health professionals and hospital staff are regularly published in the print media.

Despite the fact that there are numbers of studies on the quality of services and nature of irregularities in different institutions, there is a dearth of research that specifically covers governance related issues with particular emphasis on health services. As health is one of the priority sectors for TIB's activities, the present research has been taken.

1.2 Objective and Scope

The main Objective of the study is to identify the challenges of good governance in the health sector and to propose specific recommendations based on the findings. The specific objectives of the study are:

1. To identify various limitations with regard to law, finance, administration, and services in the public and private healthcare institutions; and
2. To analyze the nature and extent of irregularities and corruption prevailing in this sector, and to identify the reasons behind those.

The scope of the study is limited to governance issues pertaining to healthcare services. It covers analyses on the financial administration, infrastructure of public hospitals at different levels under the Directorate General of Health Services (DGHS), human resource management in public health institutions (recruitment, transfer, promotion and training), procurement, repair and maintenance in public healthcare institutions, services of public and private healthcare institutions, and supervision of private healthcare institutions.

1.3 Methodology

This is a qualitative study, where quantitative data from secondary sources have also been used. Data were collected from both secondary and primary sources. Data collection method for qualitative information included in-depth key informant interviews (KII) and group discussions. Key informants

¹ Executive summary of the report released through a press conference held at Hotel Abakash, Dhaka on 6 November 2014.

included service providers and managers/ high officials of public and private healthcare institutions, members of professional bodies, media personnel, and health sector experts.

Secondary sources include surveys such as the National Household Survey (2012),² Citizen Report Cards on 28 institutions³, other studies on health, proceedings of a Consultation Meeting on Health organized by TIB (held in Dhaka in July 2013), relevant policies, laws and rules, national budgets, official documents, and web-based and media reports. The research findings were shared with high officials of the Ministry of Health and Family Planning on 28 August 2014, and the report was updated on the basis of the comments given by the authority.

It is important to note that the research findings are not equally applicable to all institutions, doctors, nurses, officers/ employees. However, it provides an indication of the challenges of governance existing in the health sector.

2. Research findings

2.1 Limitations and Challenges with regard to Policies and Laws and Implementation

The government adopted the National Health Policy 2011 with an aim to ensure healthcare services to all. However, some limitations are observed with regard to the implementation of some of the strategic issues. For instance, so far initiatives have not been taken to formulate specific law or regulation to ensure a health personnel's accountability (Article 14). Similar lack of initiatives can be seen to make pathological and other charges of private institutions within a tolerable limit (Article 16).

There is absence of effective legal provision to take action against doctors for negligence. Though it is mentioned in the Code of Medical Ethics that a doctor's registration can be cancelled due to gross negligence, [Clause 5 (A)] the application of this has been very limited.

There are a number of limitations in terms of implementation of the *Medical Practice and Private clinics and Laboratories (Regulation) Ordinance, 1982*, which was adopted to regulate medical practice and functioning of private clinics and laboratories. With regard to inspection of registered medical practitioners, private clinics or private laboratories by the Director-General or any officer authorized by him, the number of the times or interval of the inspection is not mentioned [Clause 11 (1)]. As a result regular inspection is not ensured. The fees/ charges are not updated and not commensurate to present context [Clause 3, Schedule A (2)], as a result of which the opportunity has been created to take arbitrary charges from patients, and huge differences of fees among institutions are found. According to some experts, the punishment entailed in the law for violating any of the provisions of this law is not adequate in the present context [Clause 13 (2)],⁴ which again encourages violating the law. Moreover, in the amendment made in the law through the *Medical Practice and Private Clinics and Laboratories (Regulation) (Amendment) Ordinance, 1984*, the provision on consultation fees were omitted, and provision of mandatory display of consultation fees and investigation charges was dropped. This created the opportunity to charge arbitrarily higher fees, and weakened the flow of information for the service recipients.

2.2 Limitations of Financial Management

2.2.1 Declining allocation for health in the national budget: The allocation for health in the national budget has been decreasing gradually. It is observed that the budget has decreased from 6.58% of the total allocation during FY 2008-09 to 4.60% during FY 2013-14, although in terms of absolute amount the allocation increased. The allocation is also declining in terms of the ratio against the GDP – it was 1% in the FY 2008-09, whereas 0.84% in FY 2013-14. According to World Health Organization (WHO), the

² The number of total households receiving services from public healthcare institutions was 3,208 from 64 districts.

³ These included Upazila Health Complex, Zilla Sadar Hospital, and Medical College Hospital. The total number of respondents were 14,276.

⁴ The punishment includes imprisonment for a term which may be extended to six months or Tk. 5,000 or both.

standard is considered as 5% of GDP on health care. Moreover, according to WHO, the annual allocation for health services per head should be Tk 2,652, whereas in Bangladesh it is Tk 390.

2.2.2 Declining development expenditure: The proportion of development expenditure in the health sector in the national budget has a decreasing trend – from 42.2% in FY 2008-2009 to 38.3% in FY 2013-2014. Moreover, it is observed that the contribution of development partners in this sector is also decreasing – from FY 1998-1999 to 2013-2014 in the three health and population related programs the contribution of development partners has been reduced from 38% to 24%.

2.2.3 Inadequate allocation for regular activities of health institutions: There is inadequate allocation against the needs of public healthcare providing institutions at different levels. This has adverse impacts on infrastructure and logistics, ambulances, generator maintenance and services.

2.2.4 Lack of authority for expenditure and local level: The hospital management has no authority to spend money during emergency for repair and maintenance of medical equipment, infrastructure, and cleanliness. In addition, they have no allocation for repairing lights, fans and switch-boards.

2.3 Limitations with regard to Human Resource

2.3.1 Vacant posts under DGHS: The status of health workforce under the Directorate General of Health Services (DGHS) shows that 20% (22,618) of the total sanctioned posts (115,935) is vacant – the highest being non-doctors (56%), and the second highest being doctors (28%). The portion of vacant posts among third class employees including medical technologists (21%) and fourth class employees including domiciliary staff (8.9%) is also significant.

It was found that no appointment has been made for some positions including Civil Surgeon, Deputy Civil Surgeon, Superintendent, Upazila Health and Family Welfare Officer. For example, Civil Surgeons in three districts and Deputy Civil Surgeons (among 26 districts) in 6 districts were not appointed. Likewise there is no appointment in 4 institutions of Superintendent, and no appointment of UHFPO post (among 483 upazilas) in 11 upazilas.

2.3.2 Inadequate human resource: The doctor and nurse ratio in Bangladesh is 1:0.48, whereas 1:3 is considered to be the standard. The nurse and bed ratio is 1:13, whereas the standard ratio is considered to be for general bed 1:4 and specialized bed 1:1. There is one physician for every 3,297 persons (1:3,297), for which the standard is 1:600. There is one nurse for every 11,696 population (1:11,696), and one medical technologist for every 27,842 population (1:27,842), which are also well below the international standard.

2.3.3 Lengthy procedure in human resource management: The procedures of promotion, selection grade, and regularizing 'In Charge' positions are quite lengthy in the health sector. For example, the process of promotion of doctors in administrative posts is very time-consuming. In some cases, the 'In Charge' position is given to the juniors violating the seniority.

It is observed that the post remaining vacant against sanctioned post is due to the lengthy procedure and lack of co-ordination among the ministries of Health, Public Administration, and Finance. On the other hand, in some cases, the process is hampered due to irregularities and corruption. Legal procedures such as writ petitions filed against different appointments also cause delay in the recruitment procedure. As a result, there is shortage of doctors, nurses, and other staff against the requirement. Moreover, there is no assessment of the required manpower keeping in mind the expansion of infrastructure and equipment in health care institutions.

2.3.4 Limitations in training management: There is shortage as well as no assessment of the required number of specialized doctors. Besides, specialized doctors are not properly utilized due to lack of

supporting manpower, equipment, and infrastructure in Upazila Health Complexes. Moreover, the rule against private practices during higher education is often violated.

2.3.5 Limitations with regard to Monitoring and Supervision: Monitoring and supervision is not strong in terms of private healthcare institutions, higher education for doctors and teachers, and attendance of doctors and other staff in healthcare institutions. Doctors do not have to be accountable for not attending the office on time. The private healthcare institutions are not regularly visited/ inspected due to lack of adequate human resource.

2.4 Infrastructure and Logistics

Compared to demand, there are shortages of beds in different hospitals. For this reason, many patients do not get bed immediately after admission. There is a lack of residence facilities for doctors, nurses and other employees in hospital premises. The facilities that are available in most of the cases are not usable. This problem is acute in Upazila Health Complexes. In many cases, here sitting facilities for doctors are not sufficient. In most cases, there are no separate ticket counters and sitting arrangements for women in the outdoor of different hospitals. There are no arrangement of uninterrupted power supply and even allocation of fuel for operating generators. This problem is also acute at upazila level. Moreover, there is a lack of transport facilities for bringing doctors during emergency periods. In district hospitals, there are no CCU, ICU and CT Scan Machines.

2.4.1 Medicines and Medical equipments: The lists of available medicines in some cases are not hanged in appropriate places and even updated them regularly. The X-Ray machines of many Upazila Health Complexes are not in order. In addition, there exist lack of equipments like ultra sonogram, X-Ray film and ECG machine in the Upazila Health Complexes. Necessary medical equipments such as, digital x-ray, eco-cardiac, microscope machine etc. are also absent in district hospitals.

2.4.2 Ambulance facilities: At different hospitals, number of ambulances is not sufficient; even many from existing ones are not active. Through discussions with hospital authorities and observations, it is found that on average only one ambulance is active in upazila hospitals and two in district hospitals. Due to such shortages, a large section of patients have to depend on private ambulances. Most of them are owned by the third and fourth-class employees of different hospitals. They normally persuade patients to hire their ambulances and charge higher price than the set one.

2.5 Working Environment hampered in Public Healthcare Institutions

2.5.1 Presence of medical representatives beyond specific time-table: Although specific day and time are allocated for medical representatives in most of the hospitals to promote their products with doctors, most of cases set timetable is not maintained. In some cases, they get tacit encouragement from doctors.

2.5.2 Hampering of hospital operations because of some untoward incidences: Sometimes, some untoward incidences hamper regular operations and services of hospitals. They include misunderstanding among relatives of patients, doctors and employees because of deaths of patients, attacks on doctors and employees by influential people because of altercations on different service and treatment issues, conflicts between media people and internee doctors during media people's collection of news etc.

2.5.3 Political influences/pressure in the operations of hospital: In many cases, there exist political pressure and influences of influential people in the operations of hospitals. Particularly, these pressures and influences are very prevalent when medical certificates on death and injuries are badly needed for filing police cases. In some cases, some patients occupy paying bed without paying the fee through use of such influences.

2.5.4 Harassment by brokers in hospital premises: Presence of brokers is visible in almost all levels of hospitals. Sometimes, patients pay them for facilitating services. Sometimes, they experience harassment during receiving their support.

2.6 Access to information

There exist limitations in delivery information to patients in most of the hospitals. In many cases, advice and information desk does not exist, there is no complaint box, list of duty doctors is not displayed and Citizens' Charter is not hanged.

2.7 Health Management Committee

The Health Management Committee is formed to identify different problems of hospitals to ensure better services to patients and ensure regular presence of doctors. However, it is observed that meeting of management committees do not take place regularly. As a result, committees cannot play desired roles in improving service quality.

2.8 Servicing, maintenance and others

The Transport and Equipment Maintenance Organization (TEMO) is responsible to repair and maintenance of ambulances. However, because of shortage of manpower in it, inordinate delay takes place in servicing and repairing of ambulances. On the other hand, doctors' residences are not repaired/maintained regularly. Moreover, there exist storage problems to store different equipments and materials. Such problems are more acute in Upazila Health Complexes. The supervision committees for overseeing quantity and quality of contractors' supplies are not active enough in most hospitals.

3.1 Irregularities and Corruption

3.1.1 Recruitment

- Irregularities and corruption take place in the recruitments of ad-hoc doctors and third and fourth-class employees. In such recruitments, both political influences and illegal transactions of money take place. Corrupt elements sometimes try to recruit addition people and they collect money from job seekers by giving assurance of recruitment.
- People who are involved in illegal financial transactions include local political leaders, union leaders, Office Head Assistant, Account Officer and a section of administrative officials for recruiting ad-hoc doctors and third class sand fourth class employees.

3.1.2 Transfer

As per rule, minimum tenure of service in a posting place is three years and in remote and hilly places it is two years. However, doctors get transfer to their desired place through political influence, lobbying and illegal monetary transactions. Even ordinary employees get posting to their desired place though such means. Normally, Civil Surgeon Office and people in Health Directorate are involved in those illegal transactions. Doctors and employees posted in place for a long time developed strong networks that help them to indulge in corrupt practices and enable them to influence hospital operations.

3.1.3 Promotion

Political lobbying is highly visible in promotions through Departmental Promotion Committee (DPC) and Superior Selection Board (SSB). However, illegal monetary transactions sometimes take place during promotion through DPC. Such transactions depend on levels of positions, vacancy place and number of vacancies. Irregularities that take place during promotion through DPC include non-cognizance and scrutiny of length of service and seniority; higher educational qualifications; professional publications; passing of seniority scale exam and Annual Confidential Reports (ACR).

3.1.4 Training

In some cases, persons relevant to subject matter are not considered during selection for training. Sometimes, a person is considered for a particular training several times or a person is considered several times for training. For such anomalies, sometimes most deserving candidates are deprived of training opportunities. On the other hand, few selected people are benefited financially several times.

Illegal financial transaction in Human resources management	
Recruitment	TK.
Ad-hoc Doctors	3-5 lac
Third and Fourth Class Employees	1-5 lac
Transfer	
Administrative Officials in Dhaka and places adjacent to Dhaka	5-10 lac
Doctors from Upazila and Sadar to Dhaka	1-2 lac
Remote area to Sadar, Upazila to Upazila, and Upazila to Sadar	10-50 thousands
Fourth Class employees	50 thousands-2 lacs
Promotion	
Through DPC at post	5-10 lacs

3.1.5 Food

Political influence is also prevalent in selection of contractors for food supply. As a result, interested suppliers are deprived of the opportunities to participate in the tender process. Apart from using political influence, to get work order contractors maintain unholy collusion with members of purchase committee as well. Although contracts are usually given to the lowest bidder in most the cases, contractors deliver some items in higher than market price and some items in lower than market price. As a result, they do not supply all items and even the quantity specified in the contract. Such anomalies ultimately help them to make profits.

Supply of Medicines

In some cases, medicines are not supplied by the UDLC against the demand of the concerned hospitals. Sometimes, medicines are supplied that are very close expire date.

Equipments Purchase

In some cases, central authority buys medical equipments without assessing the demand of health facilities. As a result, such equipments remain idle for shortage of skilled manpower and appropriate infrastructure facilities. However, recently (24 June, 2014) the Health Ministry issued a circular mentioning terms and conditions for buying medicines and equipments after assessing demands.

Equipments are repaired by the National Electro Medical and Engineering Workshop (NEMEW). But, it has shortage of skilled manpower. On the other hand, they issue NOC in exchange of commission to order repair works to outsiders having collusion with Central Medical Store Depot (CMSD). Moreover, the Health Engineering Department is responsible to doing repair and renovation works of hospitals. However, there have been allegations that through collusion with concerned authorities, contractors withdrew bills without doing required repair or renovation works.

3.1.6 Irregularities and Corruption in Public Healthcare

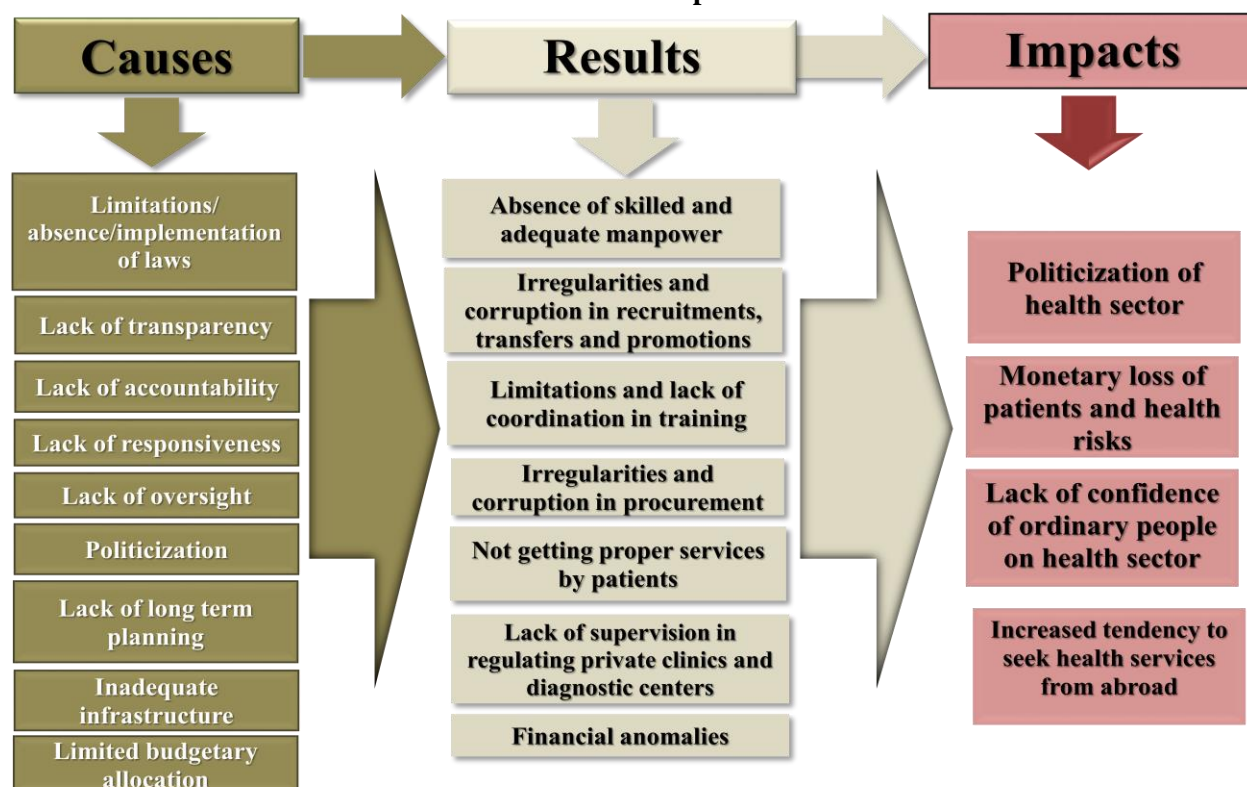
Sometimes, patients and their attendants experience corruption and irregularities during receiving services from health facilities. According to TIB's National Household Survey on Corruption 2012 40.2% households experienced corruption while receiving health services. Moreover, various surveys conducted by TIB during 2011-2013 also revealed that some doctors do not attend their duties up to the official time at different levels of hospital particularly those in upazilas and districts; some patients do not get bed immediately after admission; some patients have to stay on floor up to a certain period, some patients are asked to go to doctor's private clinics and chambers and some patients expressed their unhappiness about

the quality of food they get from hospitals. Moreover, some patients have to make illegal payments for getting services from hospitals that include services like purchase of tickets, getting bed/cabin, use of trolley, doing different medical tests and investigations, pushing of injection and saline, dressing services and ambulance services, receiving services from ward boys and sweepers etc. Sometimes, patients are asked to go to doctor's preferred diagnostic clinics or centers for doing medical tests and investigations.

3.1.7 Irregularities and Corruption in Private Healthcare Institutions

- According to Ordinance 1982, private health facilities are required to employ expert doctors, one registered doctor, 2 nurses, one sweeper for every 10 patients for running medical services and operations; however, most of private facilities do not follow such rules. Sometimes, trained and qualified technicians are not employed. Although it was made a rule to provide money receipt to patients, it is not given. Similarly, they are asked to retain name and address of patients, but they usually keep names of patients only.
- It is found that private diagnostic centers maintain contracts with doctors in exchange of commission. The rate of commission depends on the number of patients a doctor sends to a diagnostic center. According to doctors, their rate of commission normally vary 30-50%. Similarly, brokers' rate vary 10-30%.
- In some cases, private diagnostic centers do not employ qualified doctors, rather they issue investigation reports using seals of fake doctors.
- As per rule, registered doctors or dental doctors are not allowed to do medical practices using title or qualification that are not endorsed by Bangladesh Medical and Dental Council (BMDC); however, some private facilities do not follow such rules. Rather they are using fake qualifications and positions of doctors against which BMDC is not taking any punitive measures.

At a glance scenario of governance challenges in Health Sector: Causes, Results and Impact Relationship



3.2 Analysis of reasons of governance deficits and their impact

The reasons for governance deficit in health sector include absence, limitations, and lack of implementation of laws, and also lack of transparency, accountability, responsiveness and oversight. Other reasons include politicization, lack of long-term planning, limitations of infrastructure and inadequate of budgetary allocation. Moreover, irregularities and corruptions also create impact on the governance in health sector. Politicization has been prevalent in every stage of recruitment, promotion and transfer. Due to wrong treatment and presence of fake doctors in the country, patients are in the increasing risk of death. As an impact people are losing confidence on health services in the country and an increasing number of people are now going abroad for treatment. Moreover, in some cases people have to make illegal payment while receiving services. This incurs financial losses of patients.

4.1 Conclusion

Finally it can be said that there are significant efforts and laudable achievements of the government in the development of the health sector. However, the achievements could have been higher if there were less limitations, irregularities and corruption. It is observed that there are lacks of long-term planning in terms of human resource management (recruitment, transfer and promotion), procurement management, control and supervision, and ensuring transparency and accountability. The monitoring and supervising system for public and private healthcare institutions is not strong. Moreover, the institutionalization of corruption in this sector particularly with regard to administrative and service-providing aspects is observed.

4.2 Recommendations

a) Laws and Rules

1. New laws should be enacted and existing laws should be reformed-
 - Punishment against any violation of laws by private health facilities should be increased
 - Consultation fees and charges of pathological investigations should be fixed based on realistic criteria
2. The draft law on private healthcare services should be finalized in consultation with the relevant stakeholders and should be enacted as a law.

b) Budgetary Allocation

3. Allocation for the health sector should be increased in the national budget.
4. In the overall allocation, allocation for development expenditure should also be increased along with that for non-development expenditure

c) Human Resource Management

5. Immediate steps need to be taken to fill-up vacant positions of Civil Surgeon, Deputy Civil Surgeon, Superintendent, UHFPO, Medical Technologists, Anesthetists, and Senior Consultants etc.
6. Lengthy procedure to recruit manpower should be reformed. Quick measures should be taken involving hospital authorities, Health Directorate, Health Ministry, Ministry of Establishment and Finance to recruit manpower based on a need assessment.
7. Influences of the health professional bodies in line with political considerations in recruitment, promotion, transfer of doctors should be stopped.
8. A fair selection process should be ensured for training based on seniority, merit, and performance.
9. Monitoring and supervision should be strengthened to ensure the presence of health assistant at community clinics and to stop stealing of government medicines.

d) Health Services

10. Advice and Information Desk should be introduced in all hospitals; an information board that includes citizens' charter, directions of wards/departments should be hung at the entrance of the hospitals.

11. Effective law should be adopted to prevent (and to punish for) death of a patient due to doctor's negligence and ensured its application.
12. List of registered doctors along with their qualifications should be published on the website of BMDC and an SMS system should be in place to respond to any inquiry about registered doctors.
13. To ensure the presence of doctors in duty locations-
 - Livable residence facility should be ensured;
 - Special hardship allowance should be introduced for the doctors who would be posted in remote areas and for working on holidays.
14. Health Management Committee should be made active and concerned Member of the Parliament should take proactive initiative to make committee meeting regular.

e) Procurement, Repair, and Maintenance

15. E-tendering process should be introduced to ensure transparency in selecting suppliers for procurement.
16. Standard Operational Procedures (SOP) should be developed to determine types of services, manpower, equipments and infrastructure or other necessary things for providing services based on the level of health facility
17. Hospital authorities should be allowed to spend at least 50% of user fees for maintaining their emergency requirements.
