Medical Country of Origin Information

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EUROPEAN UNION
AGENCY FOR ASYLUM

Healthcare Provision in Bangladesh

June 2023

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The report has been reviewed by International SOS and EUAA.

Contents

Disclaimer

This report was written according to the EUAA COI Report Methodology (2023). The report is based on carefully selected sources of information. All sources used are referenced.

The information contained in this report has been researched, evaluated and analysed with utmost care. However, this document does not claim to be exhaustive. If a particular event, person or organisation is not mentioned in the report, this does not mean that the event has not taken place or that the person or organisation does not exist.

Furthermore, this report is not conclusive as to the determination or merit of any particular application for international protection. Terminology used should not be regarded as indicative of a particular legal position.

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The drafting of this report was finalised on 3 May 2023. Any event taking place after this date is not included in this report.

Glossary and abbreviations

Term	Definition
8FYP	8th Five Year Plan for Bangladesh
ADB	Asian Development Bank
AMC	Antimicrobial Consumption
BDT	Bangladeshi Taka [currency]
BIDA	Bangladesh Investment Development Authority
CBHI	Community-Based Health Insurance
CC	Community Clinic
Chars	Riverine sand and silt landmasses which are home to over 5 million people.
CHCP	Community Health Care Providers
CHE	Current Health Expenditure: estimates of current health expenditures include healthcare goods and services consumed during each year. This indicator does not include capital health expenditures such as buildings, machinery, IT and stocks of vaccines for emergency or outbreaks.[1]
CHT	Chittagong Hill Tracts
CMSD	Central Medical Store Depot

[1] World Bank (The), Current health expenditure (% of GDP), 2023, url

Term	Definition
COI	Country of Origin Information
CPP	Certificate for Pharmaceutical Products
DGDA	Directorate General of Drug Administration
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DGMEFW	Directorate General of Medical Education and Family Welfare
DGNM	Directorate General of Nursing and Midwifery
EASO	European Asylum Support Office
EPI	Expanded Programme on Immunization
ESP	Essential Health Services Package
EU	European Union
EU+ countries	Member States of the European Union and associated countries
EUAA	European Union Agency for Asylum
FDMN	Forcefully Displaced Myanmar Nationals
FSC	Free Sales Certificate
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor

Term	Definition
GDP	Gross Domestic Product
GED	General Economics Division
GMP	Good Manufacturing Practices Certificate
HA	Health Assistant
Haor	A wetland habitat in Bangladesh's north-eastern region that is geographically a shallow depression in the form of a bowl or saucer, also known as a back swamp, with a combined area of approximately 2 million hectare (1 ha =2.471 acres) and population of approximately 19.37 million inhabitants.
HCFC	Health Care Financing Strategy
HIES	Household Income and Expenditure Survey
HPNSDP	Health Population and Nutrition Sector Development Programme
HNPSIP	Health Nutrition Population Sector Strategic Investment Plan
HPNSP	Health, Population and Nutrition Sector Programme
HPSP	Health Population Sector Programme
HSD	Health Services Division
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
IDP	Internally Displaced People
IDRA	Insurance Development and Regulatory Authority

Term	Definition
LGD	Local Government Division
MCWC	Maternal and Child Welfare Centre
MedCOI	Medical Country of Origin Information
MEFWD	Medical Education and Family Welfare Division
Member States	Member States of the European Union
MO	Medical Officer
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development and Cooperatives
NCD	Non-Communicable Disease
NCL	National Control Laboratory
NGO	Non-Governmental Organisation
NGO-MFI	NGO Microfinance Institute
NIPORT	National Institute of Population Research & Training
OOPE	Out of Pocket Expense
OPD	Outpatient Department

Term	Definition
OTC	Over the Counter
PDAB	Permanent Total Disability Insurance
RMG	Ready-Made Garment
RMO	Resident Medical Officer
SACMO	Sub-Assistant Community Medical Officer
SBC	Sadharan Bima Corporation
SSK	Shasthyo Shurokhsha Karmasuchi
SWAp	Sector-Wide Approach
THE	Total Health Expenditure: the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.[2]
UHFPO	*Upazila* Health and Family Planning Officers
UHFWCs	Union Level Facilities
Upazila	An administrative unit, which is a subdivision of a district formerly known as "thana". Bangladesh has 495 *Upazilas*.
UPFO	*Upazila* Family Planning Officer
USD	United States Dollar

[2] World Bank (The), Health expenditure, total (% of GDP), 2023, url

Introduction

Methodology

The purpose of the report is to provide information on access to healthcare in Bangladesh. This information is relevant to the application of international protection status determination (refugee status and subsidiary protection) and migration legislation in EU+ countries.

Terms of reference

The terms of reference for this Medical Country of Origin Information Report can be found in Annex 2. The drafting period finished on 27 January 2023, peer review occurred between 27 January - 10 February 2023, and additional information was added to the report as a result of the quality review process during the review implementation up until 10 March 2023. The report was internally reviewed subsequently.

Collecting information

EUAA contracted International SOS (Intl.SOS) to manage the report delivery including data collection. Intl.SOS recruited and managed a local consultant to write the report and a public health expert to edit the report. These were selected from Intl.SOS' existing pool of consultants. The consultant was selected based on their experience in leading comparable projects and their experience of working on public health issues in Bangladesh.

This report is based on publicly available information in electronic and paper-based sources gathered through desk-based research. This report also contains information from multiple oral sources with ground-level knowledge of the healthcare situation in Bangladesh who were interviewed specifically for this report. For security reasons, all oral sources are anonymised.

Currency

The currency in Bangladesh is the Bangladeshi taka (BDT). The currency name, the ISO code and the conversion amounts are taken from the INFOEURO website of the European Commission. The rate used is that prevailing at the date of the source, i.e. the publication or the interview, that is being cited. The prevailing rate is taken from The European Commission website, InforEuro.[3]

Quality control

This report was written by Intl.SOS in line with the European Union Agency for Asylum (EUAA) COI Report Methodology (2023)[4], the EUAA Country of Origin Information (COI) Reports

[3] European Commission, Exchange rate (InforEuro), n.d., url
[4] EUAA, Country of Origin Information (COI) Report Methodology, February 2023, url

Writing and Referencing Guide (2023)[5] and the EUAA Writing Guide (2022)[6]. Quality control of the report was carried out both on content and form. Form and content were reviewed by Intl.SOS and EUAA.

The accuracy of information included in the report was reviewed, to the extent possible, based on the quality of the sources and citations provided by the consultants. All the comments from reviewers were reviewed and were implemented to the extent possible, under time constraints.

Sources

In accordance with EUAA COI methodology, a range of different published sources have been consulted on relevant topics for this report. These include: governmental publications, academic publications, reports by non-governmental organisations and international organisations, as well as Bangladeshi media.

In addition to using publicly available sources, three oral sources were contacted for this report. The oral sources are all officers in the MOHFW and they are anonymised in this report for security reasons. The sources were assessed for their background and ground-level knowledge. All oral sources are described in the Annex 1: Bibliography. Key informant interviews were carried out in February 2023.

[5] EUAA, Country of Origin Information (COI) Reports Writing and Referencing Guide, February 2023, url
[6] EUAA, The EUAA Writing Guide, April 2022, url

Map

Map 1. Bangladesh, © United Nations[7]

[7] UN, Bangladesh, Map No. 3711 Rev.1, October 2003, url

1. General information

The Constitution of the People's Republic of Bangladesh establishes the role of the State in 'planned economic growth' and 'improvement in the material and cultural standard of living of the people'. The government is responsible to its citizens for their basic needs, for example, 'food, clothing, shelter, education and medical care' (article 15(a)).[8] Article 18(1) of the constitution establishes that the State shall have regard to 'raising the level of nutrition and the improvement of public health' (article 18(1)).[9]

1.1. Geographic context

Bangladesh covers 147 570 square kilometres,[10] and is densely populated with approximately 1 286 people per square kilometre.[11] It is the world's seventh most climate risk-affected country, with 185 extreme events recorded and 0.38 fatalities per 100 000 inhabitants between 2000 and 2019.[12] According to a 2022 World Bank report, climate-related cyclones, flooding, drought, change of disease patterns and loss of agricultural lands threaten communities causing disproportional damage and disrupting lives and livelihoods. Floods have caused severe economic impacts in Bangladesh, while cyclones are responsible for the highest number of deaths. Heat stress, river and coastal flooding and landslides are predicted to increase between 2041 and 2060 with devastating effects even under low-emission scenarios.[13]

In 2022, the World Bank reported on challenges facing Bangladesh: the capital and the largest city Dhaka faces air pollution, water logging, poor waste disposal and traffic congestion, while Chattogram and Khulna are exposed to risks related to their coastal geographic location. Low-income residents are more exposed to these risks and face inadequate water supply and sanitation, high population density and poor housing quality.[14] The use of solid fuels as primary cooking fuels, mostly wood and crop residues, increases indoor air pollution and has adverse effects on the health of women and children.[15] A 2019 survey found that only 19 % of the population reported a primary reliance on clean fuels and technologies for cooking and lighting.[16]

[8] Bangladesh, Constitution of the People's Republic of Bangladesh, 1972, url
[9] Bangladesh, Constitution of the People's Republic of Bangladesh, 1972, url
[10] World Bank (The), Surface area (sq. km) - Bangladesh, 2023, url
[11] World Bank (The), Population density (people per sq. km of land area) - Bangladesh, 2023, url
[12] Eckstein D. et al., Global Climate Risk Index 2021, Germanwatch, January 2021, url, p. 13
[13] World Bank (The), Bangladesh Country Climate and Development Report, October 2022, url, p. 12
[14] World Bank (The), Bangladesh Country Climate and Development Report, October 2022, url, p. 10
[15] World Bank (The), Bangladesh Country Climate and Development Report, October 2022, url, p. 10
[16] Bangladesh, BBS, Progotir Pathey, Bangladesh Multiple Indicator Cluster Survey 2019, Key Findings, 2019, url, p. 11

Bangladesh is vulnerable to environmental change, it is densely populated and will continue to experience population increases through to 2050, by when it could have 13.3 million internal climate migrants.[17]

1.2. Demographic context

Bangladesh is undergoing social and demographic change, including urbanization and industrialisation.[18] The population has increased from 50 million in 1960 to 169 million in 2021.[19] The 2017-2018 Demographic and Health Survey reports that 32 % of the population is below 15 years of age.[20] Life expectancy at birth has increased from 50, in 1972, to 72 in 2020.[21]

Migration from rural areas to urban areas is increasing. In 1960, 95 % of the population lived in rural areas while in 2021 it was 61 %.[22] Bangladesh has a rural network of public sector health services but lacks an equivalent network in the urban areas.[23] As a result, the poorest part of the population living in urban areas is deprived of essential health care services.[24] A rapid and consistent inflow of migrants provides an additional source of pressure on services in urban slums and large cities.[25]

Bangladesh is also undergoing an epidemiological transition, especially in its urban areas. Shafique et al. cite studies from 2016 to 2019 on non-communicable diseases (NCDs) among the urban poor in Bangladesh as showing increases in obesity and hypertension, with the prevalence of hypertension in urban areas being more than double that of rural areas. Hypertension and diabetes are also prevalent among urban slum dwellers in Dhaka, with women reporting higher prevalence rates.[26]

1.3. Economic context

In 2022, the World Bank reported that Bangladesh has been among the fastest growing economies in the world, with annual per capita income growth of 4.0 % between 1990 and 2020, during which the country transited from a mainly agricultural economy to an industry and services dominated economy.[27] Ready-made garment (RMG) exports, remittances from

[17] World Bank (The), Groundswell: Preparing for Internal Climate Migration, 2018, url, p. 144
[18] Bangladesh, GED, 8th Five Year Plan, July 2020 - June 2025, Promoting Prosperity and Fostering Inclusiveness, December 2020, url, p. 587
[19] World Bank (The), Population Total Bangladesh, 2023, url
[20] Bangladesh, NIPORT, Bangladesh Demographic and Health Survey 2017-18, October 2020, url, p. 14
[21] World Bank (The) Data, Life expectancy at birth, total (years) – Bangladesh, 2023, url
[22] World Bank (The) Data, Rural population (% of total population) – Bangladesh, 2023, url
[23] Bangladesh, MOLGRDC, National Urban Health Strategy, November 2014, url, p. 6
[24] Bangladesh, MOLGRDC, National Urban Health Strategy, November 2014, url, p. 6
[25] Bangladesh, GED, 8th Five Year Plan, July 2020 - June 2025, Promoting Prosperity and Fostering Inclusiveness, December 2020, url, p. 587
[26] Shafique, S. et al., Epidemiological Transition and Non-Communicable Diseases among Urban Poor in Bangladesh: A Knowledge Synthesis, 2019, url, p. 4
[27] World Bank (The), Bangladesh Country Climate and Development Report, October 2022, url, p. 8

the Bangladeshi diaspora, stable macroeconomic conditions and domestic consumption contribute to this growth.[28]

Income levels are rising: the Household Income and Expenditure Survey (HIES) 2016 found the national average monthly household income to be BDT 15 945 (EUR 168). Monthly household incomes were found to differ between urban and rural areas being BDT 22 565 (EUR 237) and BDT 13 353 (EUR 140) respectively. This is an increase since 2010, of 38.90 % at the national level and of 36.96 % in urban and 38.40 % in rural areas.[29] The increase in non-communicable diseases is partially attributed to poor nutrition related to lifestyle changes.[30]

1.4. Vulnerable groups

The Ministry of Health and Family Welfare (MOHFW) identified hard to reach populations and the disadvantaged including:

- specific populations: there are an estimated 2.5 million people who are members of [minority] ethnic populations. 42 % reside in three hill districts of the Chittagong Hill Tracts (CHT), while others are dispersed in hilly regions in the north and some coastal districts. They belong to 45 different communities with low percentages of literacy and nutritional status. These communities are poorly served by health facilities and it is difficult to attract health workers to work in these remote areas;
- people with disabilities: many preventable disabilities are due to poverty, and disabled girls face additional problems such as sexual abuse and marginalisation;
- elderly: elderly women are particularly affected, socially and economically, due to widowhood and poverty;
- geographically excluded: populations in the *chars*, the *haor* areas and the remote coastal areas where access is difficult, especially during rainy season; and
- professionally marginalized and socially excluded groups: including, but not limited to, sweepers and sex workers who are also impoverished, who may not be aware of the health consequences of their professional activities, and who are unable to take preventive or curative measures or to change occupations.[31]

1.4.1. Rohingya refugees

As of October 2022, more than 943 000 stateless Rohingya refugees are settled in Ukhiya and Teknaf *Upazilas*, in the Southernmost coastal part of the country. The majority live in 34

[28] World Bank (The), The World Bank in Bangladesh, 6 October 2022, url; ADB, Bangladesh, Asian Development Bank Fact Sheet, July 2022, url, p. 1
[29] Bangladesh, BBS, Preliminary Report on Household Income and Expenditure Survey 2016, October 2017, url, pp. 21-22
[30] Bangladesh, GED, 8th Five Year Plan, July 2020 - June 2025, Promoting Prosperity and Fostering Inclusiveness, December 2020, url, p. 587
[31] Bangladesh, MOHFW, Strategic Plan for Health Population and Nutrition Sector Development Program (HPNSDP) 2011-16, 2011, url, p. 25

camps, the largest of which, Kutupalong-Balukhali Expansion Site, is host to more than 635 000 people.[32]

The Government of Bangladesh refers to Rohingya refugees as Forcefully Displaced Myanmar Nationals (FDMN).[33] The camps have been described as 'crowded and unsafe' and the Bangladeshi government as keeping 'restrictive policies', for instance not allowing permanent homes and restricting education and movement.[34] Public hospitals are facing increased demand.[35] Crime rates have increased in the areas of the camps. Repatriation is regarded as the goal of the Bangladeshi authorities, who are yet to allow any Rohingya to assimilate into Bangladeshi society.[36]

International Crisis Group states that the Government of Bangladesh is concerned that planning for Rohingya refugees to remain in Bangladesh over the medium to long term would relax international pressure on the Myanmar government and delay the creation of conditions for the refugees' safe and dignified return. The government is also concerned that further waves of migration would occur if the conditions for Rohingya refugees were to improve in Bangladesh and if they were to be allowed to integrate into Bangladeshi society.[37] It is also noted by another source that the Government of Bangladesh is concerned that relaxing its stance on repatriation would be 'politically unpopular domestically'.[38] The government has so far received USD 690 million in grants from Multi-Lateral Development Banks for longer-term needs in Cox's Bazar district and co-finances some activities. These funds are directed to a range of sectors, including water and sanitation, health, social assistance, infrastructure and disaster risk reduction.[39]

[32] UNOCHA, Rohingya Refugee Crisis, n.d., url
[33] Rashid, R. et al., A descriptive study of Forcefully Displaced Myanmar Nationals (FDMN) presenting for care at public health sector hospitals in Bangladesh, 2021, url, p. 1
[34] Guardian (The), 'Like an open prison': a million Rohingya refugees still in Bangladesh camps five years after crisis, 23 August 2022, url
[35] Rashid, R. et al., A descriptive study of Forcefully Displaced Myanmar Nationals (FDMN) presenting for care at public health sector hospitals in Bangladesh, 2021, url, p. 1
[36] Anwar A., Does Anyone Want to Solve the Rohingya Crisis?, The Diplomat, 2 February 2023, url
[37] International Crisis Group, A Sustainable Policy for Rohingya Refugees in Bangladesh, 27 December 2019, url, p. 10
[38] Development Initiatives, Supporting Longer Term Development in Crises at the Nexus, Lessons from Bangladesh, 2021, url, p. 32
[39] Development Initiatives, Supporting Longer Term Development in Crises at the Nexus, Lessons from Bangladesh, 2021, url, p. 37

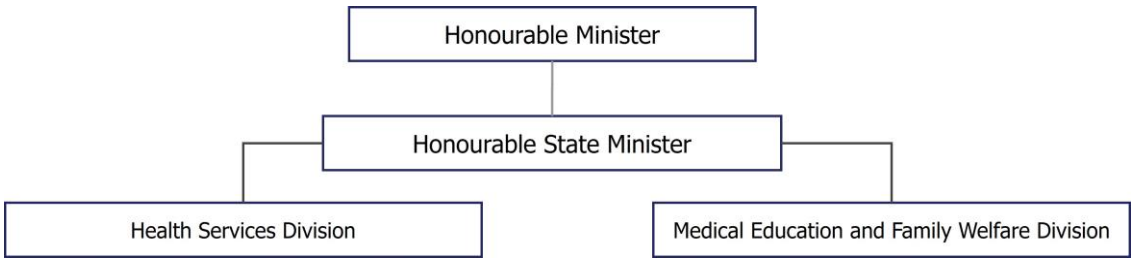
2. Healthcare system

2.1. Health system organisation

2.1.1. Overview

The MOHFW is responsible for developing national policies and for planning and decision-making. MOHFW is financed through central government and through development budgets and financing from external partners.[40] The Ministry and its regulatory bodies exert control over the private sector and NGO facilities through rules and regulations.[41] In 2017, the MOHFW created two divisions: the Health Services Division (HSD) and the Medical Education and Family Welfare Division (MEFWD).[42] Each division is headed by a secretary who works under the direction of the Minister of Health.[43]

Figure 1. Organogram of the MOHFW, 2020[44]



The HSD is responsible for nursing and midwifery; finance and audit; world health and public health and drug administration and law.[45] Its mission is to ensure the delivery of affordable quality healthcare for across Bangladesh.[46] The MEFWD is responsible for family planning and medical education.[47]

There are ten implementing authorities under the MOHFW and the head of each of these holds the title of Director General.[48] The Directorate Generals of Health Services (DGHS) and of Medical Education and Family Welfare (DGMEFW) are each implementing authorities under the MOHFW. DGHS delivers and monitors routine health services directly.[49] DGMEFW prepares and implements policies relating to medical education and family planning.[50] Each of

[40] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan, February 2016, url, p. 47
[41] Bangladesh, MOHFW, Health Bulletin 2019, 2020, url, p. 9
[42] Bangladesh, MOHFW, Health Bulletin 2019, 2020, url, p. 9
[43] Bangladesh, MOHFW, Health Bulletin 2019, 2020, url, p. 10
[44] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, p. 25
[45] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, pp. 26
[46] Bangladesh, MOHFW, মিশন [Mission of HSD], n.d., url
[47] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, pp. 27
[48] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, pp. 28
[49] Bangladesh, DGHS, About us, n.d, url
[50] Bangladesh, MOF, বার্ষিক প্রর্িববদন অর্ি র্বভাগ ২০২১ ২২ [Annual Report, Financial Year 2021-2022], October 2022, url, p. 66

these Directorate Generals operates along the eight administrative divisions of the country (see Table 1).

The Health Population Nutrition Sector Development Plan (HPNSDP) is one of the main policy documents for the MOHFW and brings the different health and nutrition programmes into a single plan. This unifies programmes that had previously been supported by different donors and planned and implemented by different government departments. The unified approach is called the Sector Wide Approach (SWAp) and it aims to avoid duplication, improve efficiency and reduce resource allocation. SWAp was launched in 1998.[51] Each HPNSDP is supported by an Implementation Programme[52] and an Operational Plan. The Operational Plan set out details of programme activities along with detailed budgets across the different programmes.[53] At the time of writing the fifth HPNSDP is being prepared.

a) Administrative structure

This section presents the administrative structure in Bangladesh and shows how the healthcare system maps onto this structure. It then introduces the Essential Health Service Package (ESP) and its four tiers.

Table 1 (below) shows the administrative structure across Bangladesh. Bangladesh has eight regional Divisions: Dhaka, Chattogram, Rajshahi, Khulna, Sylhet, Barisal, Rangpur and Mymensingh.[54] These are local government bodies and distinct administrative units which are administered under the Local Government Division (LGD) through elected representatives.[55] There are then Districts, *Upazilas*, Unions, Wards and Villages.[56] Local government in urban areas is provided through the City Corporation and the Pourashava (Municipality).[OBJ] There are 12 City Corporations and 330 Municipalities across Bangladesh.[57]

[51] Bangladesh, MOHFW, Health Population and Nutrition Sector Development Program 2011-16, Program Implementation Plan, July 2011, url, p. XV
[52] Bangladesh, MOHFW, Health Population and Nutrition Sector Development Program 2011-16, Program Implementation Plan, July 2011, url, pp. 33-34
[53] Bangladesh, MOHFW, 4th Health, Population and Nutrition Sector Program 2017-2022, Operational Plan, April 2017, url
[54] Bangladesh, Bangladesh National Portal, বিভাগসমূহ [Divisions], 25 April 2023, url
[55] Bangladesh, MOLGRDC, National Urban Health Strategy, November 2014, url, p. 5
[56] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, p. 18
[57] Bangladesh, BBS, Statistical Yearbook Bangladesh 2021, June 2022, url, p. 45

Table 1. Administrative units of Bangladesh[58]

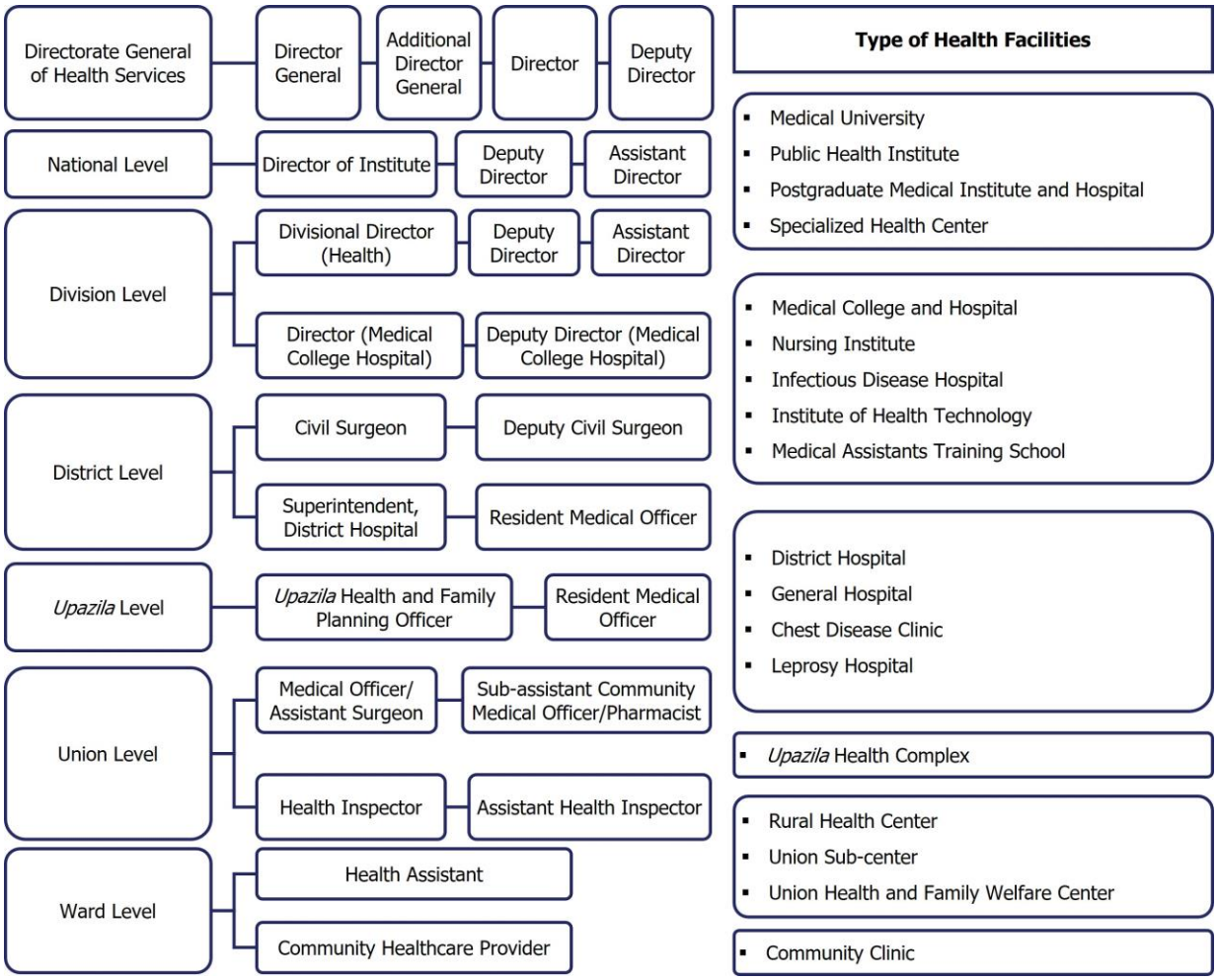
Administrative unit	Number of units
Division	8
City Corporation	12
Municipality	330
District	64
Upazila	492
Union	4 554
Ward	40 987
Village (approx.)	87 320

Figure 2 presents the healthcare system from ward to national level and shows how it maps onto the administrative structure. Figure 2 also shows that healthcare facilities span different administrative levels.[59]

[58] Bangladesh, BBS, Statistical Yearbook Bangladesh 2021, June 2022, url, p. 45; Bangladesh, Bangladesh National Portal, বিভাগসমূহ [Divisions], 25 April 2023, url; Bangladesh, Bangladesh National Portal, উপজেলাসমূহ [Upazilla List], 25 April 2023, url; Bangladesh, Bangladesh National Portal, ইউনিয়নসমূহ [Union List], 25 April 2023, url; Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, p. 18

[59] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, p. 18

Figure 2. Managerial hierarchy according to types of facilities from national to the ward level, from the MOHFW, 2020[60]



The National Health Care Standards establish the Quality of Care in health service delivery including service delivery; laboratory and other diagnostic services and pharmaceutical services; infection control and waste management; and safe and appropriate environment.[61]

An ESP was developed to improve services at the *Upazila* level and below, and also to complement urban primary healthcare.[62] The ESP is delivered through four tiers which are shown in Table 2.[63]

[60] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, p. 29
[61] Bangladesh, MOHFW, National Health Care Standards, January 2015, url, p. 12
[62] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, p. 250
[63] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan (HNPSIP) 2016 - 2021, February 2016, url, pp. 40-41

Table 2. The four tiers of the Essential Health Service Package, adapted from MOHFW's Health Nutrition Population Sector Strategic Investment Plan (HNPSIP)[64]

Tier	Description	
1	**Community Level facilities**	
	Domiciliary Visit	Field staff (both from DGHS and Directorate General Family Planning (DGFP)) conduct house-to-house visits in the community to provide services to the clients in their relevant geographical work areas.
	Satellite Clinics and Out-Reach Services	Satellite clinics (8 in each union per month) and EPI Out-Reach Services (24 per month in each union) are providing assigned services by Health and Family Planning Field Workers.
	Community Clinic (CC)	13 500 Community clinics have been established, one per 6 000 population. The Community Clinics are managed by Community Health Care Providers (CHCP), Health Assistant (HA) and Family Welfare Assistants (FWA).
2	**Union Level Facilities (UHFWCs; Sub-Centres; and Maternal and Child Welfare Centres (MCWCs) at union)**	
	Union Health and Family Welfare Centres are mainly established in each Union. Medical Doctors with additional, Family Welfare Visitors (FWVs); Sub-Assistant Community Medical Officers (SACMO) and Pharmacists, mostly staff these Union Level facilities.	
3	***Upazila* Level Facilities (Health Complex (UHC) and MCWCs at *Upazila*)**	
	The *Upazila* Health Complex is the first level referral centre in each *upazila.* They include *Upazila* Health and Family Planning Officers (UHFPO), Resident Medical Officers (RMO), Medical Officers (MOs), Medical Officer-MCHFP, *Upazila*	

[64] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan (HNPSIP) 2016 – 2021, February 2016, url, pp. 40-41

Tier	Description
	Family Planning Officers (UFPO), Specialist Doctors (Consultants); Staff Nurses; Laboratory Technologists; and a cadre of field staff. The *Upazila* Health Complexes provide both outpatient and inpatient facilities.
4	**District Level Facilities (District Hospital and MCWCs at District)**
	District hospitals are specialised health care facilities and provide consultants from all relevant disciplines. The district hospitals are the secondary referral centres. MCWCs in the districts include Maternal, Neonatal, Child and Family Planning Services. These facilities are staffed with trained Medical Officers and FWVs.

2.1.2. Public sector

This section covers primary care for urban health services and for rural areas. It then turns to secondary and tertiary care.

a) Urban health services – primary care

Urban health services are carried out through City Corporations and Municipalities[65] (see Table 1) and are the responsibility of both the MOHFW and the Ministry of Local Government, Rural Development and Co-operatives (MOLGRDC).[66] The Local Government (City Corporation) Act[67] and the Local Government (Paurashava Act)[68] mandate that the Local Government Division (LGD) deliver and maintain a range of services. These services include education and basic health services (provision of preventive and promotive health as well as limited curative care and services) and provision and the maintenance of basic services and infrastructure for environmental sanitation.[69] The 8th Five Year Plan for Bangladesh (8FYP) notes that primary health care is not adequate for the urban population and that it is particularly weak for the urban poor.[70]

The Bangladeshi news platform Business Standard reported in 2022 that the MOHFW has long been interested in taking over urban health service centres, but that MOLGRDC is

[65] Bangladesh, MOHFW, Health Bulletin 2019, 2020, url, pp. 162-163
[66] Govindaraj, R. et al., Health and Nutrition in Urban Bangladesh, Social Determinants and Health Sector Governance, World Bank, 2018, url, p. 61
[67] Bangladesh, Government of the People's Republic of Bangladesh, স্থানীয় সরকার (সিটি কর্পোরেশন) আইন, 2009 (২০০৯ সালের আইন নং ৬০) [Local Government (City Corporation) Act, 2009 (Act No. 60 of 2009)], 2009, url
[68] Bangladesh, Government of the People's Republic of Bangladesh, Local Government (Paurashava) Act, 2009, url
[69] Govindaraj, R. et al., Health and Nutrition in Urban Bangladesh, Social Determinants and Health Sector Governance, World Bank, 2018, url, p. 62
[70] Bangladesh, GED, 8th Five Year Plan, July 2020 - June 2025, Promoting Prosperity and Fostering Inclusiveness, December 2020, url, p. 587

reluctant to cede control. The Business Standard further noted that MOHFW acknowledges that it intends to develop its role in urban health care.[71]

A draft service outline for the ESP Urban Component is available in the Health Nutrition Population Sector Strategic Investment Plan (HNPSIP).[72]

b) Rural health services – primary care

In 2020, there were 15 954 primary healthcare facilities in Bangladesh being run by the DGHS (see Table 3). This includes 13 948 functional Community Clinics.[73] These are sited in rural areas and provide services to between 6 000 and 12 000 people.[74] Each Community Clinic is staffed by Community Health Care Providers (CHCP), one Health Assistant (HA) and Family Welfare Assistants (FWA).[75] The Community Clinics do not provide curative services, but they provide basic levels of care in Reproductive, Maternal, New-born, Child and Adolescent Health; Maternal Health Care; New-born and Child Health Care; Management of Child Malnutrition; Communicable Disease Control (CDC); Non-Communicable Disease Control (NCDC); Common Illness and Injury; Emergency Care; Common Skin, Eye, Ear and Dental Diseases; and Behaviour Change Communication.[76]

The *Upazila* Health Complexes range in size from 10 to 100 bed facilities (see Table 3).[77] They provide more specialised care in the categories described above for Community Clinics.[78]

Table 3 shows that outpatient services are provided at *Upazila* health offices, Union Sub-centres, Union health and family welfare centres, Urban dispensaries, School health clinics and at the Tejgaon Health Complex in Dhaka.

District hospitals, located in each of the 64 districts of the country, provide both curative, surgical and public health services including the Expanded Programme on Immunization (EPI). A draft service outline for the ESP is available in the HNPSIP.[79]

[71] Business Standard (The), Ministry for aiding private hospitals to cut patient bills, 21 September 2022, url
[72] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan, February 2016, url, pp. 52-59
[73] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, p. 247
[74] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, p. 248
[75] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan, February 2016, url, pp. 40-41
[76] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan, February 2016, url, pp. 52-54
[77] Bangladesh, MOHFW, Health Bulletin 2019, 2020, url, p. 159
[78] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan, February 2016, url, pp. 52-54
[79] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan, February 2016, url, pp. 52-59

Table 3. Primary healthcare facilities run by the DGHS, adapted from MOHFW, Health Bulletin 2020 (December)[80]

Type of facility	Type of service	Total no. of facilities	Total no. beds
Community clinic (functional) (Tier 1)*	Outpatient Department (OPD)	13 948	0
Other primary-level facilities (Tier 2)*			
Upazila health office	OPD	60	0
Union Sub-centre	OPD	1 312	0
Union health and family welfare centre (UH & FWC)	OPD	87	0
Urban dispensary	OPD	35	0
School health clinic	OPD	23	0
Tejgaon Health Complex, Dhaka		1	0
Subtotal of other primary-level facilities		1 518	
Upazila health complex (Tier 3)*			
100-bed	Hospital	3	300
50-bed	Hospital	345	17 250

[80] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, p. 247

Type of facility	Type of service	Total no. of facilities	Total no. beds
31-bed	Hospital	65	2 015
10-bed	Hospital	11	110
Subtotal of *Upazila* health complex		424	19 675
District Hospitals** (Tier 3)*			
50-bed	Hospital	2	100
31-bed	Hospital	7	217
30-bed	Hospital	3	90
25-bed	Hospital	1	25
20-bed	Hospital	38	760
10-bed	Hospital	13	130
Subtotal of District Hospitals		64	1 322
Grand total of primary-level facilities (not including community clinic)		2 006	20 999

Type of facility	Type of service	Total no. of facilities	Total no. beds
Grand total of primary-level facilities in the country (including community clinic)		15 954	20 999

* Tiers 1-4 are from the ESP and are defined in Table 2 above.

** District Hospitals with 50 beds and less are here counted as providers of primary care and shown as Tier 3.

c) Secondary care

Secondary care requires specialised equipment and laboratory facilities and includes diagnosis and treatment which has to be undertaken in a hospital: it is therefore provided at the level of District Hospital and above. The Facility Registry states that secondary care is provided from District Hospitals, General Hospitals and 100-250 Bed Hospitals.[81] The Facility Registry reports that there are 61 such hospitals with approved bed space for a total of 12 350.[82] Table 3, above, lists District Hospitals with 10 to 50 beds and notes that, in this report, these are counted as providers of primary care and shown as Tier 3 in the ESP.

d) Tertiary care

Tertiary level health facilities provide advanced medical investigations and treatment. Tertiary care is available to patients who have been referred from primary or secondary health facilities by medical professionals and tertiary care facilities must offer specialised consultative health care in both in-patient and outpatient departments. The Facility Registry states that tertiary care is provided from Medical College Hospitals, Specialised Institutes and Maternity Hospitals and that these are located at different regional levels,[83] and that in tertiary care facilities under the DGHS, across Bangladesh, there is approved bed space for 23 076 patients.[84]

2.1.3. Private sector

The economic policy of Bangladeshi governments since the 1990s has led to an increase in for-profit, private sector health care facilities.[85] The MOHFW explains the importance of it having a partnership-based relationship with the private sector.[86] The Bangladesh Investment Development Authority (BIDA) describes how the private sector plays a major role in

[81] Bangladesh, Government of People's Republic of Bangladesh, Facility Registry [tab for Secondary Health Care], 2023, url
[82] Bangladesh, Government of People's Republic of Bangladesh, Facility Registry [Report for all District/General Hospital], 7 March 2023, url
[83] Bangladesh, Government of People's Republic of Bangladesh, Facility Registry [tab for Tertiary Health Care], 2023, url
[84] Bangladesh, Government of People's Republic of Bangladesh, Facility Registry [Report for 300-500 bed Hospital (not district hospital), Chest Disease Hospital, Dental College Hospital, Infectious Disease Hospital, Leprosy Hospital, Medical College Hospital, Medical University, Medical University, Special Purpose Hospital, Specialized Hospital], 7 March 2023, url
[85] Bangladesh, BBS, Report on the Survey of Private Healthcare Institutions 2019, January 2021, url, p. 1
[86] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan, February 2016, url, p. 2

delivering healthcare services and how most tertiary healthcare institutions are run by the private sector.[87] BIDA characterises private hospitals as being:

- large-scale multi-specialty hospitals with 250 plus beds (such as Evercare, Square, United, Labaid, Ali Asgar Hospitals), that primarily serve affluent and upper-middle class segments and account for around 11 % of total beds available in Dhaka;
- foundation/ non-profit hospitals which offer specialised services with discounted pricing (such as the National Heart Foundation, Kidney Foundation, Ahsania Mission Cancer and General Hospital); and
- general hospitals/ clinics/ nursing homes as well as private medical college hospitals.[88]

A 2019 Bangladesh Bureau of Statistics (BBS) survey of private sector healthcare institutions concluded that 'private sector healthcare institutions outnumbered the public sector healthcare institutions by a large margin'.[89] In 2023, the Facility Registry reported 107 400 hospital beds as being available in 4 164 private hospitals and clinics.[90]

The BBS survey also determined that private sector healthcare provision is not comprehensive. Gaps were in particular found in the provision of emergency life support, treatment of HIV and cardiovascular conditions, and the provision of specialised cancer therapy.[91]

Private facilities that provide health care services and all pharmacies must obtain a license to operate from MOHFW.[92] In 2017 the MOHFW issued an order to all private hospitals, clinics and diagnostic centres regarding the renewal of licences.[93] The HNPSIP identifies the need to tighten regulation of private secondary and tertiary care facilities.[94] In 2022, the health research institute icddr,b reported that approximately 80 % of hospitals in Bangladesh were private facilities and that many operated with little regulation. icddr,b describes the results of a survey of private health facilities which it conducted, that found that 6 % of facilities surveyed had a valid license and that 59 % were in the process of applying for a new, or renewing an existing, license.[95] The news site bdnews24.com reported that, as of 31 August 2022, the government had levied fines worth BDT 1.1 million [EUR 11 500] on unregistered private medical facilities across Bangladesh.[96]

[87] Bangladesh, BIDA, Healthcare & Medical Device Industries, June 2021, url, p. 2
[88] Bangladesh, BIDA, Healthcare & Medical Device Industries, June 2021, url, p. 3
[89] Bangladesh, BBS, Report on the Survey of Private Healthcare Institutions 2019, January 2021, url, p. xxxv
[90] Bangladesh, Government of People's Republic of Bangladesh, Facility Registry [Report for all Private Hospital / Clinic], 7 March 2023, url
[91] Bangladesh, BBS, Report on the Survey of Private Healthcare Institutions 2019, January 2021, url, pp. xliii-xliv
[92] Govindaraj, R. et al., Health and Nutrition in Urban Bangladesh, Social Determinants and Health Sector Governance, World Bank, 2018, url, p. 65
[93] Bangladesh, MOHFW, বেসরকারি হাসপাতাল ও ক্লিনিক, ডায়াগনস্টিক সেন্টারের জন্য [Emergency Notice for Private Hospitals, clinics and diagnostic centers], 5 September 2017, url
[94] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan, February 2016, url, p. 20
[95] icddr,b, Licensing is the gateway to improving quality of services at private health facilities: finds an icddr,b assessment, 30 August 2022, url
[96] bdnews24.com, Bangladesh regulator orders private medical facilities to display registration details, 2 September 2022, url

2.2. Healthcare resources

In 2015, the WHO characterised the health system in Bangladesh as having a shortage of skilled health workers with twice as many doctors as nurses. Skilled health workers are clustered in urban areas.[97] Community Clinics, the main rural facilities, are typically understaffed and are insufficiently equipped.[98] The WHO found unqualified/semi-qualified allopathic practitioners, such as village doctors and Community Health Workers (CHWs), to be located mainly in rural areas. Traditional healers and trained/traditional birth attendants practice in rural areas. Drug shop attendants are evenly distributed between urban and rural areas. [99]

An inequitable distribution of the health workforce was first reported in 1998.[100] In 2007, Bangladesh Health Watch reported an unequal distribution and found key health providers and qualified professionals being mainly located in urban areas and the metropolitan areas of Dhaka, Chittagong, Rajshahi and Khulna.[101] An interviewee for this report stated that the distribution of skilled human resources and the allocation of funding is to this day unequal: in the divisions of Dhaka, Barisal, Mymensingh and Sylhet between 60 % and 70 % of posts for qualified health professionals are filled, while the Chattogram, Khulna, Rajshahi and Rangpur divisions have between 30 % and 40 % of posts filled. In addition, the skilled medical resources are concentrated in cities rather than being spread across the divisions and covering remote areas where demand is high.[102]

In 2015, the WHO further reported that emergency transport services (ambulance) are available in public sector facilities, but these are not in a centralized system so individual facilities need to be contacted to access the service. The authors noted there are some for-profit private enterprises that provide emergency transport services but that public sector ambulance services can be poorly equipped, inoperative and can sometimes be used for other purposes.[103]

2.3. Pharmaceutical sector

Drug administration is a directorate within the MOHFW which is led by the Directorate General of Drug Administration (DGDA).[104] The office of the DGDA is mandated to ensure quality,

[97] WHO, Regional Office for the Western Pacific, Bangladesh Health System Review, 2015, url, p. 93
[98] WHO, Regional Office for the Western Pacific, Bangladesh Health System Review, 2015, url, p. 92
[99] WHO, Regional Office for the Western Pacific, Bangladesh Health System Review, 2015, url, p. 94
[100] Ahmed, S.M. et al., The health workforce crisis in Bangladesh: shortage, inappropriate skill-mix and inequitable distribution, 2011, url, p. 6
[101] Bangladesh Health Watch, The State of Health in Bangladesh 2007: health workforce in Bangladesh, who constitutes the healthcare system?, 2007, url, p. 24
[102] Source B, interview, Dhaka, 8 February 2023. Source B is an officer in the DGHS / DGMEFW, MOHFW. The person wishes to remain anonymous.
[103] WHO, Regional Office for the Western Pacific, Bangladesh Health System Review, 2015, url p. 114
[104] Bangladesh, MOHFW, Health Bulletin 2019, 2020, url, p. 9

efficacy and safety of pharmaceutical products through the implementation of relevant legislation.[105] The main functions of the DGDA are:

- to supervise and implement the drug regulations;
- to regulate activities related to import, procurement of raw and packing materials, production and import of finished medication, export, sale, pricing, and so on;
- to monitor and regulate the activities of all drug manufacturing companies;
- as Licensing Authority (LA), the DGDA issues licenses to manufacture, store, sell, import and export drugs and medicines.[106]

Pharmaceutical manufacturing in Bangladesh currently uses advanced technology to produce medicines and, since 2009, Bangladeshi manufacturers have been supplying essential medicine to all health centres in the country.[107] In 2016, Bangladesh met 97 %[108] of its domestic demand and in 2020, this rose to 98 %.[109] BIDA reported that the industry contributed approximately 1.8 % to the GDP.[110] Since 2016 the country has exported medical drugs to 113 countries.[111] BIDA also reported that, in 2020, Bangladesh had 271 Allopathic, 205 Ayurvedic, 271 Unani (Islamic traditional medicine), 32 Herbal and 79 Homeopathic drug producing companies.[112]

Bangladesh has had three iterations of its National Drugs Policy: the first was in 1982;[113] the second was in 2005;[114] and the third in 2016.[115] The 2016 drug policy formulated specific guidelines for drug safety, efficacy, logical use of drugs and effective control of drugs.[116] It contains guidelines for production, marketing, storage and import and export of medicine.[117] A guideline on Antimicrobial Consumption Surveillance has been issued[118] as well as a centre and a clinical study for bioequivalence.[119] The 2016 national drug policy has established a Pharmacovigilance System to monitor adverse drug reactions. This was examined by external WHO assessors in July 2021 and awarded maturity level 3.[120]

[105] Bangladesh, MOHFW, DGDA, Quality manual, 18 May 2021, url, p. 13
[106] Bangladesh, MOHFW, DGDA, Background, 6 March 2022, url
[107] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, p. 2
[108] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, p. 1
[109] Bangladesh, BIDA, Pharmaceuticals & API Industries, December 2020, url, p. 2
[110] Bangladesh, BIDA, Pharmaceuticals & API Industries, December 2020, url, p. 2
[111] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, p. 1
[112] Bangladesh, BIDA, Pharmaceuticals & API Industries, December 2020, url, p. 2
[113] Bangladesh, DDA, Report of the Expert Committee for Drugs on National Drug Policy 1982, 1986, url
[114] Bangladesh, MOHFW, National Drug Policy, 5 May 2005, url
[115] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url
[116] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, p. 23
[117] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, pp. 2-30
[118] Bangladesh, MOHFW, DGDA, (Draft) Guideline on Antimicrobial Consumption Surveillance in Bangladesh, July 2022, url
[119] Source A, interview, Dhaka, 8 February, 2023. Source A is an officer in the MOHFW. The person wishes to remain anonymous.
[120] Bangladesh, MOHFW, ADRM, DGDA, Pharmacovigilance Newsletter, March 2022, url, p. 5

The national Essential Drugs List is set out in the 2016 policy, and it includes lists for essential Allopathic,[121] Ayurvedic[122] and Unani[123] drugs. It covers Homeopathic Medicine[124] and Over-The-Counter (OTC) medicines selected from commonly used Allopathic, Ayurvedic and Unani drugs with fewer or smaller side-effects.[125] The Central Medical Store Depot (CMSD) of the DGHS is responsible for the purchase, storage and distribution of all medical drugs to all required places.[126] There are 219 medicines on the list, of which 117 have a fixed retail price.[127]

Healthcare and pharmaceutical professionals are able to get information on available and recent drug products from DIMS (Drug Information Management System). DIMS is a commercial software application which can be used on mobile phones, which provides an index of clinical drug information applicable across Bangladesh and which is currently free to use. It provides information on available and recent drug products and is aimed at healthcare and pharmaceutical professionals. The developers state that it is updated frequently and that it has information on over 24 000 brand name and 1 400 generic medications.[128] DIMS provides a database into which pharmaceutical companies can upload information about their medications.[129]

The issue of counterfeit medicines and the adverse effect they have on society has been raised in the media.[130] An analysis of medicines collected from private drug outlets in Dhaka city found that the majority of the samples analysed were of good quality; and that over 90 % of the samples from the Dhaka City Corporation region were acceptable in quality and in compliance with pharmacopoeial reference ranges.[131] The authors concluded that there is scope for improving the storage of the 'distributed medicines and for lowering the prices of the medicines in the private drug outlets'.[132] The authors also noted that, during their survey, no provider asked the buyers of the samples for a medical prescription.[133]

[121] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, pp. 24-39
[122] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, pp. 40-41
[123] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, pp. 42-49
[124] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, pp. 50-57
[125] Bangladesh, MOHFW, জাতীয় ওষধ নীতি ২০১৬ [Gazette on National Drug Policy 2016], 2017, url, pp. 58-64
[126] Bangladesh, MOHFW, Central Medical Stores Depot (CMSD), url
[127] Prothomalo.com, Price of 53 essential medicines set to increase, 16 July 2022, url
[128] IT Medicus, Drug Information Management System (DIMS), 2022, url
[129] IT Medicus, What is DIMS Gateway, 2022, url
[130] New Age Bangladesh, Counterfeit medicines flood markets across Bangladesh, 25 September 2021, url; Daily Star (The), Countering counterfeit medicine in Bangladesh, 27 February 2022, url
[131] Rahman, M.S. et al., A comprehensive analysis of selected medicines collected from private drug outlets of Dhaka city, Bangladesh in a simple random survey, 2022, url, p. 10
[132] Rahman, M.S. et al., A comprehensive analysis of selected medicines collected from private drug outlets of Dhaka city, Bangladesh in a simple random survey, 2022, url, p. 14
[133] Rahman, M.S. et al., A comprehensive analysis of selected medicines collected from private drug outlets of Dhaka city, Bangladesh in a simple random survey, 2022, url, p. 4

2.4. Patient pathways

The HNPSIP identifies a functional referral system as one of its ten key messages.[134] This includes developing partnerships between the public sector and Alternative Medicine Care providers and hospitals and clinics in the private sector so as to increase accessibility of services, including in urban and rural areas that are hard to reach.[135] MOHFW recognises the importance of referral systems that span community level facilities to national-level hospitals and the need for Health Information Systems to enable this.[136]

The Business Standard reported in 2022 that the MOHFW acknowledges that patients do not use primary healthcare centres, but rather go directly to hospitals. MOHFW intends to expand its role in urban health care to counteract this issue in urban areas and to reduce pressure on secondary and tertiary healthcare facilities.[137] A functioning referral system could reportedly halve the pressure on large tertiary hospitals.[138]

This is corroborated by an interviewee for this report who stated that referrals from *Upazila* Health Complexes to secondary and tertiary level healthcare do occur but, when people fall ill, they tend to go straight to the outpatient and emergency departments of secondary and tertiary health care.[139]

In 2018, the World Bank reported that providers and services were fragmented and that there was no coordination of the health care service delivery system in urban areas, which resulted in a subsequent failure to provide comprehensive care. The World Bank authors found no sign of horizontal integration, i.e., of facilities working together to provide a comprehensive range of services to the population in their districts. They also found that the referral system lacked vertical integration, with patients accessing specialized care directly without referrals.[140]

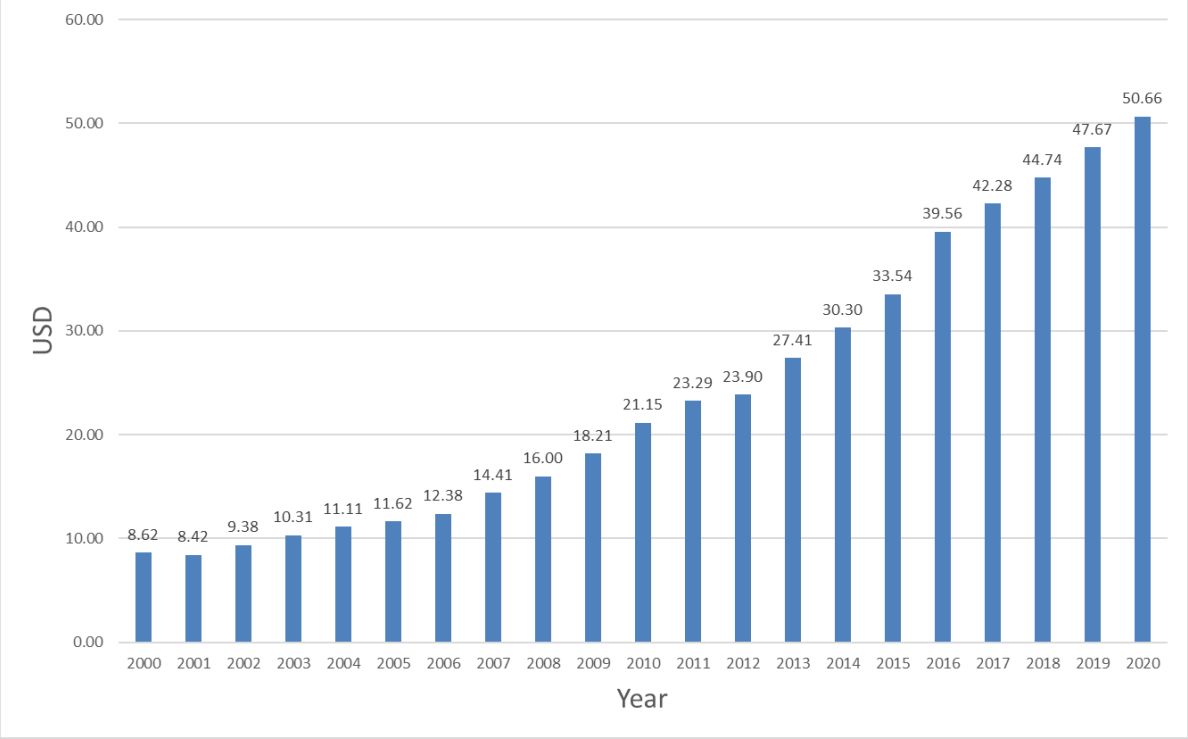
[134] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan (HNPSIP), 2016 – 2021, February 2016, url, p. 3
[135] Bangladesh, MOHFW, Health Nutrition Population Sector Strategic Investment Plan (HNPSIP), 2016 – 2021, February 2016, url, p. 17
[136] Bangladesh, MOHFW, Health Bulletin 2020, 2022, url, pp. 317-318
[137] Business Standard (The), Ministry for aiding private hospitals to cut patient bills, 21 September 2022, url
[138] Daily Star (The), Patient Referral System: Still elusive after all these years, 23 January 2023, url
[139] Source B, interview, Dhaka, 8 February 2023. Source B is an officer in the DGHS / DGMEFW, MOHFW. The person wishes to remain anonymous.
[140] Govindaraj, R. et al., Health and Nutrition in Urban Bangladesh, Social Determinants and Health Sector Governance, World Bank, 2018, url, p. 70

3. Economic factors

3.1. Health services provided by the State / Public authorities

Health services provided by the State are set out in section 2.1.2. Public sector. The Government of Bangladesh has been described as subsidising public health facilities so as to cover the 'bare minimum' of the cost of care.[141] Despite an upward trend in health expenditure shown in Figure 3 and Figure 4 below, Bangladesh continues to have the lowest per capita expenditure on health, and the lowest expenditure as a percentage of GDP, of the 11 member states in the WHO South East Asia Region.[142] Figure 3 shows that per capita health expenditure by the Government increased from USD 8.62 in 2000 to USD 50.66 in 2020.[143]

Figure 3. Current health expenditure per capita (current USD) - Bangladesh[144]



[141] Rahman, M.M., et al., Forgone healthcare and financial burden due to out-of-pocket payments in Bangladesh: a multilevel analysis, 2022, url, p. 9

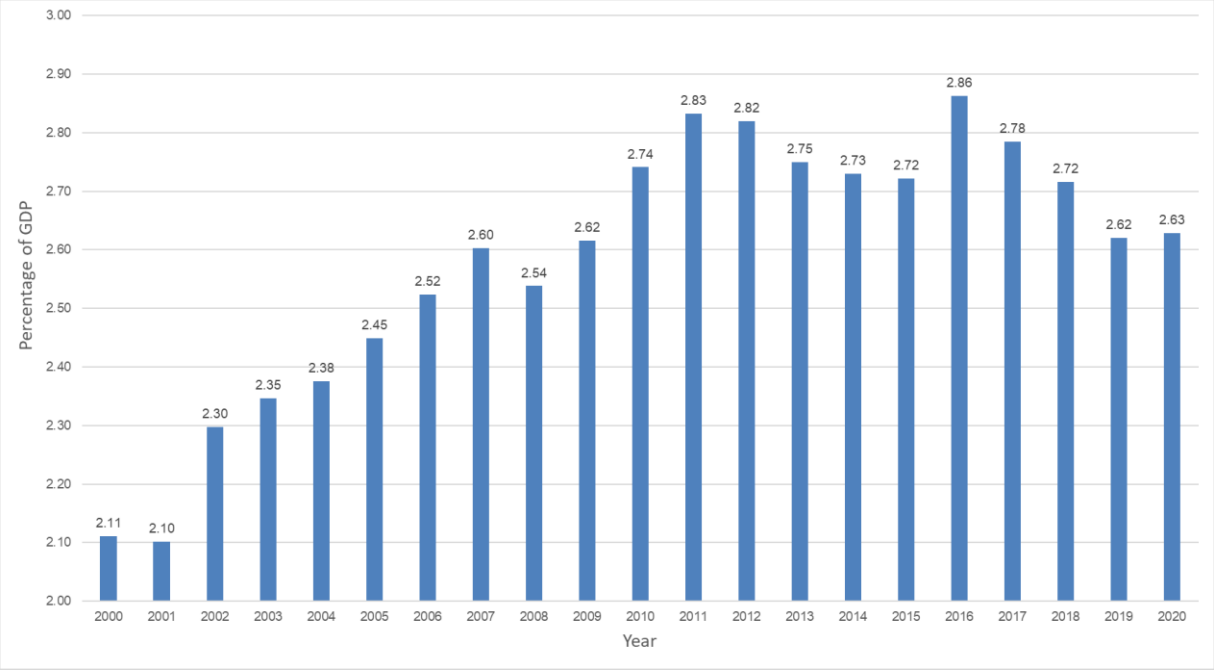
[142] WHO, Current health expenditure per capita (current USD) – WHO South East Asia Region, n.d., url; WHO, Current health expenditure as a percentage of Gross Domestic Product (GDP) – WHO South East Asia Region, n.d., url

[143] WHO, Current health expenditure per capita (current USD) - Bangladesh, n.d., url

[144] WHO, Current health expenditure per capita (current USD) - Bangladesh, n.d., url. Select: Indicators, Aggregates 'Current Health Expenditure (CHE) per Capita in US$'; Country: Bangladesh; Years 2000 to 2021; Units of expenditure: current US$ per capita

Figure 4 shows per capita spending as a percentage of Gross Domestic Product (GDP). This has risen gradually from 2.11 % in 2000 to 2.63 % in 2020.

Figure 4. Current health expenditure as a percentage of Gross Domestic Product (GDP)[145]



3.2. Risk-pooling mechanisms

3.2.1. Public health insurance, national or state coverage

The Health Care Financing Strategy (HCFC) 2012–2032[146] aims to introduce social health protection schemes for the poor and for formal sector employees and to move towards provision for the entire population.[147] In principle, all citizens with an identity card have access to public health facilities without paying a contribution. For outpatient consultation a low user charge is required, and while medical supplies should be provided for free, it is commonly not available in the facilities so the patients will need to supply them. OOP payments are still the main financer for health services, through the purchase of pharmaceuticals and medical goods.[148]

In 2016, the government introduced a demand-side social health protection scheme, Shasthyo Suroksha Karmasuchi (SSK), for the below-poverty line population in three *upazilas*.[149] The

[145] WHO, Current health expenditure as a percentage of Gross Domestic Product (GDP) - Bangladesh, n.d., url. Select: Indicators, Aggregates 'Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)'; Country: Bangladesh; Years 2000 to 2020; Units of expenditure: current US$ per capita
[146] Bangladesh, MOHFW, Expanding Social Protection for Health: Towards Universal Coverage, Health Care Financing Strategy 2012–2032, September 2012, url
[147] Rahman, T. et al., Financial risk protection in health care in Bangladesh in the era of Universal Health Coverage, June 2022, url, p. 13
[148] WHO, Regional Office for the Western Pacific, Bangladesh Health System Review, 2015, url, pp. 66-70
[149] Bonilla-Chacin, M.E. et al., Pathways to Reduce Household Out-of-Pocket Expenditure, 2020, url, p. 32

scheme covers inpatient care for 70 different disease groups, with a benefit of USD 620 per household per year.[150] SSK is in the piloting phase and while the package of benefits that it offers is expected to evolve the efficacy of the scheme in providing protection is not yet known.[151]

3.2.2. Community-based health insurance schemes

In Bangladesh, community-based health insurance (CBHI) exists mainly as a form of micro-health insurance initiated by NGO-microfinance institutes (NGO-MFIs), by private insurance companies and by the state-owned corporations, the general insurer Sadharan Bima Corporation (SBC) and the life insurer Jiban Bima Corporation (JBC).[152] Sheikh et al. categorize CBHI based on the types of insurance providers:

> '(i) provider-based model, in which private health facilities commence health insurance and offer healthcare from their health facilities;
>
> (ii) microfinance-based model, where microfinance organizations manage insurance programs for their borrowers; and
>
> (iii) non-microfinance-based model, where NGOs launch health insurance for the organized community or specified geographic areas without any link with microfinance'[153]

People who cannot secure traditional health insurance, can obtain access to quality healthcare via micro health insurance packages which have low premium rates. This can decrease OOP (out-of-pocket) expenses and provide financial protection from unexpected health care expenditures.[154] Micro-insurance for health is also designed to address spatial exclusion from health services and cultural exclusion of women from health services.[155]

In an academic study the micro-insurance sector in Bangladesh is described as not being very effective and the authors state that work needs to be done to encourage the use of micro-insurance products and to build trust among potential stakeholders.[156]

The NGO-MFIs in Bangladesh's microinsurance consists of national institutions such as BRAC, Grameen Kalyan and Proshika and smaller regional-level NGOs. The national institutions account for most of the country's microinsurance clients while smaller regional-level NGOs tend to offer a larger variety of microinsurance products and have a more substantial number of policy-holders from lower revenue groups.[157]

[150] Ahmed, S. et al., Evaluating the implementation related challenges of Shasthyo Suroksha Karmasuchi (health protection scheme) of the government of Bangladesh: a study protocol, 2018, url, pp. 1-2
[151] Bonilla-Chacin, M.E. et al., Pathways to Reduce Household Out-of-Pocket Expenditure, 2020, url, p. 32
[152] Sultana, D. et al., Evolution of Micro Insurance in Bangladesh: Financial Cushion for the Bottom of the Pyramid Population, 2021, url
[153] Sheikh, N. et al., Implementation barriers and remedial strategies for community-based health insurance in Bangladesh: insights from national stakeholders, 2022, url, p. 2
[154] BRAC, The Good Feed, Health: Healthcare made hassle-free: Micro health insurance, 12 September 2022, url
[155] Werner, W.J., Micro-Insurance in Bangladesh: Risk Protection for the Poor?, August 2009, url, p. 563
[156] Mamun, M., The Effectiveness of Microinsurance in Bangladesh: Can It Sustain? 2017, url, p. 14
[157] Sultana, D. et al., Evolution of Micro Insurance in Bangladesh: Financial Cushion for the Bottom of the Pyramid Population, 30 May 2021, url

BRAC advertises two types of insurance: one with an annual premium of BDT 1 220 [EUR 13] and one of BDT 650 [EUR 7]. Under the lower premium, BRAC states that the insured is covered for life insurance of BDT 10 000 [EUR 105] and benefits from the following services:

- outpatient treatment of up to BDT 1 500 [EUR 16];
- hospital facility stay of up to BDT 10 000 [EUR 105];
- normal childbirth of up to BDT 2 200 [EUR 23] and
- caesarean delivery of up to BDT 6 500 [EUR 68].[158]

BRAC states that a normal childbirth costs BDT 2 500 [EUR 26] at a BRAC maternity centre. In addition, there is an admission fee of BDT 100 [EUR 1] as well as check-ups performed by a midwife or a medical officer costing BDT 100 [EUR 1] and BDT 200 [EUR 2] respectively.[159]

Micro-health insurance plans are provided by NGO-MFIs to guarantee loan repayment, as health issues account for around one-third of all microcredit defaults.[160] Sultana et al. write that micro-health insurance was originally a way of safeguarding a loan and the model is now used to improve access to healthcare, especially for lower socioeconomic groups.[161]

3.2.3. Private insurance companies

At the end of 2019, 32 life insurers and 45 non-life licensed insurers were in operation.[162] Insurance penetration is low with 13 million people (approximately 8 % of the population) in Bangladesh having an insurance policy of any kind.[163] The Insurance Development and Regulatory Authority (IDRA) states that the insurance market does not offer a diverse range of products and notes that neither universal health insurance nor catastrophic insurance are available. IDRA attributes this low demand to the poor reputation of the sector and to it being complicated to there being no established practice amongst Bangladeshi households to renew insurance policies.[164] Despite this, IDRA expresses optimism about health insurance as a sector because middle-income groups are increasingly using, and various corporates are offering, health insurance.[165]

Since its inception, in 2010, to 2019, IDRA has approved different types of life insurance, for example, various types of microinsurance, deposit insurance, Pension Insurance, Accidental Life Insurance as a Rider (ADAB), Permanent Total Disability Insurance (PDAB) and Health Insurance, Children Protection Insurance, Hajj Bima,[166] Denmohor Bima,[167] Education Expense

[158] BRAC, The Good Feed, Health: Healthcare made hassle-free: Micro health insurance, 12 September 2022, url
[159] BRAC, The Good Feed, Health: Healthcare made hassle-free: Micro health insurance, 12 September 2022, url
[160] Khan, M.R., et al., Assessing Microinsurance as a Tool to Address Loss and Damage in the National Context of Bangladesh, June 2013, url, pp. 10-11
[161] Sultana, D. et al., Evolution of Micro Insurance in Bangladesh: Financial Cushion for the Bottom of the Pyramid Population, 2021, url
[162] Bangladesh, IDRA, Annual Report, 2018-2019 and 2019-2020, n.d., url, p. 14
[163] Bangladesh, IDRA, Annual Report, 2018-2019 and 2019-2020, n.d., url, p. 8
[164] Bangladesh, IDRA, Annual Report, 2018-2019 and 2019-2020, n.d., url, pp. 8, 29
[165] Bangladesh, IDRA, Annual Report, 2018-2019 and 2019-2020, n.d., url, p. 28
[166] Protection and savings policy to enable participation in the *hajj*, the pilgrimage to Mecca.
[167] Policy to enable payment of *Denmohor*, a fee payable by husband to wife as part of the marriage contract.

Insurance Plan, Mortgage Assurance Plan, Family Protection Plan and SME Loan Protection Plan.[168]

Table 5 shows that when looking at the premiums taken by Life Insurance products, the percentage of the premiums that were taken by Group & Health Insurance increased from 4.57 % in 2015 to 7.26 % in 2019. Individual insurance is the largest sub-sector and has the largest growth in percentage points.[169]

Table 4. Percentage of gross premium in Life Insurance (2015 to 2019)[170]

Year	Individual	Micro-insurance	Group & Health	Islami
2015	65.64 %	17.64 %	4.57 %	12.15 %
2016	66.95 %	15.55 %	4.79 %	12.70 %
2017	77.8 %	14.66 %	6.00 %	11.53 %
2018	66.37 %	15.45 %	6.55 %	11.62 %
2019	66.13 %	15.43 %	7.26 %	11.18 %

Private insurance companies currently offer a variety of microinsurance products and many of these schemes have similar terms and conditions. Examples include *Gono-Grameen Bima* (general rural insurance), *Grameen Jibon Bima* (rural life insurance) and *Daridra Bimochone Jibon Bima* (rural health insurance) (life insurance for poverty alleviation).[171] These seek to combine microfinance credit for the poor with health insurance. These private companies are including the disadvantaged population.[172]

[168] Bangladesh, IDRA, Annual Report, 2018-2019 and 2019-2020, n.d., url, p. 15
[169] Bangladesh, IDRA, Annual Report, 2018-2019 and 2019-2020, n.d., url, p. 28
[170] Bangladesh, IDRA, Annual Report, 2018-2019 and 2019-2020, n.d., url, p. 27
[171] Sultana, D. et al., Evolution of Micro Insurance in Bangladesh: Financial Cushion for the Bottom of the Pyramid Population, 2021, url
[172] Sultana, D. et al., Evolution of Micro Insurance in Bangladesh: Financial Cushion for the Bottom of the Pyramid Population, 2021, url

3.3. Out-of-pocket health expenditure

A study done between 1 December 2015 to 31 December 2016, found health expenditure to be one of the main reasons for poverty and deprivation amongst low-income households with approximately 4.7 million people in Bangladesh going into poverty due to health care costs.[173]

Out-of-pocket (OOP) health expenditure is unpredictable and has negative consequences which leave households exposed to the effects of catastrophic health costs. These are defined as costs that 'severely disrupt household living standards' by absorbing between 10 % and 40 % of household resources.[174]

BIDA states that Bangladesh has one of the highest OOP expenditure rates in the world (as a percentage of Total Health Expenditure (THE).[175] In 2012, MOHFW stated that the reliance on OOP payments is inequitable and inefficient with a severe impact on the poor. MOHFW set an objective to halve OOP payments for health, at the point of service and to lower them from the 2012 level of 64 % of THE to a target of 32 % by 2032.[176] The target is not being met as BIDA reported OOP payments have increased and were close to 74 % of THE in 2020.[177]

[173] Rabbani, A., Sarker, M., Understanding the effects of an employer-provided health security program on the well-being, productivity, and health seeking behavior of workers in a semi-formal manufacturing setting in Bangladesh, 2017, url
[174] Werner, W.J., Micro-insurance in Bangladesh: Risk Protection for the Poor?, 2009, url, p. 564
[175] Bangladesh, BIDA, Healthcare & Medical Device Industries, June 2021, url, p. 6
[176] Bangladesh, MOHFW, Expanding Social Protection for Health: Towards Universal Coverage, Health Care Financing Strategy 2012 -2032, September 2012, url, p. 21
[177] Bangladesh, BIDA, Healthcare & Medical Device Industries, June 2021, url, p. 6

Figure 5. Household Out-of-Pocket Payment as a percentage of Current Health Expenditure[178]

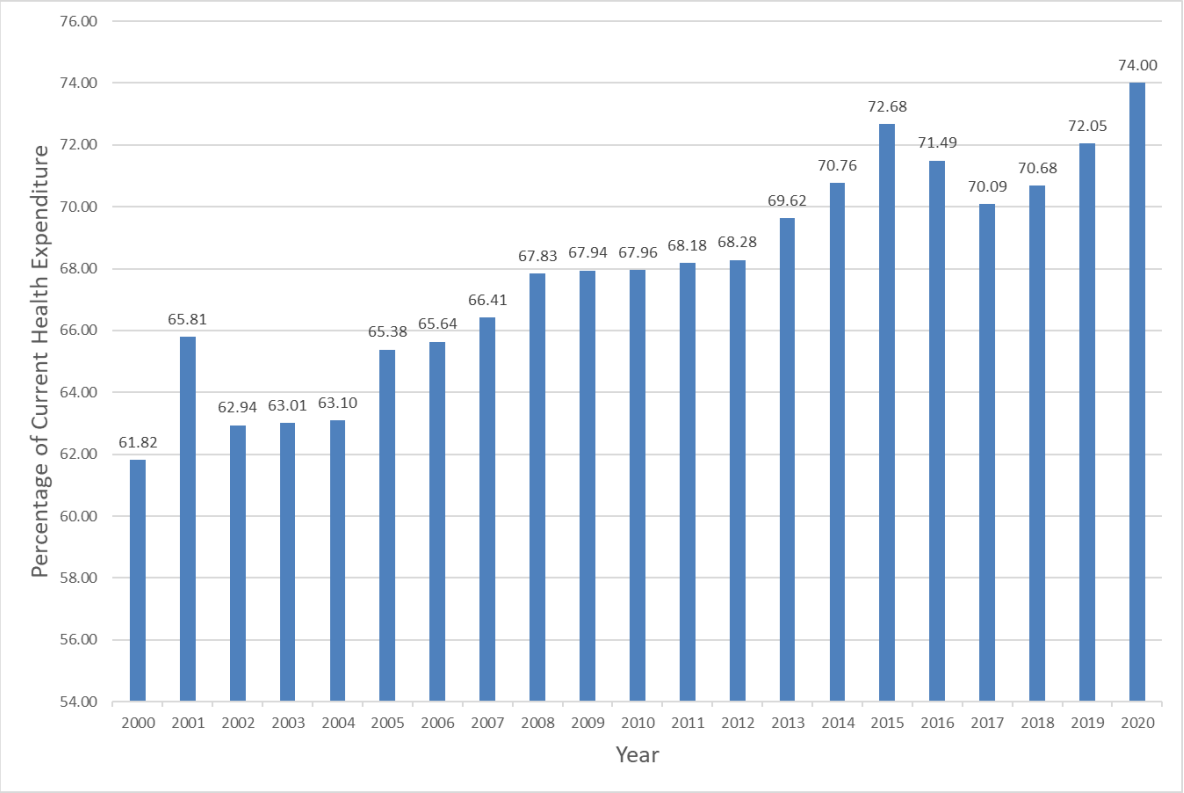
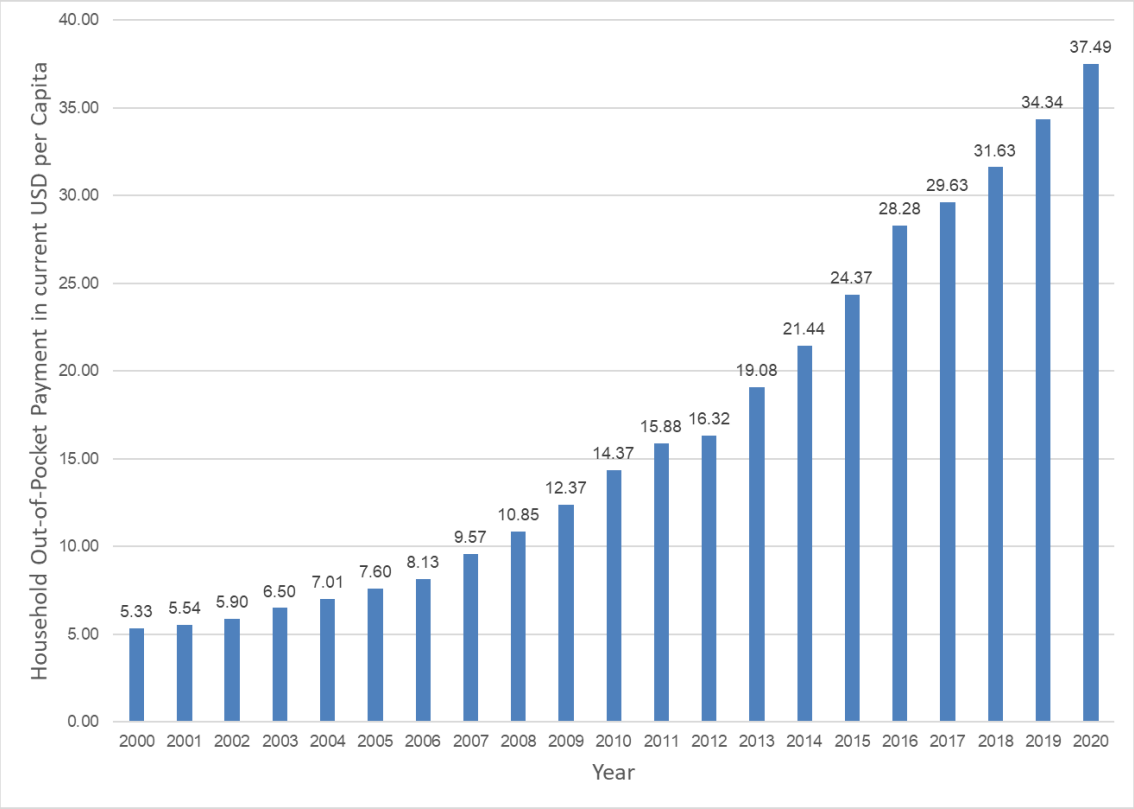


Figure 5 uses Current Health Expenditure (CHE) to show that OOPs have increased since 2000 and that they have been above 70 % of CHE since 2014.[179]

Figure 6 shows a steady increase in the money paid by each household rising to a high of USD 37.49 [EUR 34] in 2020.[180]

[178] WHO, Household out-of-pocket payment as a % of Current health expenditure (CHE) - Bangladesh, n.d., url. Select: Health Expenditure Data, Financing Schemes, Current health expenditure by financing schemes, 'Household out-of-pocket payment as a % of Current health expenditure (CHE)'; Country: Bangladesh; Years 2000 to 2020; Units of expenditure: % of Current health expenditure (CHE)
[179] WHO, Household out-of-pocket payment as a % of Current health expenditure (CHE) - Bangladesh, n.d., url
[180] WHO, Household out-of-pocket payment in current US$ per Capita - Bangladesh, n.d., url

Figure 6. Household Out-of-Pocket Payment in current USD per Capita[181]



A survey of 3 100 households in Dhaka Urban area found that the average OOP spend was 7.7 % of monthly household income (see Table 5 below).[182] Table 6 shows how this study calculates the percentage of OOP against an average monthly household income for each of five income quintiles, rather than a national average, and finds great variation in the percentages paid, from 5.2 % for the richest quintile to 13.3 % and then 32.7 % for the two poorest quintiles.[183]

[181] WHO, 'Household Out-of-Pocket Payment in current US$ per Capita - Bangladesh', n.d., url. Select: Health Expenditure Data, Financing Schemes, Current health expenditure by financing schemes, 'Household out-of-pocket payment'; Country: Bangladesh; Years 2000 to 2020; Units of expenditure: current US$ per capita

[182] Sarker, A.R. et al., Out-of-pocket payment for healthcare among urban citizens in Dhaka, Bangladesh, 24 January 2022, url, p. 11

[183] Sarker, A.R. et al., Out-of-pocket payment for healthcare among urban citizens in Dhaka, Bangladesh, 24 January 2022, url, p. 11

Table 5. Cost burden across socioeconomic groups from a household survey in Dhaka Urban area[184]

Income quintile	Average monthly income (BDT)	Average OOP Expenditure (BDT)	OOP as a percentage of monthly household income
Poorest	9 852	3 226	32.7 %
Poorer	19 655	2 610	13.3 %
Middle	29 215	2 426	8.3 %
Richer	47 256	3 490	7.4 %
Richest	143 901	7 417	5.2 %
Overall	49 362	3 794	7.7 %

The Business Standard reported that those in lower socioeconomic groups are not able to afford health services and cite maternal and reproductive health, children's health services and non-communicable diseases as services that are out of reach. The price of care at private treatment facilities in urban areas means it is not accessible to some middle-income groups.[185]

3.3.1. Cost of consultations

In an interview conducted for this report, Source C stated that in private practice, the price of consultation varies between BDT 300 and BDT 2 000 [EUR 3 and EUR 17] depending on the level of specialty. Private hospitals set the prices for follow-up by specialists and their assistants. The higher prices charged by the private hospitals are explained as being due to the price of land, cost of building and maintaining the facilities and staff costs.[186]

Institutional care is expensive as, in addition to care, patients and their families must pay for travel and food as well as hidden expenditures such as 'unofficial medical charges and

[184] Sarker, A.R. et al., Out-of-pocket payment for healthcare among urban citizens in Dhaka, Bangladesh, 24 January 2022, url, p. 11
[185] Business Standard (The), Ministry for aiding private hospitals to cut patient bills, 21 September 2022, url
[186] Source C, interview, Dhaka, 8 February 2023. Source C is an officer in the MOHFW. The person wishes to remain anonymous.

financial incentives or tips to the porters and female helpers (*ayas*)'.[187] A 2016 study in Sylhet looked beyond the price of treatment to report on both the direct, and the indirect, costs of outpatient treatment in order to establish the total cost of illness incurred by a patient and their household. This study provides an illustration of the full cost of treatment that is borne by an individual and their household, rather than the price charged by a healthcare facility. [188]

The authors divide direct costs of treatment into medical and non-medical costs. Medical costs include 'diagnosis, registration fees, medications, diagnostics, continuing care, hospitalization, rehabilitation; and non-medical costs are the costs of transport to the hospital and any informal payments'. The authors explain that informal payments include any transfer of money, from patients to staff, in the expectation of preferential treatment.[189] Indirect costs of illness arise from loss of income and productivity and can be lost time at work or lost time by a caregiver.[190]

The study found that outpatients in public hospitals experience higher total costs than those treated in private hospitals.[191] The majority of public hospital patients (71 %) were from rural areas and so had higher travel costs and spent longer travelling than the, mainly urban, patients of private hospitals. The outpatient experience in public hospitals was characterised by insufficient numbers of doctors and long queues for treatment. This prompted patients in public hospitals to make offers of informal payment in order to hasten their access to the doctors.[192]

The cost for treatment in public hospitals is comprised of approximately 97 % of indirect costs and 3 % of direct costs.[193] While the direct costs in private hospitals are higher than in public hospitals, the indirect costs incurred in getting care from public hospitals are twice that of private hospitals. As a result, this 2016 study found that the average total cost of outpatient treatment in public hospitals was greater (BDT 9 923 or EUR 114) than that in private hospitals (BDT 5 607 or EUR 64).[194]

3.3.2. Cost of medication

Kasonde et al. examined the availability, price and affordability of 61 medicines across six regions in Bangladesh. They found the private sector (retail pharmacies and clinics) had greater access to the surveyed medicines than the public sector. The study also showed that, when compared with international prices, the prices for most medicines in the private sector were not excessive although some were found to be expensive in all sectors. NCD medicines were the least affordable medicines by unit price and length of treatment.[195] NCD medicines and essential medicines were also harder to get than infectious disease medicines and non-

[187] Rahman, M.M., et al., Forgone healthcare and financial burden due to out-of-pocket payments in Bangladesh: a multilevel analysis, 2022, url, p. 9
[188] Pavel, M.S., Cost of illness for outpatients attending public and private hospitals in Bangladesh, 2016, url, p. 1
[189] Pavel, M.S., Cost of illness for outpatients attending public and private hospitals in Bangladesh, 2016, url, p. 4
[190] Pavel, M.S., Cost of illness for outpatients attending public and private hospitals in Bangladesh, 2016, url, p. 4
[191] Pavel, M.S., Cost of illness for outpatients attending public and private hospitals in Bangladesh, 2016, url, p. 8
[192] Pavel, M.S., Cost of illness for outpatients attending public and private hospitals in Bangladesh, 2016, url, p. 7
[193] Pavel, M.S., Cost of illness for outpatients attending public and private hospitals in Bangladesh, 2016, url, p. 9
[194] Pavel, M.S., Cost of illness for outpatients attending public and private hospitals in Bangladesh, 2016, url, p. 6
[195] Kasonde, L. et al., Evaluating medicine prices, availability and affordability in Bangladesh using World Health Organisation and Health Action International methodology, 2019, url, p. 8

essential medicines, respectively.[196] They also stated that, while the availability of medicines is low in public sector facilities, approximately 50 % of public hospital physicians describe themselves as satisfied with the availability of medicines in facilities from District to Union Sub-Centre level.[197]

In July 2022, the price review committee of the DGDA increased prices of essential drugs. The newspaper New Age described in an opinion piece this as adding to economic hardship in an economy that has been affected by Covid.[198] The prices of 19 generic drugs of 53 brands were increased by the DGDA and drug manufacturers also increased the prices of other drugs.[199] Media sources report increases in the prices of commonly used drugs such as amoxicillin, metronidazole, paracetamol,[200] aspirin, diazepam, penicillin, phenobarbital, phenoxy methyl,[201] benzathine benzylpenicillin, chlorphenamine, ferrous, folic acid, furosemide, lidocaine, methyldopa, norgestrel, prochlorperazine, and xylometazoline.[202]

The price of a single 500 mg paracetamol tablet was increased from BDT 0.7 to BDT 1.2; a 200 mg metronidazole tablet from BDT 0.60 to BDT 1.0; and a 15 ml bottle of amoxicillin BP from BDT 26.34 to BDT 35.[203] The increases in price vary but they range from rises of 50 % to 100 %.[204] CAB are reported as stating that prices, in retail pharmacists, rose between 13 % and 75 % between May and November 2022.[205]

New Age reported that the government has 'little control over the drug market'.[206] The newspaper further informed that the DGDA states that drug prices were last reviewed in 2015 and that the market prices of raw materials have increased. In this review, the government was reportedly under pressure from producers and that consumer's interests had been of secondary concern.[207]

[196] Kasonde, L. et al., Evaluating medicine prices, availability and affordability in Bangladesh using World Health Organisation and Health Action International methodology, 2019, url, p. 1
[197] Kasonde, L. et al., Evaluating medicine prices, availability and affordability in Bangladesh using World Health Organisation and Health Action International methodology, 2019, url, pp. 1-2
[198] New Age Bangladesh, Increase in drug prices adds to people's economic burden, Opinion, 19 July 2022, url
[199] New Age Bangladesh, Increase in drug prices adds to people's economic burden, Opinion, 19 July 2022, url
[200] New Age Bangladesh, Increase in drug prices adds to people's economic burden, Opinion, 19 July 2022, url; Business Standard (The), Prices of 53 drugs hiked, 17 July 2022, url; Financial Express (The), Cut prices of emergency drugs to ease burden on commoners, 24 November 2022, url
[201] Business Standard (The), Prices of 53 drugs hiked, 17 July 2022, url; Financial Express (The), Cut prices of emergency drugs to ease burden on commoners, 24 November 2022, url
[202] Business Standard (The), Prices of 53 drugs hiked, 17 July 2022, url
[203] New Age Bangladesh, Increase in drug prices adds to people's economic burden, Opinion, 19 July 2022, url
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[206] New Age Bangladesh, Increase in drug prices adds to people's economic burden, Opinion, 19 July 2022, url
[207] New Age Bangladesh, Increase in drug prices adds to people's economic burden, Opinion, 19 July 2022, url

4. List of useful links

Organisation	Web address
Bangladesh National Nutrition Council	http://bnnc.portal.gov.bd/
Diagnostic Centres and Hospitals	https://www.populardiagnostic.com
Directorate General of Health Services	https://dghs.gov.bd
Facility Registry	http://facilityregistry.dghs.gov.bd/index.php
Health Economic Unit	https://heu.gov.bd/
Health Services Division	https://hsd.gov.bd/
Hospital Services Management	http://hospitaldghs.gov.bd/introduction/
Ministry of Health and Family Welfare	http://www.mohfw.gov.bd/
Ministry of Health Education and Family Welfare division	https://mefwd.gov.bd
Private Hospitals	
Ahsania Mission Cancer Hospital	http://www.ahsaniacancer.org.bd/mirpur_center.php
Ali Asgar Hospitals	https://www.asgaralihospital.com
Anwar Khan Modern Hospitals	https://akmmc.edu.bd

Organisation	Web address
Birdem General Hospital	https://www.birdembd.org
Evercare	https://www.evercarebd.com
Green Life Medical College	https://greenlife.edu.bd
LabAID Hospitals	https://labaidgroup.com/specialized/
National Heart Foundation Bangladesh	https://www.nhf.org.bd
Square Hospitals	https://www.squarehospital.com
United Hospitals	https://www.uhlbd.com/bn

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Source B, interview, Dhaka, 8 February 2023. Source B is an officer in the DGHS / DGMEFW, MOHFW. The person wishes to remain anonymous.

Source C, interview, Dhaka, 8 February 2023. Source C is an officer in the MOHFW. The person wishes to remain anonymous.

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Annex 2: Terms of Reference

General information

Avoid general Country of Origin Information (COI), focus on aspects that have an impact on healthcare.

This section is devoted to the geographic, demographic, political and/or economic contexts which are relevant to analyse the health system in the country in question. If possible, explain the impact of these factors on the accessibility of healthcare. Ensure that in this section are included all particular aspects that can have an impact on the provision of healthcare in the country. (e.g., security situation, internally displaced people (IDPs) / refugees, ethnic tensions, etc.).

Healthcare system

Health system organisation

a) Overview

How is the healthcare system organised (e.g., organised as primary, secondary and tertiary healthcare)? If so, could you explain who provides care at each level and what type of care is provided at each level? Does a system of referrals and counter referrals exist?

Is the healthcare system centralised, decentralised or federal? How are the healthcare jurisdictions distributed between the levels of power? How is the health sector financing distributed between the levels of power? In the cases of states with federal / confederal structure, if the care is not available in the state / region/republic of residence of the patient, but is however available in another federated state (region / republic) of the same country, is there a possibility for the patient to be transferred there? Is there a mandatory referral system? What are the conditions?

Is there recent data on the geographical distribution of the health structures? If so, could you give an overview? Is there a difference in the care supply, in respect to the different healthcare levels, in the urban and rural regions? Do the patients in the urban and rural zones have equal access to healthcare? Are there regions / provinces particularly affected by a lack of hospitals or health centres? Ensure that there is Information on the number of healthcare facilities at each level of healthcare.

Use links to existing documents online for more detailed information.

b) Public sector

How is the public sector structured? What are the strengths? What are the weaknesses?

c) Private sector

Does a private health sector exist? How is it structured? Is there a difference (quantitatively and qualitatively) between hospitals and health structures in the public and private sector? What are the main differences, for the patient looking for medical care, between the state-financed healthcare system and the private sector?

Healthcare resources

Is there recent data on the number of healthcare personnel in the country (e.g., cardiologists, psychologists, etc. per number of inhabitants)? If so, provide a brief overview (context / comparison with other similar countries or Europe)?

How is the distribution of human resources in health care in the country? Are there regions / provinces particularly affected by a shortage of healthcare professionals? Is the distribution of the healthcare personnel equal between the public and private sectors?

Are there any specific needs with regards to human resources for health? Are there any under-represented professional categories? Could you specify?

Is there an emergency healthcare service, e.g., ambulances? How is it organised?

Health expenditure / GDP.

Pharmaceutical sector

Is there a national essential drugs list for the country? What does it mean in terms of access to drugs for patients? How often is the list updated? If generic drugs are not widely available, do patients have access to generic drugs? Are they accessible to patients and how?

Is there a supply system for drugs? Does the country experience regular stock shortages? If so, does it affect the patients' access to medication? What drugs and diseases are mainly affected by these stock shortages? What organisations regulate / control the market? Are there many illegal medications in circulation?

Are the drugs accessible both in urban and rural areas? Are the drugs accessible geographically in all the country's regions?

Are any medications only available in hospitals, not pharmacies? If so which ones?

Can non-registered medication be imported (parallel import)? How?

Patient's pathways

In general: when in need of medical treatments and/or medicines, where and how can patients find information? What is the 'typical route' of a patient who needs healthcare; treatments and/or medicines? What does he/she do and where does he/she go primarily and what

happens next? What are the main obstacles in general to access medical treatments / medicines in the country?

Economic factors

Risk-pooling mechanisms

Include only the mechanisms which are relevant to the country in question. Remove section if there are none.

Health services provided by the State / Public authorities

Is there a national health and social insurance system / certain state coverage in the country?

How is the Public Health / Social Insurance system organised?

How is health insurance financed? Is it financed by the employer and/or employee contribution or by taxation or by OOP (out of pocket payments)? What is the patient's financial contribution?

What does it consist of? Who is entitled to public health insurance (or other form of public / state coverage)? Is the entire population entitled to this insurance? If not, what are the administrative procedures that should be undertaken and/or the conditions that are necessary in order to be registered with health insurance? Are the procedures identical for the entire population? Is being employed one of the conditions to qualify for health insurance? Does the health coverage target certain groups of the population (pregnant women, children, seniors, etc.)? What are the criteria in order to be covered by public health insurance? Is a patient's financial participation necessary for the registration? If so, how much should they pay? What percentage of the population is covered by public health insurance?

Does the country have a complementary system to protect the most vulnerable and those who cannot contribute or be enrolled in the National Health insurance?

Are returning migrants / citizens covered by public health insurance?

Public health insurance, national or state coverage

Note for drafters: the aim of this section is to make clear to the reader what is covered by public health insurance and to what extent it is covered. Below are guiding aspects to take into account.

What type of healthcare / what diseases does health insurance cover? Is maternity care covered by health insurance? Where is the healthcare provided (in which healthcare facility or at what level of the health pyramid structure)?

Are medicines covered by health insurance? Does it cover all medicines or only some of them or only a percentage of the cost? What are the conditions to benefit from drug coverage?

Are there cash benefits in case of illness for employees? If so, in which cases and conditions and what is the amount of these benefits?

In case a patient needs medical care and does not have the means to pay, are there any governmental measures allowing them access to healthcare? Is there a difference between emergency care and non-emergency care? What are the solutions for patients without financial resources?

Community-based health insurance schemes

Are there community-based health insurances in the country? What are the conditions to register? Which are the practical steps to register? How much must an average person / family pay to become a member? Do all community-based health insurances offer the same coverage and have the same mechanism?

Which risks are covered? What type of healthcare, what diseases do the community-based health insurances cover? Where is the healthcare provided (in which healthcare facility or at what level of the health pyramid structure)? Are the drugs covered by community-based health insurance? Does the insurance cover all drugs or only some of them or only a percentage of the cost? Are there conditions to benefit from the coverage? Does the patient have to participate financially in order to have access to care (co-payment)? What is the recovery rate for the medical costs?

What is the percentage of population's coverage by the community-based health insurances?

Private health insurance schemes

Are there private health insurance systems? What are the main health insurances in the country? What are the conditions necessary to benefit from them?

What do these health insurances cover? What type of healthcare, which diseases are covered? Where is the healthcare provided (in which healthcare facility or at which level of the health pyramid structure)?

How much must a person / family pay to obtain a private insurance on average?

What is the percentage of the population's coverage by private health insurances? Who has access to this type of insurance?

Out-of-pocket health expenditure

Average total of out-of-pocket payment on total health expenditure.

Information on the frequency of health expenditure events that may bankrupt a person / family.

a) Cost of consultations

Provide a range of prices for consultations with a general practitioner and different specialists as well as for a hospital stay. What is the price of a consultation / hospitalisation in an emergency department? What is the share of financial participation by patients?

Is there a difference in respect to prices between the private and public facilities? Are there any geographical disparities?

Is there a practice of overcharging medical fees? Is it common? If so, could you explain the context? How much does it amount to?

b) Cost of medication

General information about the prices of medication: Are the prices regulated? Is there an inflation problem, price variation, etc.?

Are there medications provided for free (e.g., are certain medicines covered by the state)? If so, could you specify which ones and in what facilities or at what health level?

In general, what share of the health budget per person / family goes to the purchase of drugs? Does the price of medication vary between pharmacies? Is there a difference in respect to prices between the private and public facilities? Are there any geographical disparities?

List of useful links

Include links that provide long-term value and are likely to be kept updated, such as websites detailing epidemiologic data, national disease programmes, Ministry of Health website, certain large hospitals, online pharmacies, etc. Not e.g., individual research articles or other ‘static’ material.

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