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Healthcare Services in Bangladesh: Revisiting the Existing Regulatory Framework

Md. Ayub Ali[1]

Abstract

This article examines the existing laws and policies that deals with healthcare services in Bangladesh with a view to pinpointing the legislative and policy gaps which need to be addressed for securing quality healthcare for all. Despite the resource constraints, over the last three decades, Bangladesh has made remarkable progress in achieving both health and population indicators which is immensely instrumental in ensuring the rights to health. However, the healthcare sector in Bangladesh is suffering from a number of problems which pose challenges to establish a rights-based and service-oriented healthcare sector. On the basis of secondary data, the paper peruses the overall healthcare system in Bangladesh and makes a critical analysis of the relevant laws and policies. The author depicts that due to the flawed regulatory frameworks, forfeiting accountability and transparency, widespread corruption, poor monitoring system, inadequate health financing, inequity between the rural and urban population in accessing healthcare service; due to the lack of effective grievance procedure, the people are being deprived of their right to proper medical service and healthcare which the Constitution has guaranteed as the fundamental rights.

Keywords: Healthcare, universal health coverage, rights-based approach, referral system, out of pocket payment

1. Introduction

The right to live a healthy life is the core concept of human rights and development, which is a pressing issue in almost all the countries across the globe. Since its emergence as an independent state in 1971, Bangladesh has been striving with limited resources, for mainstreaming the healthcare services with international standard. According to Article 15 of the Constitution (1972), raising the level of nutrition and improvement of public health through providing balanced health and medical is one of the fundamental responsibilities of the state. Moreover, Bangladesh has ratified the major international health instruments with the commitment to securing quality health service for all. However, the fragile regulatory mechanism, implementation of health policies and development strategies at snail's pace, rural-urban and rich-poor disparity in accessing healthcare service place the health system of the country in a depressing state. Despite constitutional guarantee, healthcare is an individual responsibility in Bangladesh. Many people are seen begging in the streets to manage the expenditure of their treatment. Unfortunately, these issues appear to have been uncared for by the existing health laws. This paper used qualitative approach to examine existing scholarships, reports of WHO and other donor

[1] Assistant Professor, Department of Law & Justice, Southeast University, Bangladesh
Email: ayub_du@yahoo.com

agencies on health sector and newspaper articles. The results of this research can be useful for the policy makers to adopt strategies for encountering the challenges to formulate a comprehensive health law.

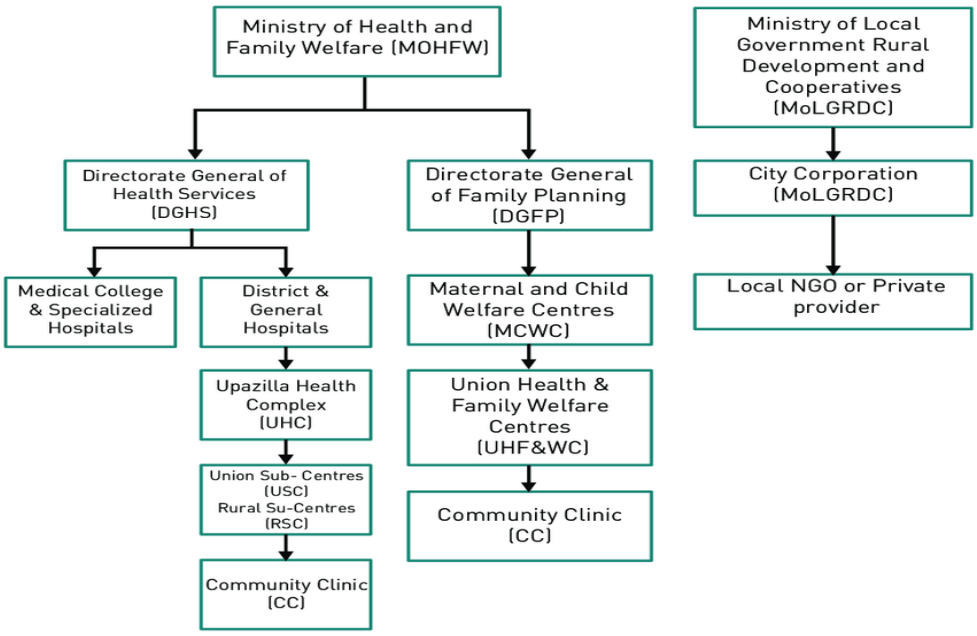
2. Healthcare Services in Bangladesh

The healthcare service in Bangladesh is beset with problems including lack of a regulatory framework and good governance, inequity, poor service coverage as well as the necessity of effective financial risk protection mechanism, widespread corruption and so forth. According to Joarder et al., (2019) "the healthcare system in Bangladesh consists mainly of four key actors: government, for-profit private sector, not-for-profit private sector and the international development organizations" (p. 1).

Government Healthcare Service

"The healthcare system of Bangladesh relies heavily on the government or the public sector for financing and setting overall policies and service delivery mechanisms" (Islam & Biswas, 2014, p. 366). The governmental healthcare services are rendered through the Ministry of Health and Family Welfare (MOHFW) and Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC).

Table 1: Shows the health service delivery organizational structure in Bangladesh (Haque, 2015)



Source: Bangladesh Health System Review

The aforementioned table (Table 1) shows "public healthcare is steered by the Ministry of Health and Family Welfare through its different Directorate Generals, i.e., Health Services, Family Planning, Drug Administration, Nursing and Midwifery, Health Economics Unit, etc." (Joarder, et al., 2019). The Ministry of Health and Family Welfare (MOHFW) is the fountain of the country's public healthcare services. It has a very extensive health infrastructure for delivering service to the whole of Bangladesh. The governmental healthcare services follow an administrative pattern, starting from the national to the District, Upazila, Union and finally to the Ward levels. The public sector healthcare services include but not limited to "the promotive, preventive, and curative services such as outdoor (outpatient), indoor (inpatient), and emergency care at different levels including primary, secondary and tertiary levels" (Ahmed, et al., 2015).

Primary healthcare services include general health and family planning services for the people in rural areas. There are 421 Upazila Health Complexes accommodating 15958 beds (DGHS, 2021), 3900 Union Health and Family Welfare Centers, and 13000 Community Clinics at ward level across the country for delivering primary healthcare services. "Bangladesh has established more than 13,000 community clinics (CCs) to provide primary healthcare with a plan of each covering a population of around 6,000" (Riaz, et al., 2020). In addition, the Ministry of Local Government, Rural Development and Cooperatives manage the provision of urban primary care services. Furthermore, "providing the primary healthcare in urban areas is the responsibility of respective local government institutions namely municipalities and city corporations which are under the Ministry of Local Government, Rural Development and Cooperatives" (Ahmed et al., 2015).

Table 2: Shows healthcare services at primary level

Facilities	**Number**	**Services**
Community Clinics (CCs)	13000	Family Planning, immunization, communicable disease control, treatment of common problems & referral.
Union Health & Family Welfare Centre	39000	Outpatient services covering Family Planning, communicable disease control, clinical care, normal delivery & adolescent health care.
Upazila Health Complexes (UHCs)	421	Outpatient services, inpatient services (15958 beds) with diagnostic and operative treatments.

Source: Ministry of Health and Family Welfare (MOHFW)

The secondary healthcare services are available at district levels. The services that people can access at secondary level includes outpatient and inpatient services, laboratory, radiographic and ambulance services, child and adolescence

mental health services, and so forth. Usually, a referral from a primary health practitioner is required to have hospital or inpatient service at district hospitals. However, people may also avail the primary health care services from the district level hospitals. Currently, there are 62 district level hospitals with 8900 functional beds (DGHS, 2021), "nine General Hospitals, three Leprosy Hospitals, three communicable disease hospitals, 13 chest disease (TB) hospitals, 43 chest clinics and 23 school clinics" (Ahmed et al., 2015, p. 85).

Table 3: Shows healthcare services at secondary level

Facilities	Number	Services
District Hospitals (DHs)	62	Outpatient and inpatient services, laboratory, radiographic and ambulance services
General Hospitals	9	Outpatient and inpatient services and emergencies.
Maternal and Child Welfare Centers (MCWCs)	54	Family planning, preconception, prenatal postnatal care, outpatient and inpatient services as well as child and adolescence mental health services
Leprosy Hospitals	3	Specialized services through outdoors and indoors
Communicable Disease Hospitals	3	Specialized services through outdoors and indoors
'National Institute of Diseases of the Chest and Hospital' (NIDCH, 2021)	13	Specialized medical and surgical treatment to complicated chest and TB patients (NIDCH, 2021)

Source: Ministry of Health and Family Welfare (MOHFW)

The tertiary level healthcare facilities have developed in Dhaka and different divisional cities of the country. A host of specialized medical institutes are located in Dhaka. Most of the Medical College Hospitals and General Hospitals are based in division headquarters and large district headquarters. There are thirty-six medical colleges under Directorate General of Health Services (DGHS), six Armed Forces and Army medical colleges and nine dental colleges and dental units in medical colleges (Health Bulletin, 2019). Moreover, a number of super-specialized hospitals which focus on teaching and research are located in Dhaka. People can enjoy all kinds of medical cares including out door, indoor and emergency obstetric care (EMOC) from tertiary level health facilities.

2.1 Private Healthcare Service

Ahmed et al. (2015) observe, "private sector provides mostly for-profit curative services and not-for-profit curative services to a limited extent at the national and subnational level (p. 26). Though the infrastructure in the private sector is limited, more providers than the public sectors are employed in the former. Apart from the government employed doctors, practicing part time in private sector, traditional healers, unqualified allopathic, homeopathic and ayurvedic physicians are providing healthcare services in private sectors as well.

At present, there are ten postgraduate medical teaching institutions, seventy medical colleges, twenty-six 'dental colleges and dental units in medical colleges' in private sector (Health Bulletin, 2019). "The total number of registered private hospitals and clinics is 5,321 and registered private diagnostic is 9,529 accommodating approximately 91,537 beds" (Health Bulletin, 2019). In addition, there is a substantial number of unregistered private hospitals and clinics most of which do not fulfil minimum standard as prescribed by laws. All types of healthcare services including specialized, outdoor, and indoor and emergency obstetric care (EMOC) are available in private sector. However, the people specially the poor and even the middle-class families could hardly avail these highly expensive services in private sectors.

2.2 Healthcare Services by the NGOs

The Non-Government Organizations (NGOs) have made a major contribution to improving healthcare service in Bangladesh through their community-based networks of services, health workers, and leadership roles in national programs (WHO, 2017). As such, NGO sector is one of the biggest providers of health care services in Bangladesh. This sector through a massive network of female community health workers, has pioneered in reaching the underprivileged and vulnerable populations rendering health services to the doorsteps of the people. For instance, the larger national NGOs including BRAC, Gonoshasthaya Kendra, and Grameen Bank have strong organizations and management capacity to provide both preventive and curative services.

There are over 6,000 registered NGOs providing a variety of services including essential healthcare, informal education, women's empowerment and human rights advocacy. "Some 500 non-governmental organizations operate in the health, nutrition, and population sectors in Bangladesh" (Pose and Samuels, 2011). The leading health sector NGOs may be listed as BRAC, Gonoshasthaya Kendra (GK), BAVS, FPA, BIRDEM, ICDDR, B, Lions Eye hospital, Mission run hospitals and so forth (Bhuiya, 2021).

Currently, there are some 450 beds in 170 small and medium hospitals run by the NGOs in different places of Bangladesh (BBS, 2016). The healthcare services which Non-Government Organizations (NGOs) are providing includes preventive and curative services, family planning, maternal and child healthcare, advocacy, research and awareness for various health related issues like nutrition and environmental health. NGOs are mainly emphasizing on community engagement in healthcare services with a view to minimizing the financial burden for curative care. A respondent from an international NGO clarified this concept: *"If we strengthen the preventive care … that actually is the best way to bring down the cost of treatment in future"* (Joarder et al., 2019). In comparison to the government and private healthcare sectors, healthcare services, sponsored by the NGOs is small. However, the poor and vulnerable populations may receive quality healthcare services from this sector at an affordable cost or free of cost.

2.3 Healthcare Services Funded by the Donors

Since the independence of Bangladesh, multilateral and bilateral donors have been playing active roles in the country's healthcare service's financing and planning. Among bilateral donors that have been actively engaged in healthcare services in Bangladesh, the role of "the governments of Australia, Belgium, Canada, Germany, Japan, the Netherlands, Norway, Sweden, the United Kingdom and the United States" is remarkable. In addition, a number of multilateral donors have been continuously providing the financial and policy support for the progress of the country's healthcare sector. The assistance and partnership of the World Bank, European Union, UNICEF, ADB, and Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the GAVI Alliance have been found very instrumental in developing health indicators as targeted in Sustainable Development Goals (SDGs). However, a significant amount of donor's funding comes directly through the channels of Non-Governmental Organizations (NGOs).

3. Regulatory Framework of Health Care Services

The regulatory framework for health care services in Bangladesh has got its own mandate in the Constitution. However, the existing healthcare service framework which in many respects includes century old outdated legislations and policies has been found to be inadequate as well as unsuitable to meet the emerging healthcare service needs which are the necessity of the people. Apart from the Constitution, a number of laws, policies and executive plans constitute the regulatory framework for healthcare services in the country. Barkat, et al. (2001) suggests "90 enactments fall under seven broad subject-areas of health legislation: Vital Registration and Welfare Legislation, Public Health, Communicable Disease Control, Food and Drugs Control, Health Education and Health Practice, Environmental Health, and Protection of Children and Women" (p. ii).

3.1 The Constitution of the People's Republic of Bangladesh

The provision of basic healthcare services in Bangladesh is a constitutional obligation of the government (IGS, 2012). Since the emergence of Bangladesh as an independent country, an utmost priority has been given to ensure human rights and dignity of the population (Health Bulletin, 2019). The medical care which is extremely necessary to enjoy the right to lead a healthy life has been guaranteed in the Constitution (GoB, 1972) as the basic necessity of every citizen of the country. According to the Article 15 of the Constitution (GoB, 1972), "it shall be a fundamental responsibility of the state to secure the provision of the basic necessities of life, including food, clothing, shelter, education and medical care of its citizens". Again, as per the Article 16, the state shall undertake pragmatic measures to improve public health, particularly for the rural people. Further, the Article 18 of the Constitution stipulates that the state shall raise the level of nutrition of its population and improve public health as some of its primary duties. The citizen cannot claim their health care services from the state as an

enforceable right. However, with regard to the right to health of the people, the provision of the Article 32 of the Constitution can be invoked. "Compared to the provisions of the Article 15(a) and the Article 18, this Article is more sanctified and effective in the sense that it offers a precise space for the right to healthcare as a corollary to the right to life" (Alom, 2013).

Since the independence of Bangladesh, the government, along with the donor agencies and non-government organizations (NGOs) has been working for providing health care services to the people at an attainable standard. Over the past few years, though it has achieved remarkable progress in health and population indicators, several issues remain critical. Chowdhury & Osmani have identified these issues as "persistent inequities in access to healthcare (including gender inequity, and inequity along the poor versus non-poor divide), lack of meaningful participation of citizens in the running of the health system, and the absence of effective accountability mechanisms through which the providers of healthcare can be held responsible for their actions" (p. 205). Thus, it appears that the people are not getting access to healthcare services as a fundamental right guaranteed in the Constitution.

3.2 Legislations and Policies

Since the Constitution was adopted in 1972, following the emergence of Bangladesh as an independent and sovereign country through a nine-month bloodstained war, healthcare had been a state concern. Under the scheme of the Constitution, securing healthcare or medical care for the citizens "is the fundamental responsibility of the state". In response to its constitutional obligation, the state has adopted various laws, policies, plans, and strategies. However, it appears that these legal measures lack rights-based approach (RBA) to ensure healthcare services to the people. Rights-based approach (RBA) to healthcare service requires a formulation of a comprehensive healthcare strategy that ensures the effective participation of the society in the adoption and implementation of the strategy as well the transparency and accountability of the service providers. In this outset, some important healthcare sector policies and strategies as well as some legislations will be analyzed.

3.2.1 Health Sector Policies and Strategies

Important health sectors and policies include National Health Policy 2011, Health, Nutrition and Population Sector of the 7th Five-year Plan, (National Nutrition Policy 2015), 4th (Health, Population and Nutrition Sector) Program (HPNSP) 2017-2022, Healthcare Financing Strategy 2012-2032: Expanding Social Protection for Health towards Universal Coverage, Bangladesh Health Workforce Strategy 2016–2021 and so on (Health Bulletin, 2019).

National Health Policy 2011

Bangladesh did not have any health policy before 2000 when the first National Health Policy was passed in the Parliament. In the absence of a formal health policy, all the health-related planning and programming were guided by

the health sector components of successive Five-Year Plans (Chowdhury and Osmani, 2010). The new National Health Policy (NHP) was passed in Parliament in 2011. The NHP sets out nineteen goals and objectives, sixteen principles and thirty-nine strategies.

According to Murshid & Haque (2020), the specific aims of the Bangladesh National Health Policy 2011 include "to ensure accessibility of primary health care and emergency care for all; to ensure quality health-care services for all based on equity; to extend the coverage of quality health-care services; and to increase community demand for health care considering rights and dignity."

The National Health Policy 2011 includes, *inter alia*, the following as the primary goals (Murshid and Haque, 2020) "Establishing health care as a right in all layers of society by ensuring essential elements of care, nutrition, and public health improvement; and providing quality and easily accessible care, irrespective of an urban and rural community, mainly focusing on the poor and disadvantaged population."

The National Health Policy has defined the term health in a broader sense as it enshrines in the preamble that 'health' is not only limited merely within medical care but it also includes pure water, nutritious food, healthy environment and so on. A concerted effort of stakeholders is required with a view to securing good health to people as envisaged in NHP.

National Nutrition Policy 2015

The National Health Policy 2015 has categorically underscored that 'health' is not limited merely within the medical care but it also includes pure water, nutritious food, healthy environment and so on. Nutrition also is a basic human right, with both equity and equality related to eliminating malnutrition and ensuring human development (NNP, 2015). The NNP (2015) aims at improving "the nutritional status of the people, especially disadvantaged groups, including mothers, adolescent girls and children; preventing and controlling malnutrition; and accelerating national development through raising the standard of living".

(Healthcare Financing Strategy 2012-2032: Expanding Social Protection for Health towards Universal Coverage)

One of the major hindrances to access health care service is financial. Health care services in Bangladesh are received out-of-pocket expenditure to a great extent. "Globally, such expenditures account for about 32% of total expenditure on health but for Bangladesh, it makes up to 64% of the total health expenditures" (MOHFW, 2012). "Such high out of pocket expenditures on health can lead to loss of productive assets (selling items to pay for medicines) and threaten economic survival, especially in countries with high rates of catastrophic illnesses, such as Bangladesh" (MOHFW, 2012).

The Healthcare Financing Strategy 2012-2032 sets out a framework for formulating a healthcare financing policy in Bangladesh. The strategy has been drawn up in line with the objectives as envisaged in the Health, Population and Nutrition Sector Development Program (HPNSDP) 2011-2016, the Universal

Health Coverage (UHC) as prescribed by World Health Organization (WHO) and the National Health Policy, 2011 that underscores the necessity of dedicating more funds in health sector development. However, in a country like Bangladesh, there are a number of challenges in financing health sector so as to offer access to health for all, e.g. (i) inadequate health financing; (ii) inequity in health financing and utilization; and (iii) inefficient use of existing resources.

As per MOHFW (2012), "the goal of the national health financing strategy is to strengthen financial protection and extend health services and population coverage especially to the poor and vulnerable segments of the population, with a long-term aim to achieve universal coverage". Further, MOHFW (2012) provides that "the role of health financing is to: (i) provide all the people with access to necessary health services including prevention, promotion, treatment and rehabilitation of sufficient quality to be effective; and (ii) ensure that the use of these services does not expose the user to financial hardship".

3.2.2 Legislations

To ensure the execution of the aforementioned policies and plans, the Government of Bangladesh adopted a number of policies, acts, rules, etc. (Health Bulletin, 2019). Some of the important legislations include the Public Health (Emergency Provisions) Ordinance, the Medical Practice Private Clinics and Laboratory (Regulation) Ordinance, the Bangladesh Medical and Dental Practitioners Act and so on. In addition, a number of acts relating to the communicable diseases, mental health, organ transplantation, community clinic, etc. have been enacted to strengthen the capacity and quality of the health services of the country.

The highest regulatory power in the health system of Bangladesh vests in the Ministry of Health and Family Welfare (MOHFW) which sets through various policies and plans for the standard of healthcare. The Directorate of Health Services headed by the Director General Health Services (DGHS) and Director General Family Planning (DGFP) is the central authority to execute the policies and plans. In this outset, several Acts and ordinances with regard to regulating healthcare service activities in Bangladesh have been discussed.

The Drugs Act, 1940 and the Drugs (Control) Ordinance, 1982

These two legislations together prescribe the regulatory mechanisms to control the manufacture, distribution, sale, and import and export of drugsin Bangladesh. In addition, the Drug Rules, 1945, the Bengal Drug Rules, 1946 and the National Drug Policy, 2016 constitute the legal regulatory framework for the drugs control. The Directorate General of Drug Administration (DGDA) is the supreme regulatory authority in the country for drug-related affairs such as licensing, production, import, export, quality control and pricing (DGDA, 2021). "The DGDA supervises and implements all the prevailing Drug Regulations in the country and regulates all the activities related to the import, procurement of raw and packing materials, production and import of finished drugs, export, sales,

pricing, etc. of all kinds of medicines including those of Ayurvedic, Unani, Herbal and Homoeopathic systems drugs and medicines" (DGDA, 2021).

The Director General who is also the Licensing Authority, is the head of DGDA. There are four Directors entrusted with the charges of "manufacturing, registration and import/export including administration and licensing, veterinary, quality control and surveillance, and drug testing" (DGDA, 2021). There are also 47 district offices under the DGDA. For testing the quality of drugs, two labs are functioning: National Drug Control Laboratory in Dhaka and Central Drugs Control Laboratory in Chattogram. Besides, "a number of Committees, such as Drug Control Committee (DCC), Standing Committee for imports of raw materials and finished drugs, Pricing Committee and a number of other relevant Committees, which comprise of experts of different fields, are there to advice Licensing Authority and recommend the DG about the matters relating to drugs and medicines" (DGDA, 2021).

One of the objectives of the Drugs Ordinance is to ensure the essential quality of drugs at an affordable price (Drugs Ordinance, Art. 11). Even though a pricing committee has been formed, it has not been possible to keep the price of essential and non-essential drugs within the reach of the general mass. The committee that is influenced by inclusion of corporate interest is supposed to fix the price of only some essential drugs while the individual companies determine the indicative price of non-essential drugs. Moreover, a consumer has to pay 15% VAT with the already high price of drugs as fixed by the individual companies.

Offences under the Drugs Ordinance and Act are non-cognizable (section 22) and triable by the Drugs Courts (section 23). The maximum penalty under this Ordinance is Taka ten lac or ten years of imprisonment. However, a consumer cannot directly go to this court to have his grievance remedied (section 22). There is no provision for compensation for the consumers who may have suffered damage or injury due to the consumption of sub-standard medicines.

Medical Practice Private Clinics and Laboratory (Regulation) Ordinance, 1982

The Ordinance is the first ever legislative initiative to regulate medical practice and function of private clinics and laboratories in Bangladesh. It provides for the process of granting license (s. 8), minimum requirements to establish a private hospital or clinics (s. 9), charges and fees in those private clinics (s. 3), inspection procedure (s. 11); and taking action for non-compliance of the standard (s. 13). However, as it suggested by Rahman (2007), the Ordinance did not provide "the requirements for many important areas, including building layout, medical support facilities and procedures, and the responsibilities of license holders".

According to section 11 of the Ordinance, the Directorate General of Health Services (DGHS) has been empowered to monitor the activities with regard to private sector regulation while the Ministry of Health has been given final appeal authority. On inspection, the Director General may show cause the owner of the concerned clinic or may recommend the Ministry of Health to close down any laboratory. However, in reality the private sector health care system is

functioning without any control as the frequent reports of medical malpractices in private clinics are published against which hardly any action is seen to have been taken by the DGHS. In the absence of any monitoring framework, there appears disparity in fees and charges of private medical services. One of the major drawbacks of the Ordinance is that there is no formal body for individual level complaint procedure against the maltreatment of private clinics and hospitals.

Bangladesh Medical and Dental Council (BMDC) Act, 2010

This Act was enacted in Parliament by repealing its successor of 1980. The Act aims at regulating medical education and medical practice by setting a standard of medical education and formulating the code of medical ethics (BMDC, 2021). Bangladesh Medical and Dental Council (BMDC) has been established under this Act with the nominated and ex-officio members (sections 3 and 4). The power and responsibility of the Council include registration of new doctors, renewal of medical licences and accreditation of postgraduate qualifications of the medical institutes (section 5). Besides, the Council also deals with all the disciplinary measures which includes disposal of complaints filed against doctors, devising of the curriculum of undergraduate ad postgraduate medical courses, "recognition of degrees awarded from abroad, recognition of different journals and accreditation of both govt. and non-govt. Medical/ Dental Colleges/ Institutes etc." (BMDC, 2021).

The Council is empowered to take punitive action, i.e., for violation of any provision of the Act against any physician (s. 23). A code of medical ethics has been prescribed with a view to regulating the professional conduct of the registered doctors. If any registered physician is found to have violated the code of ethics, s/he will be responsible for committing medical negligence for which the disciplinary committee is empowered to take measures against the accused. It may extend to suspension to cancellation of the registration and removal of the name from the BMDC's register. However, the Act did not provide any provision for compensation to the patient who might have been the victim of maltreatment of the accused physician.

The Communicable Diseases (Prevention, Control and Elimination) Act, 2018

The Act is designed to raise awareness to prevent, control, and eradicate infectious or communicable diseases, to address public health emergencies and reduce health risks (Siraj, et al., 2020). Directorate General of Health Services (DGHS) under the Ministry of Health and Family Welfare (MHFW) has been given the primary responsibility to implement the Act. Section 5 of the Act lays down the liabilities and functions of the DGHS including:

1. Adopting integrated initiatives including the formulation of strategies to prevent, control and eradicate infectious diseases, and to protect the people from its national and international spread;

2. Taking necessary initiatives to address public health emergencies and reduce health risks, raise awareness, prevent, control and eradicate infectious diseases;
3. Separating the infected area from other non-infected areas, providing necessary instructions to prevent the outbreak of the disease in the non-infected areas and to prevent recurrence in the affected area;
4. Taking necessary measures to prevent unnecessary use and misuse of antibiotics used in the treatment of infectious diseases;
5. Isolating a suspected person with a contagious disease in a specific hospital, temporary hospital, or in home (Quarantine);
6. Ordering for temporary lockdown of any market, public gathering, station, airport, naval and land port to prevent the spread of infectious diseases; and
7. Prohibiting the entry or departure of any aircraft, ships, vessels, buses, trains and other vehicles in Bangladesh or restricting the movement from one place to another within the country to prevent the spread of infectious diseases.

The DG, with the approval of the government, can declare an area of Bangladesh as infected area if the area is reasonably suspected to have been infected with an infectious disease (section 11). If it appears that the disease may be transmitted from an affected person, the DG may isolate that person or transfer him to a different place (section 11). In case a person dies of a contagious disease, s/he shall be buried or disposed off as per the direction of the DG (section 20).

Sections 24, 25 and 26 provides the punitive actions for violating provisions of the Act. If a person spreads or assists in spreading of infectious germs or conceals the risk of infection when he comes in contact with another individual or installation, it would be an offence punishable with maximum six-month imprisonment or a fine of Tk. 100,000 or with both (section 24). Obstructing the DG or Civil Surgeon from performing their duties under this Act or disobeying any order given by the DG or Civil Surgeon for preventing the spreading of infectious diseases shall be an offence which is punishable with imprisonment of three months or with fine of Tk. 50,000 (section 25).

The Penal Code and Consumer Rights Protection Act

There is no codified law in Bangladesh which exclusively deals with medical negligence and medical error. However, legal action may be taken against the responsible physician under the provisions of the Penal Code, 1860 and the Consumer Rights Protection Act, 2009. Under the Penal Code, causing death by medical negligence is a punishable offence (section 304A). Again, acts done rashly or negligently endangering human life is punishable with maximum three months' imprisonment or with a fine of taka 250 (section 336). Resort may also be taken to the provisions of Consumer Rights Protection Act against medical

negligence (sections 52, 53). However, the above provisions appear to be very general and vague in practical sense to cover medical negligence.

"The High Court Division (HCD) of the Supreme Court of Bangladesh" pronounced a number of proactive decisions awarding monetary compensation to the victims of medical negligence. In a writ petition, the HCD directed Labaid Hospital to pay compensation to a victim's wife who died due to delayed treatment and negligence (the Daily Star, 2018). In *Delwara Begum vs. Dr. Md. Surman Ali case*, where "following the surgery on the patient to remove his piles, Dr. Ali had left a broken needle inside the body, the HCD ordered the magistrate court to proceed with the case against the accused" (Ali, 2019).

4. Findings and Discussions

The aforesaid discussions and analysis of relevant legislations dealing with health care services in Bangladesh made it conspicuous that, ensuring quality healthcare for all the citizens as envisaged in the Constitution as one of the fundamental duties of the state will not be possible without a comprehensive legal framework.

4.1 Entrepreneurial Health System

The healthcare system in Bangladesh is generally entrepreneurial in nature which means according to Ahmed et al. (2015) "access to health services is the individual's responsibility counting on his or her condition". "Out of pocket (OOP) contributions to health expenditure in Bangladesh is among the highest within the world" (Ahmed, et al., 2015). Globally, such expenditures account for thirty-two percent of the total expenditure on health sector. But for Bangladesh, it makes up to sixty-four percent of the total health expenditures (MHFW, 2012). In comparison to the other south Asian countries, health financing in Bangladesh is the lowest as only 2.64% of the gross domestic product (GDP) is spent on health sector in the country (Joarder et al., 2019). A significant amount of out-of-pocket money is spent on purchasing medicines. Joarder et al. (2019) found that "Health financial coverage is so sparse that 9 percent households face catastrophic health payment, 5.6 percent face impoverishment, and 7 percent face distress financing (borrowing or selling household assets to finance healthcare costs)".

4.2 Inequity in Healthcare Services

Equity is one of the important requirements to secure Universal Health Coverage. Despite the constitutional duties and international obligations on the state to ensure equal access to healthcare services for the rural and urban mass at large, there exist inequalities in almost all health indicators. The rural population has a little access to tertiary level specialised health services as those are centred in the capital cities. Mismanagement, widespread corruption, doctors' absenteeism, etc. are causing barrier to accessing the limited specialised health care at government facilities. Moreover, due to the out-of-pocket health expenditure, people belonging to the lower and middle income cannot afford the highly expensive private healthcare.

4.3 Poor Quality Healthcare Services

The quality of healthcare services in Bangladesh is highly questionable. A number of factors may be accountable for poor services in governmental hospitals. Inequitable distribution of healthcare equipment, want of proper maintenance of the infrastructures and logistics, lack of efficient manpower, etc. have lowered the standard of public healthcare. For instance, in many General Hospitals in district level, there is no expert to operate ICU beds. As such, most of the logistics in hospital labs are either unused or gone out of order causing the 'patients to go to private clinics and diagnostic centres for medical tests as are prescribed by the doctors at the government hospitals. The number of qualified doctors and nurses are very poor against the increasing number of service seekers. According to WHO, there is less than 1 doctor per 1000 people in Bangladesh. Moreover, widespread absenteeism, particularly in rural government hospitals is a great concern. Among the complaints the DGHS received in 2018 through the recently launched SMS-based Complaints & Suggestion Box, 'absence of workforce' was the highest complaint, i.e., 14.94% (Health Bulletin, 2019). It appears that the government doctors are more interested in practicing either in their personal chambers or in the private clinics.

4.4 Poor Monitoring System

The Directorate General of Health Services (DGHS) is primarily responsible for monitoring the overall health care services in Bangladesh. The responsibility for monitoring healthcare services in private hospitals and clinics has also been entrusted to DGHS. However, it lacks sufficient logistics and legal mechanism to ensure the monitoring in true sense.

4.5 Widespread Corruption

Widespread corruption in healthcare sector is the major barrier to ensuring access to healthcare for all. Most of the corruption incidents are related to procurement of health equipment and infrastructure development. The Financial Express (2020) suggests, "Syndicates involving a section of officials of Ministry of Health (MoH), Directorate General of Health Services (DGHS), Central Medical Stores Depot (CMSD) and some senior officials of different hospitals are controlling all the procurements in the health sector." Recently, the Anti-Corruption Commission (ACC) has reported that 45 officials working as a driver, clerk, office assistant, storekeeper, or computer operator, etc. under offices of the DGHS amassed a huge illegal wealth (Dhaka Tribune, 2020).

4.6 No Effective Grievance Procedure

There is neither any pragmatic mechanism for seeking or redress against violation of the patients' right to health nor for making the violators accountable. Though the 'Bangladesh Medical and Dental Council (BMDC)' is empowered to take disciplinary action in response to complaints against doctors, the action is limited to suspension or cancellation of the registration of concerned doctors. The DGHS launched an SMS-based complaint and suggestion box in 2012 with a

view to integrating citizen's participation. However, this measure is not sufficient to redress the grievance of the patients.

5. Conclusion

A strong and vibrant health sector ensuring universal health coverage is the key parameter to assess the overall development of a country. In comparison to the other South Asian countries, Bangladesh has made a remarkable success in reducing child mortality rate and women's reproductive health which has been highly acclaimed by the international community. Nonetheless, these gratified progresses will be diminished unless the entire population irrespective of rich-poor, rural-urban, male-female disparity is brought under the universal health coverage. Despite the commitment 'of the state to secure the provisions of medical care for its citizens' at an attainable level, a large number of people are being deprived of necessary healthcare. The various shortcomings of health-related legislations and policies pin-pointed in this paper are mainly responsible for militating against the citizen's right to health. A comprehensive health law should be enacted codifying the existing scattered rules and policies and addressing the uncared areas in health sectors, code of conduct for the doctors, patients' rights and providers' duties and responsibilities, health insurance and so on.

The poor and underprivileged people should be provided with necessary healthcare services free of cost. Like Vulnerable Group Development (VGD) Card, the government may issue 'Health Card' for this section of the people. In order to ensure specialized treatment at tertiary level for the patients with complicated diseases from rural to urban areas, effective 'Referral System' should be introduced. Widespread corruption must be uprooted to secure quality healthcare for the citizens. The government may appoint 'Health Ombudsman' for this purpose. Stringent administrative measures should be taken in order to reduce private practice of the government doctors at the hospital levels. The measures may include among others, transfer to other places, holding promotion, etc. 'Clients' Bill of Rights' should be implemented for raising awareness among the citizens with regard to their right to quality healthcare. It will obviously ensure the accountability of doctors and nurses also. A body of arbitration involving judges and other experts may be formed for the resolution of complaints against health providers. In order to ensure proper implementation of health laws, National Health Service Council under the head of the government as envisioned in National Health Policy should be formed. The regulatory authorities should be provided with necessary manpower and logistic support. Above all, the effective initiative should be undertaken to implement the National Health Policy, 2011 in its entirety.

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