



BANGLADESH
HEALTH WATCH

Launching Ceremony of
**“50 years of Bangladesh:
Advances in Health”**

Keynote Address

Charting a Path to Reach Health for All in Bangladesh

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Introduction

Friends, colleagues, Honorable Chief Guest Dr. Momen, and Special Guests Ambassador von Linde and Mr. Seral, along with other esteemed guests:

I am deeply grateful for this opportunity to stand before you with reflections on the extraordinary history of health achievements that has been Bangladesh's over the past half-century. You have the world's admiration at what your country has achieved in the midst of such daunting challenges.

I lived here from 1995 to 1999. I then had the opportunity to know many of you and learn about the unsurpassed gains that Bangladesh had made over its first 25 years. As we reflect now at this special moment on the gains of the past half-century and look forward at the challenges and opportunities for the next half-century, let us take a moment to remember those Bangladeshis whose lives were cut short in the struggle for independence, those whose lives were cut short by death from readily preventable or treatable conditions, and those who have suffered from stigma, discrimination, and sub-human poverty. And let us remember with profound gratitude those who provided fearless and inspired leadership in overcoming what to most of us would have been insurmountable odds. Many of these people are no longer with us today. Among the many of hundreds if not thousands of people that one might mention, I would like to offer a special remembrance to the founder of this great country, Bangabandhu Sheikh Mujibur Rahman, Sir F. H. Abed, the founder of BRAC, and Dr. Zafrullah Chowdhury, freedom fighter and war surgeon, founder of Gonoshastya Kendra, and champion of Bangladesh's renowned drug policy.

I am most grateful to Mushtaque Chowdhury for his friendship which began when I was living here. His life and work are truly extraordinary, as are the many contributions that his leadership has made possible. The lives of millions of people in Bangladesh and beyond have benefitted from his pioneering work in the creation of the field of delivery science.

The book which I wrote and which University Press in Bangladesh published in 2000, entitled ***Health for All in Bangladesh: Lessons in Primary Health Care for the Twenty-First Century***, was in one sense an ode to the spirit of the people of Bangladesh and to the truly remarkable health achievements that had occurred during its first quarter of a century. As I wrote in the Introduction, it was “a labour of love and a token of my affection for the people of Bangladesh - especially the women and children.”[1]p. xxi The most important lesson to me that I learned was that the foundation of much of the country’s progress in health to that point had been produced by partnerships among the government, non-governmental organizations, and the people themselves - communities, civil society, and inspired leadership at all levels.

I now have had the opportunity to read all 370 pages of the amazing book whose English version we are celebrating the publication of today. I stand in awe at your collective action to produce this book. And I also stand once again in awe at the extraordinary achievements described in this book. Collectively, they are the product of so many individuals, institutions, organizations and programs who dedicated themselves to improving the health and wellbeing of the 170 million people who inhabit this special place on our earth.

Throughout the world, good health is routinely put at the top of the list of individuals’ priorities for their own wellbeing. Health, like education, is among the basic capabilities that give value to human life and that create human capital, one of society’s basic building blocks [2]. The value that people place on health is also evidenced in many other ways, not the least of which is the vast sums spent in highly developed countries on health care. In the United States in 2020, for example, per capita spending on the health sector was 20% of the national gross domestic product (GDP) and amounted to \$12,530 per capita per year [3]. One can anticipate that Bangladesh will follow a similar path as its economy grows. The overarching question is not whether there will be the money to reach “Health for All” in Bangladesh over the next 50 years but whether that money will be used in a way that will bring the greatest benefits possible for the health of the population and particularly for the poorest members of your society.

Achievements of note

In their landmark 2013 series of papers in *The Lancet*, Mushtaque Chowdhury and his colleagues referred to the “the Bangladesh paradox: exceptional health achievement despite economic poverty” that were achieved by community health workers reaching all households with gender-equity-oriented, highly focused interventions [4].

Among the many noteworthy achievements that might be mentioned, let me cite just a few, which are all well-known to us but are important to recall:

- The improvement in life expectancy at birth from 50 years in 1971 to 72 years in 2021 [5];
- The reduction in mortality of children younger than 5 years of age from 251 to 31 deaths per 1,000 live births [6, 7];
- The reduction in the total fertility rate from 6.6 in 1975 to 2.0 births per woman in 2021 [8, 9];
- The expansion in coverage of childhood immunizations from 2% in 1978 to 86% in 2018 and elimination of polio as a result of the visitation of all homes by community health workers to come to outreach sites for monthly immunization sessions [10, 11];
- The discovery of oral rehydration therapy as an effective treatment for dehydration produced by diarrhea, the visitation of all homes in the country to teach its use, and the achievement of the sustained highest usage rate (87%) [12] that has contributed to the decline in the percentage of under-5 deaths from diarrhea from 25% in 1970 to 2% in 2000 and since [10];
- The reduction in the rate of open defecation from 34% to less than 1% between 2000 and 2015 [12];
- The detection of over 70% of cases of pulmonary-active TB and the completion of treatment in 90% of detected cases;
- The development of a community-based services through community engagement and the empowerment of female community health workers.

- The gradual scaling up of interventions and approaches that have been proven to be effective at the local level, with careful monitoring and adjustment as each new level of scale was reached.
- The development of strategies that have mitigated the mortality associated with cyclones and floods through early warning systems, construction of shelters and housing that provide a safe haven, and pre-planning for rapid response when disaster strikes [13].

All of these achievements were aided and abetted by the benefits of broad socioeconomic development, of course. Bangladesh's progress in women's empowerment, elimination of illiteracy, raising the level of education (especially for girls), formation of women's groups and microcredit programs and other poverty alleviation programs, expansion of agricultural output, as well as improvements in roads, communications and other infrastructure have all helped to make the above health achievements possible. The book concludes that "[c]reating a cadre of female health workers ..., demystifying health care and making it more understandable for the general public have been found to be critical factors for success of Bangladesh's health sector" [14]p.365.

National systems of primary health care in middle-income countries worthy of emulation

My father often said, "You can learn a lot from a bad example." With this in mind, I would like to suggest that you take a careful look at the history of my country, the United States. We have given hospitals and specialized curative care priority at the expense of not developing a strong primary health care system that reaches everyone. The result is a healthcare system that is the most expensive in the world (absorbing 20% of our gross national product), a life expectancy that is among the lowest of all the major developed countries, and outrageous disparities. In some geographic areas, including many of our major cities, there is a 20-year lower life expectancy in some areas than in adjacent areas. No wonder that the United States is now realizing that one of the greatest innovations in the history of modern healthcare - namely the capacity of community health workers to serve as the foundation of an effective health system - has an important contribution to make in reducing health disparities in my own country. The numbers of CHWs are growing rapidly in the United States as is the evidence of their effectiveness [15].

But, of course, you can also learn a lot from a good example as well. I would like to offer three middle-income countries that I think have important lessons for Bangladesh moving forward: Brazil, Costa Rica, and Sri Lanka. Each one of these countries has a strong outreach program of community health workers who reach all homes on a regular basis. Their community health workers are well-trained, full-time and salaried, and closely integrated into their primary health care system [16-19]. Costa Rica is notable because its life expectancy exceeds that of the United States and spends a small portion of its gross domestic product on health than the United States does. Sri Lanka, also a lower-middle-income country like Bangladesh, has a maternal mortality ratio that is five times lower than Bangladesh's (36 versus 170 maternal death per 100,000 live births, and its government spends three times more of its GDP on health than Bangladesh (0.7% versus 2.0%).



The way forward

From my perspective, there are eight key priorities for the next 50 years that arise from the book we are launching today:

1. Support for bold innovations from “outside the box”

What has worked in the past is not necessarily going to work in the future. Bangladesh has picked much of the “low hanging fruit” in its success in reducing child mortality and fertility, but picking the “high hanging fruit” by creating a strong and effective primary health care system for all citizens (including the elderly) will require a bold and innovative commitment of the government together with civic society - with considerably expanded resources and rigorous ongoing assessment of effectiveness. A second generation of primary health care system delivery is needed. What got us here is not necessarily going to get us there. As Amartya Sen has reminded us, the key to Bangladesh’s laudable success has been the avoidance of the twin dangers of inertia and smugness. The future will demand more from these virtues” [20].

2. Major expansion of funding for the health sector, with priority given to expansion of coverage at the lower levels of the health system

Major expansions of funding for the health sector will be required together with large increases in the number of health workers. This will require a tripling of the portion of the GDP that the government spends on health services, from 0.7% to 2.0%. Funding for primary health care will need to be expanded more than funding for hospitals. This funding will need to be decentralized, and apportioned locally on an equitable per capita basis [21].

The government’s health expenditure as a percentage of the gross domestic product is the lowest in the world - 0.7% [22]. Government expenditure for health as a percentage of total government expenditure has been declining and at present is 7.8%. Public sector spending accounts to only 23% of total health expenditures [22]. The expenditure of government health funds is inequitable, with poorer rural divisions receiving lower allocations per capita and government tertiary hospitals providing care disproportionately to better off citizens.

3. Development of a strong primary health care system with continued outreach to every home

Bangladesh needs a strong, effective, and affordable primary health care system that gives emphasis on the prevention, early identification, and ongoing treatment of non-communicable diseases, almost all of which are chronic. This will require, among other things:

A major expansion in the number of primary health care workers, distributed in a pyramid fashion so that progressively larger numbers of mid-level and lower-level workers can work in health teams with higher-level frontline healthcare workers, with each team having an assigned geographic area for which it is responsible. All of these workers need to be well-supervised and paid a salary that is commensurate with their level of training and workload to overcome the apathy, absenteeism and high turnover that is endemic.

Such a PHC system will require regular contact with all households, and have more frequent contact made with those households with greater health needs.

The dangers of “hospital centrism” in which hospitals and specialty care capture a disproportionate share of public sector financing must be overcome by careful and transparent monitoring of government expenses for health and a political commitment to give priority to expanding the healthcare budget at the lower levels of service delivery for the foreseeable future [21, 23].

4. Creation of a strong professionalized cadre of community health workers

Bangladesh also needs a strong professionalized cadre of well-trained, full-time community health workers who can provide a broad array of primary health care services beyond maternal and child health, who are well supervised, who have the needed logistical support, and who are closely integrated into the primary health care system. CHWs should no longer be considered as an underfunded afterthought but rather as the firm foundation of any effective health system. Globally, CHWs are at the dawn of a new era [24] and in fact, in many countries, leading the way to “Health for All” as their potential for achieving high levels of coverage of evidence-based interventions that are impossible to obtain through facility-based services alone is being increasingly recognized [25]. In the United States and in fact throughout the world,

the number and scope of CHW programs are growing rapidly and are proving to be a critical link between marginalized communities and health care and public health services, improving the management of chronic conditions, increasing access to preventive care, improving patients' experience of care, reducing health care costs, playing an important role in pandemic preparedness and response, and advancing health equity by addressing social needs and advocating for systems and policy change [15, 26].

Given the high prevalence of hypertension in the population (around 25% of adults), its contribution to heart disease, renal failure and strokes, the simplicity of identification of cases through home visits from CHWs, and the simplicity and low cost of treatment of most cases, the potential of CHWs for the detection and treatment of hypertension is perhaps the most exciting opportunity for health improvement in Bangladesh for the foreseeable future [27]. A cadre of well-trained, full-time CHWs integrated into the health system represents, as Mushtaque Chowdhury has said, "our best bet ... [to] build on these local strengths as a priority rather than aiming to replicate high-cost medical interventions with limited, and in some instances, unproven, prospects of efficacy [28]. BRAC's success in recent years in training its CHWs to identify older people with seeing and reading difficulties due to presbyopia, which is easily treated with inexpensive reading glasses, represents but one of many potential services that CHWs can provide as their work moves beyond the MCH domain [29].

5. Decentralization of funding and authority for primary health care

The decentralization of funds for primary health care and the decentralization of authority over the use of those funds will be required in order to revitalize the primary health care system and to ensure that every locality has the funds it needs to provide essential services. The local entities that receive these funds will need to have the capacity to speak and act on behalf of the communities they serve. Giving the people a stronger voice in their health services will be essential for improving the quality of primary health care. Collecting information about current local epidemiological priorities and coverage of essential services can, if local entities have control over resources, help local health systems become more effective.

Government will need to begin to more effectively regulate the practice of medicine in the private and public sectors, requiring practitioners to meet basic standards of training and competency, prohibiting the charging of excessive fees

and the provision of treatments that are harmful or unnecessary, and certifying that hospitals meet basic standards of care.

6. Provision of catastrophic health insurance to all citizens

Bangladesh has one of the highest rates of out-of-pocket expenditures as a percentage of total health expenditure in the world: 67%. In 2016, 11 million people (7% of the population) fell into poverty because of health expenditures [30]. 24% of the poorest households are forced to borrow money and sell assets each year to pay for the cost of illness [22]. Universal Health Coverage requires, among other things, the creation of a safety net to protect families from these tragedies. Not only will this require supplemental funding to families with these expenses, but it will require government regulations to protect families from being overcharged (including “informal” charges; from unnecessary, unproven and poor quality treatments; and from malpractice.

7. Continuation and further enhancement of the culture of research and evidence in healthcare

Bangladesh has developed for its health sector a “culture of research and evidence” [31]. icddr,b and BRAC, among many others, have made enormous contributions by conducting field research related to health services implementation and effectiveness, with the learnings applied through iterative implementation. The vital role played early on by Matlab in developing the model of maternal and child health and family planning services in the country is well-known.

There will be a need for field sites around the country where innovations in health services can be implemented and tested, preferably in a controlled fashion, to provide a more scientific and rigorous approach to innovations in service delivery. The government will need to give these field sites the freedom and the money to modify government rules, regulations and practices in order to have the capacity to innovate. As Bangladesh has done so well already, innovations need to begin at the local level and gradually scale up with monitoring and evaluation at each level of scaling up.

8. Strengthening of civil society watchdogs and civil society leadership

A vibrant, informed civil society (that includes the NGO community) will be essential for Bangladesh to make progress on all these fronts. This calls for a strong role for Bangladesh Health Watch and other similar organizations that can take a dispassionate view of the health needs of the country and the steps that need to be taken to address them. This will also require the emergence of strong leaders who can inspire others in these efforts. Making government expenditures transparent and holding the government accountable for how it uses its money will be critical.

Conclusions

The Universal Declaration of Human Rights, which is the United Nations' moral charter and whose 75th anniversary is being celebrated this year, resoundingly affirms that “Everyone has the right to life, liberty and security of person,” that “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, ...including medical care,” and “Motherhood and childhood are entitled to special care and assistance” [32]. The “right to life” includes the universal right to accessible basic health care services that are effective for preventing and treating serious conditions. The 1978 Declaration of Alma-Ata called for the achievement of “Health for All” by the year 2000 – “a level of health that will permit them to lead a socially and economically productive life” and that “[p]rimary health care is the key to attaining this target as part of development in the spirit of social justice” [33]. The Declaration of Alma-Ata also reminds us that “[t]he people have the right and duty to participate individually and collectively in the planning and implementation of their health care” [33].

Over the past 50 years Bangladesh has inspired the rest of the world because of its achievements – your achievements – in the implementing of the science and art of public health – saving lives and overcoming poverty, thereby bringing dignity and hope to millions of people. The closing remarks to the book being launched today proclaims that, “The government must play a bold role and lend a hand towards the transformation of the health system. That is, the government needs to have courage and full commitment” [34]. Only through this, but within a pluralistic health system that incorporates the full spirit and participation of civil society and local communities, will such efforts succeed in providing “Health for All.”

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About Henry Baker Perry, III

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