Provision of Primary Health Care in Bangladesh: An Institutional Analysis

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Abstract

New institutional economics and organizational theories suggest that the choice of institutional arrangements in service provision should be based on the goods characteristics of the services to be provided. The success of any system whether decentralized public sector or private and community-based organizations, depends on the regulatory and coordinator role of the government. Taking the example of Bangladesh the paper argues that the financier role of the government is justified because of the consumption characteristics of the primary health care services and market failures. But the provider role of the government has to be considered carefully keeping in mind the goods characteristics on the production side. The public health facilities in Bangladesh function poorly due to lack of proper decentralization with the result that a majority of the clients seek medical services in the private sector - both for-profit and not-for-profit. The quality and access to these services are far from satisfactory because the government has failed to perform its regulator and coordinator role. The paper points toward the need for research on institutional issues like principal-agent problems, contract formulation and enforcement procedures.

JEL classification: I12; I18; I38.
Key words: decentralization; primary healhcare; NGOs.

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Introduction

It is now widely recognised that investments in the social sector, particularly in health and education, contribute to improved performance of the national economy. Adequate access to primary health care is also important for poverty alleviation. It is directly related to the well-being of individuals, and it contributes to human capital accumulation and enhances productivity of workers. Bangladesh has experienced improvements in the health status of her population in the past decade. Infant mortality rate (IMR) has declined from 94 to 67 per thousand between 1990-1996. Population growth rate has slowed down from 3% in the 1970s to 1.5% in the late 1990s. Total fertility rate is now 3.3 compared to 6.0 in the 1970s (World Bank and ADB, 2003). Some of these improvements may be partly attributed to the performance of the health sector, for example, fertility decline has been possible due to extensive family planning services, mortality decline is due to increased immunization coverage, better identification of TB among the poor and treatment of diarroeal diseases with oral rehydration therapy.

However, morbidity, disability and life-years lost due to illnesses are still very high. Maternal mortality rate is one of the highest in the world. There is also a great difference in the health indicators between the poor and the rich that can be partly ascribed to inequality in the access to primary health care. Current situation with respect to access to primary health care of reasonable quality is far from satisfactory. It is often assumed that the lack of resources, both public and private is the main reason. This paper argues that there is a problem of institutions as well that leads to misallocation and underutilization of the limited resources. It focuses on the role of the government as a provider of primary health care in Bangladesh. The paper is organized in four sections: Section I deals with institutional issues related to the health sector particularly service provision in primary health care based on the insights from institutional economics and organizational theory[2]. Section II analyzes the institutional structure in primary health care of Bangladesh in light of the discussion in Section I and looks at the performance of different health providers and the health outcomes.

[2] Preker, A. S. And Harding, A. 2000; Girishankar, 1999

Section III identifies the areas where empirical research with respect to the health sector is needed .

I. Institutional Issues related Health Sector and the Provision of Primary Health Care

One of the hotly debated issues in economic policy analysis is the role of the state versus the private sector (including both for-profit and not for-profit organizations) in health care services. Government can intervene in different forms - as financier, provider and/or as regulator. The health sector encompasses a range of goods and services that have public good characteristics with high externalities, and government intervention is justified in areas where market failure is present.

Primary health care (preventive and curative care) in developing countries deserves government financing on the grounds of the *consumption* characteristics - non-rivalry, non-excludability and high externalities. Positive externalities of preventive care may mean sub-optimal consumption if left to individuals. Other arguments are poverty/equity (poor people do not have the means to buy necessary care) and insurance against traumatic events. Following the recommendations of World Health Organization, many poor countries have accepted the financing or funding role of the state with respect to the essential service package (World Bank 1993) consisting of public health and clinical services (Table 1).

Table 1. Packages of Essential Public and Clinical health Services

Package of Essential Public Health Services

- Expanded program on immunization and micro-nutrient supplementation
- School health programs to treat worm infections and micronutrient deficiences
- Programs to increase public knowledge about family planning and nutrition, self-cure, and vector control/disease surveillance activities
- AIDS prevention program with strong STD components

Package of Essential Clinical health Services

- Prenatal and delivery services
- Family planning
- Integrated management of the sick child (including diarrheal deseases, acute respiratory infections (ARIs), and malaria)
- Treatment of tuberculosis
- Case management of sexually-transmitted diseases (STDs)

Additional Components in the Bangladesh Package
- behaviour change communication
- violence against women

Source: World Development Report, 1993

Institutions for Service provision

Accepting the financier role of the state does not automatically justify direct production and provision of ESP goods and services by the government. This should be guided by the production characteristics of services in question. According to the current literature on institutional economics and organizational theory, the three economic variables attached to ***goods characteristics*** are measurability, information asymmetry and contestability .

"*Measurability* is the precision with which policymakers can specify and observe the provision of a given service delivery output. Accordingly, the effects of good or bad delivery performance in the provision of high measurability outputs are more easily monitored, reported and audited, even by hierarchs in the public sector.

Information asymmetry is defined here as the degree to which information about service delivery performance is available to users or beneficiaries, but not principals within the public sector. By this definition, the information asymmetric quality of a service is at issue when the performance of a low measurability goods *(such as family planning service)* can be more effectively monitored by beneficiaries rather than public sector hierarchs."
Contestability is a measure of the potential and actual competition from other suppliers for the business of the purchaser." (Girishankar, op. cit.)

The service delivery activities that are included in the essential public health and clinical services can be categorised according to goods characteristics. Such a categorisation helps to identify appropriate institutional arrangements for different services and different phases of the project cycle. There are three broad sets of institutional arrangements – exit/market mechanism, voice/participation and loyalty/public sector management – that provide incentives for efficient service provision (Hirschman, 1970).

Service delivery in the health sector involves different types of activities broadly classified into two – production of inputs/factors and production of services (Table 2). For example, pharmaceuticals and medical supplies belonging to the first category are highly measurable, highly contestable, and involve no information asymmetry, whereas expensive high technology services although non-information asymmetric and measurable, but are not contestable due to heavy capital costs involved. The second category items such as most clinical and public health services, family planning, integrated management of sick children, programmes to reduce consumption of tobacco, alcohol and drugs, dissemination of health and scientific information have low measurability and are information asymmetric. Finally,

management services, support services, immunisation and screening of donors to prevent blood borne transmission are not highly measurable but are non-information asymmetric.

Corresponding institutional arrangements for these services on the basis of their goods characteristics may be described as follows (Table 3). Market solutions are efficient in the case of pharmaceutical supplies whereas a combination of market and administrative solutions may be sought in the case of contestable but difficult to measure activities such as immunisation. Since high externalities are involved in immunisation, government financing is needed, while the delivery may be entrusted to NGOs. Participation approach or voice is efficient for activities that are contestable but are not easily measurable, and are information asymmetric, for example, prenatal and delivery care. Government has comparative advantages in certain areas such as referral, regulation and information. On the other hand, the provision of primary health care may be entrusted to non-government entities or local-level government agencies. It may be noted that governments in many developing countries have the ambition to finance and provide basic health services through government-owned health facilities dispersed throughout the country. It is, therefore important to discuss in which ways the existing infrastructure can be improved.

Table 2: Categorizing ESP in Bangladesh by Goods Characteristics

<table>
<tr><td>Variables</td><td colspan="2">High contestability</td><td colspan="2">Low contestability</td></tr>
<tr><td>High measurability</td><td colspan="2">Type I
• Pharmaceuticals
• Medical supplies</td><td colspan="2">Type II
• Expensive high technology</td></tr>
<tr><td>Low measurability</td><td>Non-information Asymmetric
Type IIIA
• Management services
• Support services
• Immunization
• Screening of donors to prevent blood
Borne transmission</td><td>Information Asymmetric
Type IIIB
• Most clinical health services
• Family planning
• Integrated management of sick children
• Programs to reduce consumption of tobacco, alchohol, and other drugs
• Dissemination of health and scientific information
• Behaviour change communications</td><td>Non-information Assymmetric
Type IVA
• Epidemiological surveilance
• Research</td><td>Information Asymmetric
Type IVB
• Violence against women</td></tr>
</table>

Source: Girishanker, 1999, p. 17

Table 3: Corresponding (appropriate) Institutional Arrangements for Different ESP

<table>
<tr><td>Variables</td><td colspan="2">High contestability</td><td colspan="2">Low contestability</td></tr>
<tr><td>High measurability</td><td colspan="2">Type I
• Private sector participation in provision of pharmaceutical supplies
• Medical supplies</td><td colspan="2">Type II
• Competitive bidding for expensive, high technology services, with
Auditing of outputs
•</td></tr>
<tr><td>Low measurability</td><td>Non-information Asymmetric
Type IIIA
• Private participation in Immunization and screening subject to Professional health Standards
• “One stop shopping for case management of STD patients
• Fixed-term contracting for Management and support services; Reporting of outputs and inputs by public and private professionals</td><td>Information Asymmetric
Type IIIB
• Beneficiary participation in family planning
• Community-based primary care (with both traditional and modern healers
• “One stop shopping “ for integrated management of the sick child with parental feedback
• Providing public information on HNP with feedback from clients
• Behaviour change communications in domestic violence</td><td>Non-information Assymmetric
Type IVA
• Hierarchical management of disease control And surveilance functions (at local and national levels)</td><td>Information Asymmetric
Type IVB
Combination of community –based institutions under strong central government surveilance</td></tr>
</table>

Source: adapted from Girishanker.

Decentralization of public health sector facilities

One of the ways to improve service provision by the govrenment is decentralization. In recent years, decentralization of primary health care provision has been strongly supported by donors, and many countries have undertaken reforms along these lines. Decentralization may be viewed in narrow and broad terms. In a naroow sense it may mean delegation or deconcentration of central government functions to lower levels while the central government exercises authority with respect to policy, finance and adminstration. In a broad sense, decentralization means devolution of central government authority to local levels. It can work in different spheres –administrative, fiscal and political.

Administrative decentralization means that local government bodies are entrusted with daily administration including the personnel relationships and supply of inputs, etc. On the other hand, fiscal decentralization in the health sector may mean that local government bodies have the responsibility and the autonomy to disburse and allocate funds to different activities, and to mobilize resources locally either through taxes or user fees. Decentralization in the political sense refers to civil society participation through local election. A democratically-elected local government is supposed to work as ”voice” mechanism in service delivery.

Rationale behind decentralization: Decentralized governance and local level participation can contribute to improving the health care system, through better monitoring and supervision of the functioning of the health system at the local level. The small jurisdiction of decentralized local bodies allows them to adjust to local social and cultural particularities while the adoption of short and simple administrative process facilitates quick and focused responses to immediate needs. In short, it can improve both allocative and production efficiencies (Sekher, 2003).

Prerequisites for successful service delivery through decentralization

One important question here is - how far decentralization can deal with measurability, information asymmetry and contestability problems. This depends first of all, on the degree of devolution of power with respect to administration and fiscal matters. Secondly, while health sector reforms focus on decentralization of central government machinery and increased involvement of community-based institutions, it is important to underscore the role of the

central government and its diverse functions - overall health strategy and setting priorities; financing; regulation and monitoring, evaluation and inter-sectoral coordination (Parker and Harding 2002). Changing the level of government or changing the ownership status of service delivery agencies (legally dependent, semi-autonomous, or autonomous) does not necessarily affect the underlying determinants of efficiency and effectiveness. Policymakers still have to identify mechanisms for affecting the *underlying checks and balances that govern service delivery.* (Girishankar, P. 5)

Empirical studies confirm that underlying checks and balances work through civic discipline, inter-governmental discipline and overall public sector discipline (Azfar, Kähkönen, 2001). Civic discipline works with the development of democratic institutions whereby the citizens express their *voice* or utilize *exit* options. Either they criticize (voice) or switch (exit) to alternative health service providers. With respect to health sector this may mean that beneficiaries are vigilant about government objectives, specific goals and their fulfillment.
With respect to intersectoral discipline, principal-agent problem has to beresolved with proper contract and monitoring between different levels of government. Public sector discipline is achieved through efficient public sector management affected by general bureaucratic culture and the political system.

Summing-up: arguments for government intervention in financing the provision of essential public health and clinical services are different from the arguments in case of service provision. The choice of institutions should be based on the goods characteristics of services to be provided i.e. measurability, information asymmetry and contestability. While plurality of institutions are called for, government-owned facilities may also be decentralized to fit the needs of the clients and to improve technical efficiency. The success of decentralization depends on intergovernmental discipline, vigilance of civil society and general political and social institutions specific to a given country.

Most developing countries are moving towards institutional pluralism with more involvement of the private sector in health service delivery including both for-proft and not-for-profit providers. It is important to understand the role of the government demanded by the new situation – coordinator, regulator, commissioner of services.

II. Primary health care in Bangladesh

According to National health policy, the government has accepted the financier role of the Essential Service Package (ESP) on the ground of market failures and poverty/equity considerations. Insurance against risks of injuries, disabilities and death is very important for Bangladesh because of its impact on the poor. However, government intervention in insurance matter is not possible due to resource scarcity in spite of market failure. ESP consists of public health and clinical services that encompasses both preventive and curative care. Bangladesh has two additional components – behaviour change communication and violence against women. Given the prevalence of communicable diseases in Bangladesh and their impact on mortality government intervention in financing is justified. Without this, the consumption of preventive care would have been sub-optimal. Secondly, poverty and nutrition-deficiency related diseases, for example TB, respiratory infections are also very common and both mortality and morbidity are found to be associated with them (Table 4). Thirdly, women especially among the poor households in Bangladesh are more disadvantaged than men in terms of the access to health care while they are subject to violence leading to physical injuries. These problems although have health implications are rooted in the socio-cultural institutions, and have to be tackled through communications and appropriate legal measures. Since individuals are trapped in social norms and behaviour, external force like the government has to intervene.

Considering the importance of ESP in the context of Bangladesh, government has also assumed the provider role. ”Government health services are provided by a four-tier system of government owned and staffed facilities. Thirteen government Medical College Hospitals (MCH) with 650 beds, six Post-graduate Hospitals and 25 Specialised Hospitals provide tertiary services, in principle, on referral from lower level units. They represent a 30 per cent share of the government sector by expenditure on services. In reality, the MCHs also provide a great deal of primary and specialist care without referral. There are 80 District Hospitals, representing an 11 per cent share of the government sector. Each serves a population of between one and two million people. They vary in size between 50 and 250 beds. At the sub-district (*Thana* or *Upazila*) level, 460 *Thana* Health Complexes, comprising 31-bed inpatient facilities with outpatient and supporting services, provide both primary and secondary care for

a population of between 100,000 and 400,000 people. *Thana* Health Complexes were developed during the 1970s to provide integrated health care. Services delivered at *thana* level represented 31 per cent of the government sector, but only 9 per cent of expenditure in the sector as a whole. Within *Thanas*, 3,275 Health and Family Welfare Centres serve Unions covering between 25,000 and 30,000 people. Municipalities are responsible for publicly financed health service provision in urban areas." (World Bank Report pp. 21-22). However,

Table 4: Top ten causes of death in Bangladesh by age group: 2000

0 to 4 yrs		**5 to 14 yrs**		**15 to 44 yrs**		**45 to 59 yrs**		**60+ yrs**	
	%		**%**		**%**		**%**		**%**
Respiratory Diseases	24.2	Unintentional injuries	35.8	Unintentional Injuries	28.2	Cardio-vascular	32.4	Cardio-vascular	52.7
Diarrhoeal	23.1	Respiratory	20.3	Tuberculosis	17.3	Tuberculosis	18.7	Respiratory	18.9
Perinatal	21.6	Diarrhoeal	10.9	Maternal	10.9	Malignancies	17.9	Malignancies	8.2
Childhood Diseases	8.8	Childhood Diseases	7.3	Intentional injuries	10.7	Unintentional injuries	10.4	Tuberculosis	6.8
Congenital Diseases	5.4	Nutritional/ Environment	5.7	Cardio-vascular	7.7	Respiratory Diseases	7.9	Unintentional injuries	3.3
Nutritional/ Environment	4.5	Tuberculosis	3.5	Malignancies	6.5	Intentional injuries	3.4	Diarrhoeal Diseases	3.0
Unintentional injuries	3.9	Intentional injuries	2.6	Respiratory Diseases	4.5	Digestive Diseases	3.4	Digestive	2.6
Syphilis	1.0	Congenital Diseases	2.3	Digestive Diseases	4.0	Diabetes	1.8	Diabetes	1.9
Tuberculosis	0.6	Cardio-vascular.	2.3	Diarrhoeal Diseases	2.4	Diarrhoeal Diseases	1.5	Nutritional/ Environment	1.3
Cardio-vascular	0.5	Tropical diseases	1.8	HIV-AIDS	1.6	Nutritional/ Environment	0.8	Intentional injuries	0.5

(Source: Streatfield GBDINDIATOTALAGESUM2 – 03/03/01)
Cited in World Bank Report, p. 9.

in spite of the good intention of the government to finance and provide essential services, only 30% of the health expenditure value comes from the public sector.
Other sources are:

- Traditional and homeopathic
- Private modern unqualified
- Private modern qualified clinical
- Private dianostic services
- NGOs and non-profit
- Qualified and unqualified pharmacists
- Government health services

Matching the institutional structure with goods characteristics of ESP in Bangladesh

We have discussed in Section I the goods characteristics of ESP and appropriate institutional arrangements. The supply of factors/inputs and the production of public health and clinical services have different degrees of measurability, information asymmetry and contestability. Epidemiological surveilance and research need government intervention because of their low contestability. In Bangladesh, government organizations are entrusted with this while the lack of resources remains the major problem. Both the private sector and governement clinics are involved in the provision of pharmaceutical and medical supplies while the government holds strict control in the distribution network. High technology services are provided by both the

Table 5: Contribution of main health service providers in Bangladesh (1997)

HEALTH SERVICE PROVIDERS	**Main provider groups**			**Provider sub-groups**		
	Taka Mn	**US$ Mn**	**Shares**	**Taka Mn**	**US$ Mn**	**Shares**
Government providers	**16009.1**	**364.2**	**29.27%**			
of which						
MoHFW Secretariat				2277.1	51.8	4.16%
Medical College Hospitals				1963.0	44.7	3.59%
District Hospitals				1783.1	40.6	3.26%
Thana level facilities				5001.9	113.8	9.14%
Lower level facilities				1564.9	35.6	2.86%
Specialised hospitals				2684.7	61.1	4.91%
Other MoHFW facilities				130.3	3.0	0.24%
Other government facilities				604.1	13.7	1.10%
Local government facilities	**185.0**	**4.2**	**0.34%**	185.0	4.2	0.34%
Corporations and autonomous bodies	**60.0**	**1.4**	**0.11%**	60.0	1.4	0.11%
Research & training organisations	**2725.0**	**62.0**	**4.98%**			
of which						
Government				1945.8	44.3	3.56%
Non-government				779.2	17.7	1.42%
Non-profit and NGO facilities	**1578.1**	**35.9**	**2.89%**			
of which						
NGO Affairs Registered (large)				1336.5	30.4	2.44%
Social Welfare Department registered				241.6	5.5	0.44%
Private modern qualified providers	**3340.6**	**76.0**	**6.11%**			
of which						
Private clinics & hospitals				1207.9	27.5	2.21%
Private practitioners				2132.7	48.5	3.90%
Other practitioners	**2442.3**	**55.6**	**4.47%**			
of which						
Private modern unqualified practitioners				1400.5	31.9	2.56%
Private traditional providers				205.0	4.7	0.37%
Private homeopathic providers				102.5	2.3	0.19%
Other unqualified providers				734.3	16.7	1.34%
Diagnostic & imaging services	**3122.1**	**71.0**	**5.71%**	3122.1	71.0	5.71%
Drug retailers	**25234.5**	**574.0**	**46.14%**	25234.5	574.0	46.14%
TOTAL	**54696.7**	**1244.2**	**100%**	**54696.7**	**1244.2**	**100%**

Memo: Taka/US$ in 1997 ***43.9624***

government and modern private clinics. The problem of huge investment and capital costs makes the sector highly monopolized in Bangladesh.

Services related to violence against women are characterized by low contestability, low measurability and information asymmetry. Institutional arrangements should be a combination of community-based institutions under strong central government surveilance. In Bangladesh NGOs have played an important role in empowering women, communicating with men and dealing with legal institutions that have had direct and indirect impact on this particular problem.

Low measurability, high contestability and non-information asymmetry are the characteristics of immunization and of management and support services. These characteristics warrant private participation at local-level under the regulation of the government. In Bangladesh, immunization is handled by different service providers – public health clinics, private clinics and the NGOs. Given the fact that govenment facilities remain underutlized (reasons discussed below), this particular service may be handed over to private providers including the NGOs while the government should continue to play the financier role because of high externalities involved. Immunization needs urgent attention as its coverage has stagnated in recent years.

The services characterized by low measurability, high contestability and information asymmetry such as family planning, primary care and health related information to clients should be entrusted with community-based organizations. In Bangladesh, government-owned facilities assume the major responsibility while the NGOs are also contracted as partners in service provision. The success of such arrangements depends on how much the clients can use exit or voice mechanism to put pressure on the service providers be it the public clinics or NGO-run clinics.

Decentralization of the health sector

Decentralization is thought to be one of the ways to bring service provision close to the people who should hold the service providers accountable. In Bangladesh decentralization has not worked in practice although a decentralized administrative structure exists (Table 6**).** It is

not far reaching and has been interrupted by different political profiles of the government in power. One positive development in Bangladesh is the role of non-government organizations (NGOs) in encouraging community-based organizations (CBOs) for the empowerment of the poor as well as their involvement in development programmes related to education, health, common-pool resources.

Table 6
The extent of decentralization in Bangladesh

Component of Decentralization	
• Political authority devolved	a mixture of deconcentration and devolution at Thana/upazila some basic services devolved education, health, infrastructure
• Fiscal authority devolved	Upazila/thana level Mainly expenditure, Ineffective in raising revenues
• Grant mechanisms mainly from central govt.	maintenance & development funds
• Sectoral authority devolved: health, education, infrastructure, development programmes	centralized decisions implementation at upazila /thana level
• Intergovernmental disciplines	central govt. control of finance, adminstration personnel in paper only. Elite capture pronounced.
• Civic disciplines Voice Exit Information channels	Patrimonial society, new democracy, limited political participation controlled by political parties NGOs playing a role. Media - TV, radio, newspaper - limited due to poverty Exit options are limited
• Public sector management	interference by govt. Officials Weak legal and judicial framework

Note: Based on *Taming Leviathan* World Bank (2002); Ali, Q. A. (1995).

The system of local government has strong impact on service provision in general. When it comes to the health sector, it is apparent that health facilities are brought down to local level but actual devolution is lacking as decisions on policy, finance and adminstration are in the hands of the central government. Complete devolution of power to local level may not have worked to the benefit of common people in Bangaldesh because of the risk of elite capture and weak capability of the local-level workers in policy formulation, design and delivery of health services. Given these problems delegation of authority under proper regulation and control of the central government is probably more desirable. At present while the central authority delegates the functions at lower levels, monitoring, control and evaluation and feedbacks do not work properly. There are problems that "pertain to the rigidities in budget management and the duality of the health budget, leading to sub-optimal geographic allocation rules and imbalances between recurrent and development expenditures" (Bangladesh Public Expenditure Review May 2003, p. 73, footnote 60). In recent years, some improvements have taken place in budgeting and auditing procedures. How they will affect service delivery is yet to be seen.

The main problem with ineffective decentralization is the lack of civic discipline and the bureaucratic culture plagued with corruption and inefficiency. Widespread poverty and lack of empowerment impairs the voice mechanism. On the other hand, exit mechanism is of little value because of the absence of a regulatory framework under which the private providers should operate as discussed below. On the whole, many of the problems in the public health sector are due to lack of intergovernmental, civic disciplines and poor public sector management.

Effects on allocative and production efficiencies

To determine whether allocative efficiency has been achieved by the publicly owned primary health care facilities, the supply situation may be compared with what is demanded. The pattern of demand is roughy reflected in the use of different service providers and their shares in health expenditure value (Table 5 above). The government is the largest single health service supplier with 30% of health expenditure value. The total per capita health expenditure is $10.00 of which only $3.00 are from the government. The share of the government in terms of estimated client share is also low. Interestingly, even the poor depend largely on private sector providers (pharmacies) for curative care. While government facilities remain

underutilized, there is a huge unmet demand. People experience different types of barriers to the access to health care such as distance, long waiting hours, expenses related to medical advice and medicine, non-chalant behaviour of health workers etc. Women face more difficulties because of their disadvantaged position in the household and lack of mobility. Available studies indicate that there is a mismatch between people´s expectation and health-related behaviour and what the providers think as important (World Bank Report; Ensor 2002). The quality of health care is understood differently by the clients than by health providers and evaluators of health services.

The reasons behind the lack of allocative efficiency are complex. It is often argued that local-level operators know the need of the people, but they have little power to influence government policies or adjust the supply of inputs and services according to the client demands or to influence the behaviour of health workers. On the other hand, problems arise due to lack of intergovernmental discipline. For example, low pay and the lack of any effective restriction create distorted incentives among doctors to engage in private practice. Moreover, the lack of monitoring and control from the central authority and weak civil society participation have led to extraction of medical fees from the clients for inputs and services which are supposed to be free. The poor suffer more from such inefficiency as reflected in the differential infant and child mortality among the rich and poor (Table 7).

Table 7: Infant and Under-Five Mortality Rate by Wealth Quintile 1996/97

Quintiles	**IMR (Infant Mortality Rate)**	**U5MR (Under 5 Infant Mortality Rate)**
Poorest	96.3	141.1
Second	98.7	146.9
Middle	97.0	135.2
Fourth	88.7	122.3
Richest	56.6	76.0
All	89.6	127.8
Poor/ Rich Ratio	**1.701**	**1.857**

Source: Demographic and Health Survey 1996/97. Compiled from Wagstaff et al (1999).

Prices paid by clients for different services (some of them are supposed to be free of charge) are also reported in World Bank Report on Health Futures in Bangladesh. One example is given in Table below.

Table 8 Out of pocket payment for outpatient treatment at government* Thana *Health Complexes (1999-2000) and private clinics (2001) average* taka *per service

	N	Medicines	Consultation & other	Total
Thana health complex	983	19	14	33
Private clinic	na		<50 - >200	

Source: Begum, T. et al. (2001) Who benefits from public health expenditure?(ibid).Cited in World Bank Report, p. 25.

Production efficiency may be measured in terms of the degree of corruption, waste and cost recovery. The recent Public Expenditure Review writes,

”There is also a growing perception of increasing corruption in health service delivery. Doctors as well the public are very vocal about systemic corruption in procurement, the registration of clinics, the provision of medicine and supplies, and the appointment, posting and promotion of medical professionals. Even after admission, extra payments are routine aspects of treatment, whether in government or public facilities.” (Bangladesh Public Expenditure Review May 2003, p. 73).

Institutional pluralism in health service provision

Not-for-profit organizations – NGOs

In spite of the failure of the government to provide public health care in the manner envisaged in the policy document, there is substantial institutional pluralism in Bangladesh especially in rural areas. One of the main features of the recent Health and Population Sector Programme (HPSP) is to establish partnership with NGOs in the provision of health care services. NGOs are thought to be closer to the people and are more aware of beneficiary needs that can facilitate achievement of allocative efficiency. NGOs are considered to be in a better position to impose user fees that can lead to better cost recovery and community participation.

Empirical studies on the provision of essential services indicate that NGO beneficiaries are more satisfied with NGOs as service providers than government health clinics. However, the

contribution of NGOs in total expenditure (includes private and public expenditures including donor contributions) on health services is very small only 3%. Given the underutilization of government health facilities and the fact that NGOs have developed infrastructures in many parts of rural Bangladesh, the public provision of health care should be complemented with not-for–profit providers. This will give consumers greater choice, and lead to more competition among service providers.

The question is whether the NGOs are ”choice” or ”voice” of the people. Empirical studies on the perfromance of NGOs versus public health care facilities indicate that NGOs provide an alternative source of medical service (choice), rather than conduits for consumer preferences. NGOs are not people´s organizations. They are not accountable to the people/clients but to the government. But the clients cannot express their demand/needs through NGOs to the policymakers at the top. In such a case it is important to explore what kind of contracts the government has with NGOs and what the rules are for monitoring and enforcement.

Private sector – for-profit prividers

The largest service provider in Bangladesh in terms of household expenditure for different services is the pharmacy sector. The reason they outcompete government facilities in spite the greater costs invloved are easy access to both services and medicines. However, there are considerable market failures in this sector. We quote from the report of the World Bank:

> Pharmacists who provide clinical advice have incentives to propose a more expensive remedy than may be necessary. The common dual employment of clinicians, together with differential returns to time between public and private sectors, provides incentives for clinicians to direct patients attending government facilities to their private clinics. In some cases, they advertise their private practice at the government hospital. Second, there is no effective separation of prescribing and dispensing functions. Most private clinics have pharmacies associated with them. Clinicians have incentives to over-prescribe where they can capture some of the margins on the drugs that patients buy from pharmacies in which they have a commercial interest. There is growing evidence of both over-prescribing and inappropriate prescribing in Bangladesh.[3] Third, clinicians' financial interests in laboratories and other diagnostic facilities also provide incentives for over-investigation. Physicians commonly receive a commission from private diagnostic services to refer patients to them. This raises the cost of the investigation to the patient. (World Bank Report, p. 36).

The regulator role of the government is extremely important in dealing with these problems. At present there is no in-depth study related to these issues.

III. Conclusions and implications for future research

The role of the government in ESP provision is justified on the grounds of market failures and poverty/equity together with the disease pattern in Bangladesh. The government has also the ambition to provide these services through its decentralized health infrastructure. Since public health facilities do not function properly, people resort to other alternatives which are, however, far from satisfactory. It has been the policy of the government to promote pluralism in service provision together with the improvement of its own facilities. It implies that capacity building must be developed in the government sector regarding regulation, coordination and commission of services. Institutional economics and organization theories provide useful tools that have been considered in industrial countries. Developing countries have not kept pace with this development. We suggest the following issues for future research in the case of Bangladesh.

- The relationship between the line ministry and lower tiers of government as service providers.
- The relationship between the central government, local government and the NGOs. How does the contract of partnership look like? What kind of incentive mechanisms are there?
- the regulatory framework of the central government for control, monitoring and evaluation of the private sector
- the relationship between health administrators (local government bodies or NGOs) and health personnel (doctors, nurses)
- the relationship between health providers and the beneficiaries
- how to increase client awarness about their rights and responsibilities?

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