‘Good health at low cost’ 25 years on
What makes an effective health system?

First published in 1985, the Good health at low cost report sought to describe how some developing countries were able to achieve better health outcomes than others with similar incomes. An iconic publication of its day, it highlighted the linkages between the wider determinants of health and their impact on health outcomes using country case studies. In an extension to the original analysis, recent research explores five new countries asking why some developing countries are able to achieve better health outcomes. With chapters focusing on Bangladesh, Ethiopia, Kyrgyzstan, Tamil Nadu (India) and Thailand, ‘Good health at low cost’ 25 years on has identified a series of inter-linking factors, within the health system and beyond. This third briefing in the series focuses on findings from Bangladesh.

‘Good health at low cost’ 25 years on

During the past 40 years, Bangladesh has made enormous advances with basic population and health indicators, which are now on a par with, or better than, its neighbours who have higher per capita income. Bangladesh’s health gains can be attributed to a series of effective health sector strategies and policy processes, and to a strong emphasis on delivery of health and family planning services at the community and household level. Bangladesh has promoted low-cost targeted technologies and proven interventions and policies that have played a significant role in improving health outcomes.

Bangladesh’s health gains have been made with relatively low total health expenditure when compared regionally, 3.4% of GDP or US$ 12 per capita in 2007.

Achieving better health in Bangladesh

Since becoming a nation in 1971, Bangladesh has made huge strides in improving its population’s health. Compared with other countries in the region, Bangladesh has among the longest life expectancy for men and women, the lowest total fertility rate and the lowest infant, under-5, and maternal mortality rates. Between 1994 and 2008, life expectancy increased from 58 years to 66 years. Infant mortality has declined dramatically from 85 deaths per 1000 live births in the late 1980s to 52 deaths per 1000 live births between 2002 and 2006. There has been a dramatic decrease in total fertility among women aged 15–49 years. Huge improvements in under-5 mortality mean that Bangladesh is on track to achieve MDG 4 to reduce under-5 mortality.

Paths to Success

Our research shows that a fundamental factor in better health outcomes in Bangladesh has been political continuity. Bangladesh has demonstrated a strong commitment to health as a national priority and as a human right. This political commitment has transcended

Key messages

- Bangladesh became a nation in 1971 with the transition to independence acting as an important catalyst for health reform.
- Health policy in Bangladesh has endured political change while constantly adapting to address new issues.
- As a young country Bangladesh was a pioneer in its strong national family planning programme, which resulted in a dramatic drop in fertility.
- Government engagement with non-governmental organisations (NGOs) and non-state providers has helped to meet the needs of a large population.
- Bangladesh is an innovator in health policies and in testing and adapting low-cost technologies in the health sector.
- Other contributing factors to Bangladesh’s health achievements have been improved literacy, economic development and disaster preparedness.

icddr,b

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE


© 2002 Shehzad Noorani, Courtesy of World Bank

political party politics and, despite rapid changes in the political landscape and in key actors, many policies have been sustained for a significant period of time. Another factor in Bangladesh's success has been the government's ability to collaborate with non-state actors. The government views NGOs as a way of extending their reach, particularly in the implementation of national strategies and policies. NGOs have developed strong capacity and innovative delivery models that have prompted a two-way learning exchange between government and non-governmental entities.

Policies that have been pivotal in improving the population's health include; the Population Policy (1976), which pioneered a community based intervention that brought family planning services, including contraceptives and education, directly to individual households. The Drug Policy (1982), which included categorising and procuring essential medicines and the establishment of the Essential Drugs Company Limited. This led to the domestic production of drugs appropriate to local needs, saving the country approximately US$ 600 000 million. Finally, the Sector Wide Approach (SWAp)(1998), facilitated by the World Bank, has reduced duplication and financial waste in the health sector and has simplified the process of programme development and implementation.

Bangladesh's health system was developed along the Health for All model with nationwide networks of health care facilities, family planning and child welfare centres and an immunisation programme. Insightful investments in human resources and innovative delivery methods have resulted in universal coverage of primary health care services; with 21,000 health assistants and 23,500 family welfare assistants serving communities and rural households across the country providing home visits.

Bangladesh is a global leader in developing low-cost interventions such as the use of zinc in the treatment of childhood diarrhoea, oral rehydration solution, delivery kits, tetanus vaccinations for pregnant women, and iodized salt. These interventions have been rolled out locally, scaled up and even used in other developing countries. Bangladesh's strong emphasis on childhood immunization has provided almost universal access.

Finally, non-health, poverty reduction initiatives have played an important factor in Bangladesh's progress. Participation in microcredit programmes has been connected to better child survival and the expansion of electricity coverage, and road infrastructure has assisted the roll out of immunization programmes to rural areas. An increase in net primary education enrolment from 74% in 1991 to 87% in 2005 has resulted in improved literacy rates. The economic and social position of women has improved in line with education, income-generating activities, access to microfinance and employment in the garment industry. Bangladesh's disaster preparedness has shown the world that it has the ability to plan, coordinate and implement crisis action. This demonstrates the good governance structures that exist across public sectors.

Lessons learned and future challenges

Considering that Bangladesh came into being as one of the poorest nations in the world, it has made remarkable progress in improving the health of the population since 1971. This has been achieved against a backdrop of strong political direction, leadership and effective health strategies, which has driven the health agenda forward resulting in a wide reaching primary health programme. Notable successes have been achieved in reducing fertility, and improving access to vaccinations and other basic interventions, often delivered by NGOs.

The series of inter-linking factors, as in the other study countries, that have made Bangladesh's health system successful in realising better health for its population can be expressed by four words all beginning with C – referred to as the 4 C's. They are Capacity (the individuals and institutions necessary to design and implement reform), Continuity (the stability that is required for reforms to succeed), Catalysts (the ability to seize windows of opportunity) and Context (the ability to take context into account in order to develop appropriate and relevant policies).

While great progress has been made, new approaches that incorporate innovation, while responding to changing cultural and socioeconomic realities, must be developed. In order to continue making improvements in the health of the population Bangladesh must re-commit to relatively low-cost and less complex interventions that address an increasingly aging population and a significant increase in non-communicable diseases, which are currently not provided for in the public health care system. The number of skilled birth attendants needs be increased and improvements made in the delivery of basic health interventions to hard-to-reach urban slum communities.

Further reading

Chapter 3, Health transcends poverty: the Bangladesh experience. In Balabanova D, McKee M and Mills A (eds). 'Good health at low cost' 25 years on. What makes an effective health system? London: London School of Hygiene & Tropical Medicine, 2011. Available at http://ghlc.lshtm.ac.uk

Acknowledgements

ICDDR,B gratefully acknowledges the contributions of the Rockefeller Foundation and of our partners from the London School of Hygiene & Tropical Medicine for making this work possible. The authors are grateful to the many past and present health leaders in Bangladesh who served as key informants to this work as well as the grassroots level workers who shared their valuable time and knowledge with us.

The opinions expressed are those of the authors and do not necessarily reflect the views of the London School of Hygiene and Tropical Medicine.

This policy briefing was edited by Pamoja Consulting www.pamoja.uk.com