Developing the Private Sector Health Services in Bangladesh

by Mahmud Hassan

VER the past twenty years, Bangladesh has made substantial progress in Family Planning (FP) and Maternal and Child Health (MCH) Programmes. Crude Birth Rate (CBR) is down from 48 per 1,000 in 1970 to 38 per 1.000 in 1989 (World Bank, 1991). Between the same time period, Infant Mortality Rate (IMR) has also decreased from 150 per 1,000 to 110 per 1.000 (World Bank, 1991). However, these results are far from the levels seen in other countries in Asia and in other low-income countries of the world. In 1989, the CBR for the Asian and the worldwide low-income countries were 26.8 and 30.4 respectively (World Bank, 1991). During the same period, the IMR was 61.5 and 72.6 respectively for the Asian and the worldwide low-income countries. These data indicate that FP and MCH programmes are on the right

track. Besides the FP and MCH activities, another significant factor in the social and economic development of Bangladesh is the health status of the general population. It is fair to state that the concentration of the country's attention on the FP/MCH Programmes has resulted in the relative neglect of the broader health questions. The adult death rates for some diseases in Bangladesh are far greater than those in India. In 1989, the death rates for congestive heart disease and cerebrovascular accident for Bangladesh were 18 per cent and 5 per cent respectively, whereas the corresponding rates for those diseases in India were 8 per cent and less than 1 per cent respectively. Even though the access to medical care in Bangladesh has improved over the last twenty years, it is still quite inadequate compared to those in other Asian and worldwide low-income countries (World Bank, 1991). The population per physician has decreased from 8,400 in 1970 to 5,900 in 1989, but it is far greater than the corresponding number in other Asian and worldwide low-income countries. In 1989, these numbers were 1,422 for the other Asian countries and 1,462 for the worldwide low-income countries* (World Bank, 1991). The population to nurse ratio and the population to hospital bed ratio are even worse in Bangladesh than in the other Asian and world-wide low-income countries.

Economics in Health Care Service

In the face of constrained resources, it is fundamentally important to recognize the significance of a systematic approach for planning, delivery, and evaluation of health and health-related services. Economics in general is concerned with issues of choice * related to production, distribution, and consumption of goods and services. Economics also provides a ready vehicle for consideration of how best to use scarce resources for the production and delivery of healthcare services and it is already being used in many countries of the world. Economists have applied many of their standard theories, analytical techniques, and ways of solving problems to the study of the healthcare sector. The application of economic analysis in the healthcare sector gives us a clearer understanding of the ways in which the production and delivery of healthcare services might be

improved For most goods, a competitive market with income redistribution by government policies is the most successful way to combine consumer choice. producer autonomy, economic efficiency and equity. In a competitive market, the consumer is motivated to balance the benefits gained from the

physician has any incentive to economize the use of health care services when a third party pays the bill. Although institutions such as health maintenance organizations have been developed to control the overutilization, they may still select their own risk group, denying coverage to some groups of individuals. The consumer is in a weak position in the market for healthcare services. This is partly because of asymmetry of knowledge and information. The consumer may know when he or she feels sick but is usually too ignorant to judge what can best be provided by the way of remedies and to judge retrospectively the quality of care, because of the complexity of medical technology and the relative infrequency of consumption. In addition, sickness can itself impair judgement.

For these reasons, the consumer is obliged to rely heavily

Special characteristics of the demand for and supply of health care discourage the reliance solely on the functioning of free market along with government's policies for income redistribution for the provision of health service. The requirement for income redistribution is particularly important for the health care market to work efficiently.

consumption of goods and services against the price that has to be paid for them, the profit maximizing producer has an incentive to maximize the cost. Competition will ensure that prices are related closely to opportunity cost. Special characteristics of

the demand for and supply of health care discourage the reliance solely on the functioning of free market along with government's policies for income redistribution for the provision of health service. The requirement for income redistribution is particularly important for the health care market to work efficiently. This is because human lives should be valued equally. A strong inverse relationship often exists between ill-health and the ability to pay for healthcare (Mills and Lee. 1993). Private charity is unlikely to provide an adequate means of meeting this demand for altruism, partly because of the free rider problems, many individuals are tempted to escape the burden of giving to

The need for healthcare is often highly unpredictable and very costly for an individual. yet it is predictable and affordable for larger groups. Insurance can be used to spread the financial burden but private insurers tend to exclude, or raise premiums, of high-rick individuals. In general, individuals with pre-existing conditions are denied any insurance coverage.

others.

Health insurance might induce the insureds to overconsume healthcare service. Neither the patient nor the

on the advice of the doctor and to obtain medical approval for making most health care service decisions. It is often the physician who makes the decisions. Consumer sovereignty in the healthcare services is not viable. The difficulties of relying on a private market for healthcare have encouraged governments to intervene in the financing and delivery of

What Can the

healthcare services.

Government Do? Government may choose to finance and provide healthcare services to a vulnerable group or to the whole population. with salaried physicians, in public clinics and hospitals. This type of system may be capable of supplying services at a reasonable cost but usually is associated with over-load and lower quality of service. It is also possible for the publicly financed health services to be corrupted by private "under the table" payments from patients to professionals.

Another form of intervention could be the introduction of a compulsory health insurance system financed by income-related contribution. The system could include low income and the vulnerable groups with the help of transfer income and other subsidies. Such an arrangement can be very successful in improving access to healthcare and income protection for the disadvantaged groups but is usually associated with unacceptably high levels of public expendi-

ture (OECD, 1992). The most widely used form

of intervention is the government's regulation of private or mixed markets of health insurers and providers. Regulations attempt to limit the rise of insurance premiums: to fix prices, quantities, and quality of health service; and to plan and control the capacity of health services production and delivery in an efficient manner. While regulation can control cost, it may impose distortions and rigidities on markets due to inappropriate use of power. Government regulations should aim at creating conditions for proper functioning of the private market by giving the providers financial incentive for the production and delivery

service. Types of Health Care Services

of high quality health care

Health services can be di vided into two broad types of categories: Preventive and curative care. Preventive care may be initiated by the government or by individuals. Government-initiated preventive care includes immunization, supply of safe drinking water, obstetric services healthcare information and dissemination of health-related information and other public health services. Some preventive care such as diet, annual check up, physical exercise, pre and post natal care may be initiated by individuals.

Curative services are, how-

ever, initiated by individuals only. The curative services can be categorised into three groups: hospital services, physician services and pharmaceutical services. Government must provide the society with a system for proper coordination of demand and supply of such services. Allocating more resources to the health care sector may not be the right answer to enhance the access of the healthcare services. The proper balance of resource allocations between hospital and non-hospital programmes is fundamentally important for the success and effectiveness of the healthcare system. For proper planning, policy-makers need to know unit cost of a service, determinants of cost of service, the extent of economies of scale and scope, factors and mix of factor input for the production and delivery of healthcare services, and other pertinent economic data. Better understanding of the interaction, production and delivery of the different components of healthcare service is obtained through rigorous studies. Specific research agenda might include organization and financing aspects of healthcare

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This is the introductory part of a two-part feature. The concluding part will be published after a fortnight.

AIDS: The Killer Awaits Closeby

person's helper T-cells out-

number the suppressor cells

it is at this stage that the HIV

The HIV virus enters the

body to join the T-blood cell

and from thence starts a con-

version process. The RNA ge-

netic material of the virus gets

converted to the DNA genetic

material by the aid of an en-

zyme which the virus manufac-

tures. After this the DNA virus

gets united into the DNA of the

T cell and stays there for as

long as the individual lives.

The infected T-cell now be-

comes crowded with viruses.

Consequently, the cell pro-

duces more viruses which

comes out of the cell only to

attack more new T-cells and

destroy them. As years go by.

the T-cell count of the in-

fected person falls down to a

dangerous level and the indi-

fact, a great difference be-

tween a patient infected with

HIV and one suffering from T-

cell. And there is a lot of con-

fusion among people in this

particular aspect. Before ex-

plaining, it would be useful to

know that all patients with

There is a difference, in

vidual develops AIDS.

affects a person.

by Farhana Yusuf AIDS originated from? There had been and still is a lot of speculation and controversy about the origin of AIDS over the years. However, AIDS was first diagnosed in 1981 among the homosexuals of New York. Los Angeles and France.

Once the immune system



E all know that AIDS

can kill, it is incura-

ble. We know this

because these are, in fact, the

two most irrevocable truths.

But apart from this, how much

do we really know about AIDS?

For instance, what the disease

actually is, what causes it or

where it originates from. The-

se questions, will of course,

An innocent victim of AIDS

unknown answers, expose important facts.

But first of all, what is AIDS? AIDS is the abbreviation of Acquired Immune Deficiency Syndrome. Our body's immune system fights infections. The Human Immune Deficiency Virus (HIV) which causes AIDS, changes the cells' genetic structure and gradually weakens, totally damages and finally destroys the body's immune system. Destruction of the immune system makes the person increasingly defenseless, thus helpless against all kinds of non-life-threatening infections. So, AIDS is the con sequential stage of an infection caused by HIV virus, which is also known as anti-virus, a sort of retro-virus. The infections caused by anti-viruses takes a long time to manifest themselves so that it takes months and even years before the virus captures the person's body and the person becomes aware of the actual symptoms of the disease. But where has this

infections take a hard grip on it. Consequently important components of the immune system are destroyed, thereby rendering it completely unable to fight infections. How does the whole mechanism work then? And how does AIDS affect the human body?

There are different types of white blood cells in the human blood which play different roles in protecting the body against the various diseases. Lymphocytes are one type of white blood cells - they carry two types of cells, namely the B-cells and the T-cells, T-cells are again classified into the "helper T-cells" and the "suppressor T-cell". Helper Tcells helps antibody-producing B-cells to fight the organism that cause diseases while suppressor T-cell" suppresses the attack of any invading disease that had been controlled already. Now depending entirely on the balance between the two types of T-cells, a healthy immune system func-



start to develop that the per-

develop itself as AIDS. modes of HIV/AIDS transmis-

 Through intimate sexual contract if one of the partners

2. Through blood transfusions of infected needles.

tions and in this case a healthy 3. By an infected mother to her foetus during pregnancy or by the ratio 2:1. This balance delivery. makes the difference because

By breast feeding and 5. During organ transplant. Symptoms of HIV infection include swollen lymph glands in the neck or under-arm area. repetitive fever, night sweats, rapid loss of weight for no particular reason, constant fatigue, diarrhoea, less appetite, white spots in the mouth. muscle or joint pains, sore throat, skin rashes, headaches and pain in the eyes. There is a 50-50 chance of HIV affecting the nervous system and if that is the case, that particular individual's brain will be damaged including the spinal cord.

Today, AID activists are bulging out from every nook and corner, desperate and urgent with their message. celebrities appearing in the television saying "AIDS is deadly, so keep away from it". and so forth. But every few people are explaining "how". What is most important here and what should be done is to give these slogans a touch of reality by including intervention and protection against AIDS. A few of these measures

Identifying individuals



AIDS are HIV infected but inwith high risk behaviour. dividuals infected with HIV 2. Sex education, singly the may not develop AIDS. It has most important tool for effecthus become clear to all of us tive prevention and control of that an HIV carrier is one who AIDS, gives a thorough inforhas been affected by the Human Immune Deficiency Virus. An HIV carrier remains infected throughout his life time, but he will appear to be absolutely normal and what's more he will be healthy. This 4. Using doctors, social is because there is a possibility of his remaining asymptomatic for years on end. But it is when an HIV positive individual's Tcell counts start dropping to a crucial level and symptoms

Some of the common

son is also about to develop

AIDS. For an individual in-

fected with HIV, it may take

vears (ranging from a few

months to eight years) or even

longer, for the HIV infection to

sion are:

mation about the disease and the safety measures that should be taken against it. 3. Use of mass media for

discouraging people to indulge in high risk sexual behaviour.

workers, hospitals and health care centres etc. for guiding the masses to help prevent the spread of this potentially fatal

Up till now there is no cure at all for HIV/AIDS. As the disease is spreading and getting out of control, research still continues worldwide in the hope of finding a cure. For the persons who tests for HIV positive and 'yet remains asymptomatic, they have the possibility of a hopeful future. But for those who develops the symptoms, death waits on the other side of the door.

The Future of Clinical Psychology in Bangladesh

f is an applied science. It applies the principles and knowledge of Psychology to the treatment of people's mental health problems, and to health problems in general. Being an applied scientist, the clinical Psychologist will approach psychological problems in a scientific manner. This means making a careful assessment of the symptoms, reaching a diagnosis or formulation of what the problem is, defining the aims of treatment, making continuous assessments to monitor progress, defining and justifying scientifically the methods used, knowing how the techniques work and their efficiency and improving the techniques themselves, and the treatment of the individual patient, by a process of controlled investigations. In a nutshell, Clinical Psychologists undertake the scientific assessment and treatment of psychological problems.

How to assess and diagnose problems?

Clinical Psychologists systematically collect information so as to reach the point whereby they can offer a formulation or explanation of the problem i.e. the cause of the problem and why it persists.

The collection of information usually begins with a structured internlew which emphasise - the psychological aspects of the history. A note is taken not hist of the history of the symptoms, but the patients' attitudes to their problems: the reaction of family and friends; how the patients explain or understand their own problems; the nature of their thoughts and mood and motivation; and the way that they have tried to cope thave they denied the problem? Have they been constructive and tried to find ways around it? How have they dealt with the emotions generated?). Usually, other people such as a spouse or key family member will also be interviewed

Next, there may be stan!

dardized questionnaires given which have been scientifically constructed so as to be reliable (they will give the same answer if given twice) and valid they measure what they are supposed to measure). Such questionnaires include the measurement of depression, phobic anxiety, trait anxiety, social avoidance, the impact of sickness, the severity of alcohol dependence, degree of drug dependence, degree of post-traumatic stress, degree of dysfunctional attitudes, ways of coping, degree of hopelessness and so on. The reliability of a scale is measured from 0 to 1, which is called the reliability coefficient, and all of these scales and many more, will have a coefficient of greater than 0.8. The Clinical Psychologist is therefore, sure of collecting reliable informa-

gist may administer some psycho-metric tests, perhaps to measure intelligence or specific activities like motor skills or reading; perhaps to measure the functions of the brain, such as memory. This can usten be complicated. For example, there is no single test of memory that is sufficient. You have to measure long term memory, short term memory, visual memory, verbal memory, memory for faces, learning, rate of forgetting, memory for life history, ways of encoding memories, and so on. All of these tests will also have been scientifically constructed to be. reliable and valid.

Next, the clinical psycholo-

Finally, the clinical psychologist will also directly observe the problem if at all possible. This may involve going into a classroom to look at how a certain child behaves, seeing how a phobic patient reacts to the feared object, or looking at how a schizophrenic patient interacts with his/her family.

All this information enables a diagnosis or formulation of the problem to be made which describes the problem, and explains why it has arisen and why it continues. To give a simple example, "Mr X has social anxiety with social avoidance of moderate severity because once he nearly had a panic attack in front of other people. He is afraid of this happening again and so now avoids groups of people. Because he avoids groups of people he keeps his anxiety level under control. Because avoidance is rewarded by lowered anxiety, his avoidance has become stronger and stronger. An underlying inability to relax also persists, which led to the panic attack in the first place".

A general feature is the change of dysfunctional beliefs. There are beliefs which undermine our confidence or self-esteem or lower our mood. For example, when we feel good we might think :

"There are some things am quite good at" "Hard work will help me

get the job done" "My headache will soon go

"I am looking forward to the cinema next week" But when we feel bad we might think:

"Look at all the things I am hopeless at "No matter how hard I work I will fail"

"My headache will come back tomorrow too" "I am not doing anything interesting" etc.

When we have toughts like these, they reinforce our anxiety or depression. Patients are helped to challenge dysfunctional thoughts by looking at the evidence; thinking of alternative view-points; considering whether the thought hinders or helps them; thinking whether there are any errors in the thought, for example, whether it is an exaggeration; and by considering what

action can be taken. Finally, another general feature is to transfer treatment from the clinical psychologist to the patient him or herself. The emphasis is upon the patient learning gradually to help himself to take away better skills of coping and managing. The problem of relapse will be discussed with the patient who will be prepared for symptom to tend to come back, and who ' will know what to do if that

up, from least to most frightening. The patient learns to relax while imaging the least frightening image and then moves on to more frightening images, relaxing at each stage, until even the most frightening possibility can be imagined without undue anxiety.

Obsessions : The patient is exposed to situations that would normally precipitate compulsive rituals, but is prevented from doing them. For example, the woman who compulsively washes her hands because they may be contami-

How to treat specific prob-

I would like to give a thumbnail sketch of how the Clinical Psychologist contributes to the treatment of different problems :

Stress: The patient is taught awareness of the symptoms and of the signs that stress is building up. Causes of stress have to be identified and dealt with. For example, the person may have to learn to manage their time better or to relax or to communicate with people better.

Anxiety and panie: Insight is established into the way that panicky feeling arises out of chronic anxiety and hyperventilation. False beliefs about panic (for example, that it can send you mad or cause a heart attack) have to be dealt with. The person is taught to distract himself with non-anxiety thoughts, to relax at the onset of panic, and to let the panicky feelings wash over them in the knowledge that the feeling will pass rather than cause anything catastrophic.

Phobias : The person is

taught to relax fist of all. A

hierarchy of fear related

thoughts or images is drawn

nated, has her hands made dirty but is then denied access to washing facilities until the anxiety goes down. The patient learns to tolerate an "intolerable" state until it no longer cause anxiety and the rituals to reduce that anxiety.

Depression: When a patient is depressed there is a negative cognitive triad. The self is seen as defective and inadequate. Life is seen as making extreme demands. The future is expected to be negative and failure is anticipated. In cognitive therapy for depression these three sources of low mood are tackled and the dysfunctional thoughts changed to more positive ones, as I have already outlined. 70% of depressions that are resistant to drug therapy, can be helped by

this newer technique. Interpersonal skills : Feedback is given, clearly and plainly, about what the person is doing wrong — what they are doing to be rejected by people. what they do that is irritating, how their behaviour can be interpreted as lack of concern or interest, or love. The skills that have to be learned are pinpointed and then rehearsed in sessions until they are learned well enough to prac-

Schizophrenia: Much of the work is with the family because it is known that family pressures can cause relapse. There has to be an avoidance of blame. The patient must retain a place in the family structure. The focus has to be on the "here and now" rather than possible problems in the

Drug addiction : One main thrust of treatment is harm minimization". For example, if the addicts cannot give up drugs they must at least not inject. If they have to inject. they should not share, syringes. If they have to share they could at least use bleach to sterilize in-between. Keeping the patient as healthy as possible increases the chances that they will eventually exert self-control and resist.

Why is clinical psychology

needed in Bangladesh? In the I.K. which is an average country, not particularly well staffed and trying hard to increase the number of Clinical Psychologists, there are 3,000 clinical psychologists for a population of 60 million. In Bangladesh, there are no clinical psychologists for a population of 120 million. The statistics arguing for the provision of psychology services are staggering

· At any one time 3% of the general population are seriously depressed; 3.6 million people.

 At any one time 5% of people have problems associated with chronic or acute anxiety: 6 million people

 A half per cent of people have disabling obsessions or compulsions: 0.6 million peo-

 At any one time 1% of the general population will have schizophrenia or other psy chotic problems; 1.2 million people.

 2.5% of people have a learning disability; 3 million people.

In terms of general health issues with a psychological component :

 10% of the adult population have damaging addictive behaviours, if only cigarettes; 6 million people.

14% of adults will develop

(hypertension), 8.4 million · 10% of the population will

blood pressure problems

face a chronic illness like pain. asthma dr diabetes: 10 million people. • 0.25% of people will suffer

significant brain damage, often through head mury; 0.3 mil-• 00° mi an risits to a gen-

eral i hysician will be to do with problems either consed by physiological factors or exacerbated by them.

How is it to begin? In July 1995 the University

of Dhaka with UK cooperation is to start a three year training course in Clinical Psychology which will award the degree of Doctor of Psychology (PsychD). Its philosophy is that it will integrate academic knowledge, clinical skill, and research expertise, and that it will be a oint enterprise between the University of Dhaka and professional psychiatric colleagues at the Institute of Mental Health and Research, Dhaka, and other mental health facilities. It is aimed specifically at contributing to the current and developing psychiatric services. As the three year course progresses, so the students will see patients from the whole of the age range.

The future of Clinical Psychology in Bangladesh? Initially there has to be a period of establishing the professionals. This means having a code of conduct to protect the

public and ensure that anyone

calling himself a "clinical psychologist" has the necessary skills, competencies and training. There will doubtless have to be a register of qualified clinical psychologists. from which individuals can be struck off for breaches of the Code of Conduct; by taking advantage of their patients, for example, or by making clams about the efficacy of their treatments that cannot possibly be true, or by using treatments that have no scientific credibility.

At the same time, the newly trainee Clinical Psychologists will be treating individual patients and helping psychiatrists cope with intense demands upon mental health services.

. In addition, the knowledge of Clinical Psychology must be disseminated to other professionals, by lecturing to other professionals in training, and indeed to those staff already qualified. Next, Clinical Psychology

knowledge must be available. to people by informative leaflets, and self-help manuals. These will not only be about how to combat mental illness and psychological problems. but how to prevent them in · the first place.

Finally, the mass media has a crucial role. Regular coverage in newspapers of key areas is a must, but on top of this television has to be constructively used to offer programmes on psychological health and wellbeing, systematically covering the areas of greatest need.

The writer nowned Clinical Psychia. He took his training in Clinical Psychology and Ph. D. in Experi mental Psychology at the Institute of Psychiatry. London University. He had been a teacher there until 1984. Since then he has been working as the Director in Clinical Psychology at the University of Surrey, UK. He recently visited Bangladesh to attend a seminar on the above subject.