Public health is failing, act now

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Bangladesh stands at a critical juncture in its public health journey. While the country has made remarkable progress since independence, deep structural gaps, rising disease burdens, and growing inequities continue to undermine the health of millions. If we consider the existing healthcare system in Bangladesh, it becomes clear that we need many more hospitals to serve the urban population. Dhaka alone now has a population of nearly 36.6 million (UN Report 2025), yet the number of large public-sector hospitals has barely increased since independence. Apart from facilities such as Dhaka Medical College Hospital, Sir Salimullah Medical College Hospital, and Shaheed Suhrawardy Medical College Hospital, there have been very few major additions.

At the same time, there has been a mushroom growth on private clinics. However, they are largely unaffordable for people from lower socioeconomic backgrounds. For low-income urban residents, government hospitals remain the primary, and often the only, place to seek care. This makes it crucial to expand and strengthen hospital-based care for urban populations.

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KEY POINTS

1. Bangladesh faces persistent public health gaps, with rising non-communicable diseases, urban overcrowding, and inequitable access to care.
2. Expanding and decentralising hospital and primary healthcare services is critical, especially for low-income urban residents and rural populations.
3. Out-of-pocket health expenditure is high; ensuring availability of diagnostics, essential medicines, and surgical supplies can reduce financial burdens.
4. Malnutrition, poor dietary diversity, and climate-related health risks continue to threaten children, women, and vulnerable populations.
5. Strong governance, effective implementation, and ethical practices in prescribing medicines are essential to translate investments into tangible health outcomes.

Decentralisation is equally important. When specialised hospitals are only concentrated in Dhaka, patients from districts such as Noakhali or Kurigram are forced to spend significant amounts of time, money, and effort to seek treatment in an unfamiliar city. This is neither appropriate nor sustainable. Medical colleges and medical college hospitals outside Dhaka must be well equipped and adequately staffed so that patients can receive quality care closer to home.

Of course, the country also needs a much stronger healthcare system for the rural population, which still outnumbers those living in cities. Bangladesh has an extensive primary healthcare infrastructure, including upazila health complexes, union sub-centres, and community clinics. Each community clinic caters to a population of around 10,000–12,000 people and is staffed by a community healthcare provider. However, the system as a whole needs revitalisation. Facilities must be functional, well-staffed, and properly equipped so that people can seek treatment for common and basic health problems. Strengthening primary healthcare at the grassroots level is essential to reducing pressure on higher-level facilities.

Another major concern is the rapid increase in non-communicable diseases such as diabetes, hypertension, and chronic respiratory illnesses. This trend is visible across both urban and rural populations. Surveys show that 6–10 percent of the population is living with diabetes, many without knowing it. The situation with high blood pressure is even more alarming: around 20–25 out of every 100 people are affected.

These individuals are at a much higher risk of complications and premature death. Strengthening primary healthcare services is therefore critical so that chronic diseases can be detected early and managed with simple, low-cost treatments that prevent complications.

Urban slums are another major public health hotspot. In Dhaka and other cities, an estimated one-third of the population lives in slum settlements under extremely poor conditions. These communities are deprived of many basic healthcare services.

While rural populations have access to community clinics and other primary healthcare platforms, similar fixed-site facilities are largely absent in urban slums. Establishing community clinic–type facilities near large slum settlements could dramatically improve access to care. Even basic services, such as checking blood pressure or blood glucose, can make a meaningful difference by enabling early detection and prevention of diseases and complications.

Out-of-pocket health expenditure in Bangladesh remains persistently high, exceeding 70 percent. For diagnostic tests, this share often climbs to 80–90 percent or even higher, placing a severe financial burden, particularly on people from lower socioeconomic backgrounds.

To address this, we must ensure the availability of basic diagnostic services such as blood tests and X-rays at public facilities. Although X-ray machines exist in many rural areas, they are often out of order or lack essential supplies. Why should a low-income patient be forced to seek a chest X-ray from a private facility? Community clinics should have basic equipment—such as blood pressure machines, blood glucose meters, and essential medicines—provided free of charge. Ensuring these services would significantly reduce out-of-pocket spending.

Access to affordable surgical care is another critical issue. Procedures such as caesarean sections or appendicectomie remain expensive even in public hospitals due to the cost of medicines and other supplies. Suppose a rickshaw puller in Dhaka develops acute abdominal pain and is taken to a hospital, where he is diagnosed with appendicitis and advised to undergo an appendicectomie. Surgery is essential, but there are very few facilities that provide it free of charge.

Even when surgery is offered at no cost, patients often face unforeseen expenses. To truly reduce out-of-pocket health expenditure, it is crucial to ensure that all necessary components—

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