Expanding hospitals is not enough. We must plan healthcare resources better



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Bangladesh's healthcare crisis is often seen as a shortage of hospital beds or doctors. However, the problem actually lies in how healthcare resources are planned, allocated, and coordinated. Essentially, hospital infrastructure continues to expand without corresponding investments being made in skilled personnel, essential services, and operational capacity.

Consequently, overcrowded hospitals, overburdened healthcare workers and inadequate quality of care have become persistent features of our public health system. Two recent investigations by The Daily Star highlight this disconnect. One reported that 2,688 of 2,879 additional public hospital beds (approximately 93 percent) approved recently were allocated to selected districts, while several severely overcrowded hospitals elsewhere received no expansion. Another report revealed that Bangladesh had only 15.16 doctors, nurses, and midwives per 10,000 people in 2025, far below the World Health Organization's (WHO's) indicative threshold of 44.5.

According to the DGHS Health Bulletin 2024, average bed occupancy reached 178 percent in district hospitals and 164 percent in medical college hospitals. Mymensingh Medical College Hospital recorded 329 percent occupancy, while several other tertiary hospitals operated at more than twice their capacity in 2024.

Due to overcrowding, patients receiving treatment on floors and corridors face compromised privacy, inadequate monitoring, and increased infection risks. Excessive workloads leave healthcare profes proper examination, communication, counselling, and follow-up. When a nurse has to care for far more patients than is manageable, timely medication administration, infection prevention, and complication detection become increasingly challenging. Expanding hospital beds without ensuring adequate workforce and operational resources may increase nominal capacity without improving the actual quality of care.

Communicable diseases such as tuberculosis, dengue, and measles continue to challenge Bangladesh's health services, while non-communicable diseases (NCDs), including diabetes, cardiovascular diseases, cancer, and chronic respiratory conditions, require sustained management. Simultaneously, maternal and child healthcare, family planning, immunisation, neonatal care, and emergency services require continued attention. These diverse needs demand different levels of competency, appropriate staffing mixes, and coordinated services across primary, secondary, and tertiary health facilities.

Managing diabetes requires continuous follow-up, counselling and diagnostic support. Safe childbirth requires skilled midwives, nurses, obstetricians, and emergency referral arrangements. Infectious disease outbreaks demand trained laboratory personnel, surveillance workers, and infection prevention teams. Emergency care requires the availability of immediate access to properly trained health professionals. A healthcare system designed mainly around hospital beds and doctor numbers cannot adequately respond to these changing demands.

Workforce shortages are not limited to doctors and nurses. The DGHS Health Bulletin 2024 reported that 42,903 of 122,433 sanctioned DGHS positions (35 percent) remained vacant as of December 2024. Vacancies extended across staff grades, including medical officers, technologists, field workers, administrative personnel, and essential support staff. These shortages have consequences throughout the healthcare delivery chain. Without adequate laboratory technologists, diagnoses are delayed. Shortages of health assistants and field workers weaken immunisation, disease surveillance, and community-level prevention. An insufficient number of cleaners, ward attendants, and other support personnel compromise hygiene, infection prevention and hospital operations.

More recent reporting by The Daily Star indicated that 73,045 of 234,024 sanctioned posts (31.21 percent) were vacant across DGHS, the Directorate General of Nursing and Midwifery (DGNM), and the Directorate General of Family Planning (DGFP). Equally important, sanctioned positions may themselves be inadequate relative to actual patient workloads. Filling existing vacancies is therefore necessary but insufficient.

Workforce shortages become particularly dangerous during emergencies, when timely intervention determines survival. District and upazila hospitals and health centres often lack sufficient personnel trained in emergency triage, resuscitation, and stabilisation. Emergency departments need dedicated, round-the-clock teams, trained nurses, functional diagnostics, and coordinated ambulance and referral services. Expanding emergency rooms without ensuring appropriate staffing across shifts will not improve emergency preparedness.

Retention of health personnel in rural areas remains another challenge. Bangladesh's Health Workforce Strategy 2024 provides a starting point, but vacant posts and new graduates will not translate into quality care without supportive management. Rural service cannot rely solely on compulsory placement. Workers need safe accommodation, functioning equipment, mentoring, transparent transfers, career progression and financial incentives.

Bangladesh should pilot retention packages in its hardest-to-staff districts, evaluate results, and adopt applicable outcomes. Improving healthcare requires investment beyond the health ministry. Education helps train healthcare workers, transport services enable patient referrals, and effective public financial management ensures that approved positions are funded and filled. In addition to recruitment, a credible reform needs a costed, multi-year plan.

Institutional fragmentation further weakens healthcare delivery. The DGHS, DGNM, and DGFP operate through separate recruitment, deployment, and management arrangements, despite delivering interconnected services. These parallel administrative structures result in duplication and weak coordination. For patients, these administrative divisions are irrelevant. A pregnant woman requires accessible antenatal care, skilled delivery services, and emergency obstetric support, regardless of which directorate employs the professionals.

Bangladesh therefore needs integrated workforce planning, coordinated recruitment, and a shared human resources information system across directorates. The objective should be to match staffing to service requirements rather than maintain separate institutional priorities.

International experience offers useful lessons. England's National Health Service uses weighted population-based funding formulas that consider demographic characteristics, healthcare needs, deprivation and inequalities. Bangladesh could adopt a simpler framework incorporating population size, disease burden, poverty, geographical accessibility, patient volumes, bed occupancy, and existing workforce capacity. The WHO's Workload Indicators of Staffing Need also provides a practical approach for determining staffing based on actual service workloads. Bangladesh has already applied this methodology in selected facilities, demonstrating substantial staffing gaps.

Three reforms deserve immediate prioritisation. Firstly, hospital expansion must be accompanied by a fully costed workforce and operational plan that covers all staff categories, diagnostics, medicines, and emergency services. Secondly, the Ministry of Health and Family Welfare should establish coordinated, district-level workforce planning across the DGHS, DGNM, and DGFP, supported by publicly available staffing and service delivery-related information. Thirdly, recruitment must be complemented by rural retention incentives, continuous professional development, supportive management, career progression, and improved working conditions. Strengthening primary healthcare and referral systems is equally essential to reducing unnecessary pressure on tertiary hospitals. Financing must prioritise functional services rather than infrastructure alone.

Bangladesh's progress towards universal health coverage depends not only on increasing the number of hospital beds or producing more graduates, but on ensuring an adequately staffed, appropriately skilled and equitably distributed workforce. The ultimate measure of healthcare progress is not how many beds are sanctioned, but whether every patient receives timely, safe and quality care.



People leave their belongings on the floor to secure their places in the chemotherapy token queue at NICRH in Mohakhali. PHOTO: **ANISUR RAHMAN**

What outcomes can COP31 realistically deliver?



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The Conference of the Parties-31 (COP31) of the Climate Convention, scheduled for November 9-20 in Antalya, Türkiye, arrives at an uncomfortable moment for the climate regime. Ten years after the Paris Agreement, the political energy that built it has thinned significantly. Leadership is fragmented, finance remains contested, and the conference format itself is questioned. The question is no longer about COP31's success or failure, but what kind of politically negotiated result is most likely, and its ramifications for climate diplomacy in the coming years.

For the first time, this climate conference will have dual leadership: Türkiye will host the conference and be the principal actor in the non-negotiated Action Agenda, while Australia will be the President of Negotiations with authority to steer the process. It is an experiment in dividing the political, convening and procedural functions, usually concentrated in one host government.

The model has advantages. It lets Türkiye showcase implementation of its priorities in electrification, halving global waste generation and reducing energy intensity of buildings, promoting partnerships and business engagement, while Australia, backed by Pacific partners, concentrates on the grinding work of drafting and consensus-building. The Pre-COP meetings in Tuvalu and Fiji in October gave the process a Pacific legitimacy from small island developing states (SIDS). The risks are equally clear: ambiguity over who speaks for the Presidency in the final hours, divergence between the Action Agenda and negotiated text, and the temptation to claim successes and attribute failures to the other.

The COP31 context is sobering. An El Niño-influenced year, Europe's unprecedented heat for the fifth time in recent years, flash floods, rainstorms and typhoons ravaging the world. Such events shift domestic narratives, as disaster-stricken publics appear more receptive to positive actions. Yet extreme weather has repeatedly proved a weak driver of ambition; it raises rhetoric faster than commitments.

Additionally, the conference is taking place amidst the US's withdrawal from the process and Europe's reprioritisation of military and energy security, at the expense of climate security. Meanwhile, China is the largest emitter and the world leader in renewable energy, but its intended leadership role remains unclear. The result is a vacuum with no actor able and willing to pull the process forward, making the skill of the Presidency more decisive than ever.

There is a structural pattern in these United Nations Framework Convention on Climate Change negotiations. Until around 2017–2018, the regime's characteristic response to finance needs was the proliferation of funds, in the public, private and philanthropic sectors, in a very fragmented fashion. In the last few COPs, the proliferation has shifted to work programmes, expert committees, alliances, coalitions, partnerships and dialogues. These generate activity and reports, but hardly any substantive decisions.

This feeds a growing debate about reforming the COP format: limited, prioritised agendas, stronger linkage between formal negotiations and the Action Agenda, and clearer accountability for implementation. COP31 is unlikely to deliver a formal reform, but may issue a mandate through a set of presidency consultations. The dual-presidency format itself provides an unintended pilot, since it separates negotiation from implementation, as proposed by reform advocates.

The COP outcomes depend significantly on how a Presidency reads disparate interests and steers the process. Both Tü rkiye and Australia NDCs show positive trends in emissions reduction, which gives them credibility. Türkiye is also a member of the Coalition to Grow Carbon Markets and is likely to promote it as a business-friendly pathway. Australia, as a major fossil fuel exporter, now taking on the role of voice for Pacific SIDS, must balance domestic interests with the vulnerability narrative it carries from Tuvalu and Fiji. These interests will shape the texture of any deal, with a strong emphasis on adaptation and ocean issues that resonate with both hosts.

With more than two dozen agendas spread across several tracks, the plate is crowded and a handful of items might dominate the talks. The Mitigation Work Programme will test whether the "transition away from fossil fuels" language of recent years can be translated into anything operational. The climate finance work programme, including the interpretation of Article 9.1 of the Paris Agreement on developed countries' obligations, will reopen the argument over who pays and how much. Article 2.1(c), aligning all financial flows with low-emission, resilient development, is linked to Article 9, and developing countries will resist any reading that shifts responsibility onto them. Other issues that will be at the centre of discussion are: the Just Transition Work Programme, the New Collective Quantified Goal and its follow-up, adaptation finance and the Ocean agenda. The Presidency's challenge is to bridge these narratives without papering over the disagreements, perhaps by pairing a transparent accounting of past commitments with a more concrete delivery plan.

Based on the presidency pronouncements and Pre-COP Ministerial, several outcomes can be expected. First, COP31 may adopt a cover decision with language on implementation, adaptation, finance and just transition; establish or extend several work programmes; announce a set of priority Action Agenda partnerships; and leave the hardest questions on Article 9.1 and fossil fuel pathways for later years. Few will be delighted, and few will walk out.

Or, if the Presidency keeps the two tracks coordinated, builds trust with the SIDS and LDCs, with quiet backing from China and the EU, a credible adaptation finance roadmap and a clearer finance-for-mitigation linkage can be secured. That would require political capital in short supply.

Third, a visible split between the two presidencies could lead to disputes over Article 9.1, trade-related measures or the scope of just transition, blocking agreement on major items, producing a thin outcome and a heavy reliance on voluntary announcements. The Paris Agreement would continue to hold, but COP's credibility suffers further, strengthening calls for reform.

The most probable outcome of COP31 is an incremental outcome. Its success is more likely to be measured by the initiatives and commitments announced under the Action Agenda and by progress on climate adaptation and ocean-related issues than by major agreements reached through formal negotiations. Besides, the Presidency's choices in prioritising items, managing the dual role and handling the finance debate also matter more in a landscape marked by leadership vacuum and process fatigue. So, the Antalya experiment will be judged not only on its decisions but on whether a divided presidency can deliver a more disciplined and credible COP.

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