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Health Sector Problems in Bangladesh: *Developing a Management Point of View*

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Abstract

Purpose: This paper aims to critically examine the persistent service delivery failures in Bangladesh's health sector through a management lens, against the popular claim of budget shortage or inadequate resource allocation. **Research Design:** A multi-method qualitative design was employed, combining media content analysis, field visits, and citizen interviews. Data were gathered in two phases (2009–12 and 2021–24) to reveal recurring patterns. The study uses ethnographic observation, narrative inquiry, and analytical narratives to understand the nature and depth of management failures in the public health system. **Findings:** The longitudinal findings over more than ten years reveal widespread inefficiencies including chronic vacancies, mismatched deployment of health professionals and equipment, non-functional logistics, absenteeism, regulatory failures, and broken accountability mechanisms. These issues are not isolated incidents but recurrent patterns spanning over a decade. They illustrate that despite physical and infrastructural progress, service delivery remains undermined by the absence of strategic HR planning, weak operational systems, and poor governance. **Contribution:** The study underscores the need for a managerial transformation in public health governance. Based on health sector case, it contributes to the literature on public sector management in developing countries by emphasizing the importance of management capability over mere resource infusion.

Keywords: management in government; health sector management; bangladesh health system; human resource planning; qualitative case study; citizen experience

1. Introduction

This paper originated from a series of research focused on 'management in government' in Bangladesh where author argued that government of Bangladesh as an organization need to develop managerial approach both from top down or strategic angle or from bottom up view of citizens (Khaled, 2013; 2018). Using the media reports, field visits, and citizen interview, an earlier paper argued for education sector problems that those are management problems rather than budget shortage problem (Khaled 2023). Similarly, this paper focuses on health sector problems.

According to reports from the World Health Organization and other development partners, quantitative figures show Bangladesh has made notable progress on key public health indicators (WHO, 2015; Ahmed et al., 2015; Chowdhury et al., 2013). Though the exact figures vary across organizations like WHO, USAID, and DFID, there is consensus that Bangladesh has made commendable strides in basic health service coverage—particularly in immunization, child and maternal health, and life expectancy (World Health Organization, 2015; Ahmed et al., 2013). However, substantial challenges persist, such as low doctor-to-population ratios, under nutrition among children, and uneven access to quality care (Chowdhury et al., 2013; Ahmed et al., 2015). Across multiple reports, the quality of service delivery and the effectiveness of management systems have consistently been identified as key areas of concern, overshadowing the progress made in physical infrastructure and coverage (Haque et al., 2021; WHO, 2022).

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This paradox suggests that health sector performance is often undermined not by the lack of medical expertise or funding, but by weak planning, poor coordination, and insufficient accountability in service management.

Bangladesh has a health system predominantly governed by the public sector, with the Ministry of Health and Family Welfare (MOHFW) playing the central role in policy formulation, planning, and resource allocation. Under this ministry, key agencies such as the Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), Directorate of Nursing Services (DNS), and Directorate General of Drug Administration (DGDA) are responsible for service delivery at various levels (Ahmed et al., 2015). However, poor coordination, overlapping roles, and centralized control often delay implementation and reduce responsiveness at the local level (Osman, 2004; World Bank, 2010). Accountability remains weak, especially in upazila and district facilities, where local needs are often unmet due to bureaucratic rigidity (Martinez et al., 2011; Haque & Osman, 2021).

There are many reforms and projects in the health sector by Bangladesh government and international donors. While appreciating the right reforms, we need to continuously check and balance what all these mean at the citizen experience level. As we know, there are so many reforms that failed by design or by implementation, or produced too little result (Andrews, Pritchett, & Woolcock, 2017; Martinez et al., 2011). How can management in the health sector be improved where many health sector problems may not be health-related problems, but rather management-related ones (Haque & Osman, 2021; Lewis, 2006)?

With this central question, we conducted a qualitative inquiry by systematically reviewing national newspaper reports and conducting field visits to medical colleges and health centers across Bangladesh. Rather than focusing on frequently reported incidents, we intentionally selected diverse examples to reflect the broader range of systemic health service failures. The aim was not to statistically map the prevalence of specific problems across administrative regions (e.g., upazilas or districts) or health workforce categories (e.g., physicians, nurses, or equipment technicians), nor to analyze public perception through attitudinal surveys or factor analysis. Instead, our primary objective was to explore the type, scope, and recurring nature of service delivery breakdowns - especially those which we think is a matter of management (or lack of it). That means we looked for those problems that stem from weaknesses in public sector management rather than from medical or financial deficits (Haque & Osman, 2021; Andrews, Pritchett, & Woolcock, 2017; Khaled, 2023).

The remainder of this paper is organized as follows. Section two outlines the qualitative methodology used for this study, including case selection strategies, data collection techniques, and the rationale for combining secondary media analysis with primary field observations. Section three presents findings from the content analysis of newspaper reports collected in two distinct phases (2009–2012 and 2021–2024), highlighting recurring patterns of management failures in the health sector. Section four complements these findings with citizen narratives and field-based observations gathered during site visits to various healthcare facilities. Section five synthesizes these insights to provide a consolidated analysis of systemic dysfunctions from a management perspective. Section six offers policy recommendations to address the identified management gaps, while Section seven concludes by reflecting on the broader implications for public health governance and service delivery reform in Bangladesh.

2. Methods of Observations and Analysis

Since our objective is to understand in-depth, the nature of the problem, the qualitative approach was deemed appropriate (Creswell and Creswell, 2017; Bryman & Bell, 2011; Saunders, Lewis, & Thornhill, 2012). Case development is a particular type of qualitative approach where s*ystemically detailed examination* combines various methods of inquiry using multiple sources of evidence (Yin, 2018; Stake, 1995). Case study research is particularly valuable for developing in-depth understanding of complex issues within real-world settings, as it draws upon multiple sources and

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methods to construct a comprehensive view of the phenomenon under investigation (Yin, 2018; Stake, 1995; Creswell & Creswell, 2017).

In this study, the health sector of Bangladesh is treated as a **holistic case**, where various sub-instances across time and place were synthesized to analyze the broader pattern of public sector management failures. This method was more suitable than conventional health sector metric studies, which are already abundant from government and donor sources, but often fail to capture the operational realities on the ground (Ahmed et al., 2015; Buse, Mays, & Walt, 2012).

To understand the main problems in the Bangladesh health sector, both primary and secondary information was gathered from the ground.

Secondary: Leading newspapers were randomly selected and articles related to health sector were selected up to the point that all levels of health and problems are represented in the sample. This was done in two phases, 2009-12 and 2021-24 to see the recurrence of the same nature of the health sector problems. This longitudinal approach helped to capture persistent patterns of dysfunction, in line with qualitative content analysis strategies (Bowen, 2009).

Primary: An ethnographical approach was followed to understand the nature of the study problem. **Primary data** were collected through 'living is the setting' field visits, direct observation, and citizen interviews, to study how service failures are experienced at the point of care (Hammersley & Atkinson, 2007). Observations were conducted both on-site and off-site over extended periods (Marshall & Rossman, 2016).

Another important point to repeat here is that in such empirical, naturalistic, in-depth qualitative and field research, analysis is intertwined with observation (Yin, 2003; 2018; Creswell & Creswell, 2017); Charmaz, 2014). Thus, the following sections integrate observation, interpretation, and narrative to develop a management-oriented diagnosis of health sector problems in Bangladesh.

3.Analysis and Discussions: Secondary Sources

The data collected from secondary sources like recognized national dailies in two phases with a longitudinal time gap of 10-12 years.

First phase (2009-12)

The first phase covered the period from 2009 – 2012 having a sample of reports from the leading dailies. As it is known, in case of qualitative and analytical research like this, analysis is intertwined with findings.

1. Nurses missing in Medicare: Patients suffer for lack of nurses. Source: Daily Star, July 5, 2009

   Analysis: There is a mismatch between demand and supply of nurses, despite many unemployed female youth. The issue reflects poor HR planning and lack of forecasting in workforce development. A little planning in this case could go a long way.

2. X-Ray machines at health complexes inoperative for years Source: *Daily Star, July 7, 2010*

Analysis: This is one of the most frequently encountered examples of poor operational planning and overall inefficiency in health sector management. Machines lie idle due to absence of trained operators or maintenance. It is not corruption as most people quickly mentions, but a case of poor operational planning and waste of resources.

3. Drug Administration (DA) poorly equipped to detect spurious drugs. Source: *Daily Star, July 28, 2009:*

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Analysis: The regulatory body lacks adequate manpower and capacity, undermining drug monitoring. This situation reflects a fundamental weakness in the governance structure of the health sector. It raises critical questions about the regulatory capacity of the Directorate General of Drug Administration (DGDA): How can such an under-resourced institution effectively oversee a sector as vast and vital as pharmaceuticals? What benchmarks or standards guide its monitoring activities? And what provisions exist for strengthening its technical and institutional capabilities? This represents a clear case of neglecting foundational regulatory functions. In such a context, discussions about broader issues—such as the overall state of drug manufacturing and distribution—become premature and ineffective without first addressing these core deficiencies.

4. Civil Surgeons lose control over drugs. Source: *Daily Star*, *December 18*, *2009*

Analysis: To curb local-level corruption, the government centralized drug procurement by assigning the responsibility to the Central Medicine Store Depot (CMSD), thereby removing the authority previously held by civil surgeons to procure medicines directly from the state-owned Essential Drugs Company Limited. While this was a well-intentioned initiative by the Ministry of Health, it inadvertently shifted the potential locus of corruption from local to central levels. This case illustrates that good intentions alone are insufficient; without robust end-to-end accountability mechanisms, such reforms may merely relocate, rather than resolve, governance failures. It highlights the critical need for systemic management reforms to ensure transparency and effectiveness.

5. No waste management still in 70% city hospitals. Source: Independent, January31, 2010:

Analysis: Only a limited number of hospitals follow proper clinical waste management protocols. In contrast, many facilities dispose of medical waste indiscriminately in nearby dustbins. In some instances, informal traders engage street children or individuals with substance use disorders to collect this waste, which is then repurposed and sold to wholesalers. Additionally, in certain hospitals, cleaning staff themselves sort through clinical waste and sell it to these traders, further exacerbating public health and safety concerns. The incident reflects complete lack of priority and absence of regulatory enforcement.

6. Nine doctors drawing salary without attending hospitals! Source: *Prothom Alo*, *March 27*, *2010:*

Analysis: Doctors do not feel interested to attend their work area if it is outside Dhaka, Chittagong, and other city areas. Doctors are often absent from rural areas but continue to receive salaries. The system lacks effective monitoring and accountability mechanisms. Health officials do not even know the current status of posted doctors. This is a widespread, normalized form of absenteeism in the health sector. Such indiscipline is a serious failure of human resource governance, management, and monitoring system.

7. Power outages hamper treatment at hospitals Source: *New Age*, *April 8*, *2010:*

Analysis: There is a lack of clear protocols regarding the prioritization of critical services during power outages. Surgical procedures are often delayed or canceled due to frequent load-shedding and inadequate generator capacity. Decisions about which medical equipment should be supported by backup power, and under what conditions, fall under the purview of hospital-level operational management. In some cases, surgeons hesitate to proceed with operations out of concern that power

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may fail during the procedure. This reflects a serious deficiency—or complete absence—of operational guidelines and contingency planning within healthcare facilities.

8. Almost half of the posts for Doctors are vacant in Barisal Adhunik Sadar Hospital

   Source: *Jugantor, April 13, 2011:*

Analysis: Surprisingly, not a single doctor is available in the Medicine and Surgery department, and only one out of every three doctors is available for emergencies. It should be mentioned that the majority of patients require care from the medicine department. Long-standing vacancies disrupt emergency services. Recruitment delays are chronic. This shows poor execution of staffing plans. HRP (human resource planning) in the health sector is neither responsive nor realistic.

9. Hospital, Civil Surgeon office Vandalised in Jhenidah, Gaibandha-Unsuccessful candidates go berserk alleging irregularities in recruitment process Source: *Daily Star, October 3,2010*:

Analysis: Job seekers protested irregular recruitment and vandalized Civil Surgeon's office. Many alleged they paid bribes for guaranteed selection but were not selected. It is an example where problems seen at health sector is not at all related to doctors and nurses. It is an overall governance and public management problem of the country. But when it happens in health sector, people's life become vulnerable. This is a governance failure affecting institutional credibility. Health sector recruitment must be transparent and merit-based.

10. Hospital without gynecologist for long 29 years!! Source: *Prothom Alo, January 17, 2011*:

Analysis: The post of gynecologist in Moheshkhali Upazila Health Complex is vacant for long 29 years since its establishment. Being unable to find any gynecologist there, the patients need to go to distant city area of Cox's Bazaar. In case of emergency, the nurses treat the patients. Vacancies may take time to be filled. But the amount of time, 29 years, shows the absurdity of management in health sector. This shows extreme institutional apathy and example of systemic failure. Such long-term neglect reveals absence of oversight from higher authorities.

11. Posts vacant in the government hospitals, nurses remain unemployed. Source: *Prothom Alo, January 23, 2011*:

Analysis: Each year around 1000 students graduates from the nursing institutes across the country whereas the total demand of nurses in the government and private hospitals is around 1, 80,000. Despite shortages, thousands of trained nurses remain jobless. Meanwhile, hospitals use untrained aides. This paradox stems from poor coordination between training institutions and health employers. It is a total breakdown of demand supply management in health sector HR. Clear policies and recruitment pipelines are needed to bridge the gap.

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12. Messy Upazila Health Complex-Five posts vacant-Doctor absent for four years! Source: *Prothom Alo*, *February 1*, *2011*:

Analysis: Sonagaji Upazila Health Complex has nine sanctioned positions for doctors, of which five currently remain unfilled. One doctor remained on "leave" for four years without reporting. Civil surgeon could not confirm his status. This shows that leave and absence management is almost nonexistent. 'No monitoring system' leads to 'no accountability' leading to systemic inefficiency.

13. A total of 8507 posts are vacant in the Family Planning department. Source: *Prothom Alo*, *February 19*, *2011*

Analysis: Recruitment has been stalled for years in a key department like Family Planning under the health ministry. Field operations are paralyzed due to lack of manpower. Senior officials blame administrative corruption and political interference. Family planning is vital for national development. Its neglect shows absence of strategic priority and focus.

Khulna Medical College Hospital: Services not available due to manpower shortage. Source: *Prothom Alo, March 7, 2011*:

Analysis: Khulna Medical College started its journey in 1989 with 250 beds but later another 250 beds were added to tackle the increasing pressure of the patients. But unfortunately the number of doctors and other staffs has not been increased with that proportion. However, the number of doctors and support staff has not been scaled up accordingly. At present, the total workforce—including physicians, nurses, and auxiliary personnel—stands at only 350, against an estimated requirement of 855.This mismatch reflects planning failures. Expansion must be synchronized with staffing and budgeting.

14. No Health centers, but 43 doctors in Rajshahi!! Source: *Prothom Alo*, *April 6*, *2011*

Analysis: Doctors were posted to places without functioning health facilities. Some just rotate shifts or practice privately as there are nothing to do or nowhere to sit at their job location. Whereas, there are many health centers lacking doctors posted. Just like this, in numerous instances, significant public resource wastage occurs due to poor sequencing and misalignment of activities within government operations.

15. Doctor's assistant themselves became doctors!! Source: *Prothom Alo*, *July 1*, *2011*

Analysis: This situation reflects the weakness of the regulatory environment governing medical practice in Bangladesh. The Bangladesh Medical and Dental Council (BMDC), which is responsible for licensing and regulating medical professionals, appears to lack effective oversight mechanisms. As a result, numerous diploma-level technicians have begun using the title "Dr." without possessing valid registration from BMDC. Similarly, many dental assistants and technicians assume the "doctor" title and list unrecognized or unofficial degrees after their names. The limited enforcement capacity of BMDC creates ambiguity for law enforcement agencies, creating uncertain situation for taking appropriate actions against such unauthorized practices.

Second phase (2021-2024)

After twelve years of first phase, we collected a few random selection of health related media reports during 2021-2024[i]. They are presented below:

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1. **Over 350 posts for doctors, nurses vacant in Nilphamari**
   — *Dhaka Tribune, June 29, 2021*

   A total of 383 posts (131 doctors, 252 nurses) remained unfilled across Nilphamari's upazilas, severely affecting healthcare delivery during the pandemic.

2. **With doctor shortage, rural hospitals hang patients out to dry**
   — *The Daily Star, July 21, 2021*

   Over 6,000 physician posts at upazila hospitals remained vacant, exposing structural collapse in rural healthcare.

3. **Free facilities lie vacant as private hospitals fill up in Ctg**
   — *The Business Standard, July 8, 2021*

   A 70-bed free Covid-19 hospital in Chattogram was largely unused, while private facilities were overwhelmed—highlighting public-private coordination failure.

4. **Covid-19 exposes Bangladesh health sector shambles**
   — *The Daily Star, August 2, 2021*

   Over 35% of 131,103 public health posts were vacant; 50% shortfall in physician positions alone reflected systemic weaknesses.

5. **75% seats vacant in Dhaka hospitals as Covid infections eased**
   — *The Daily Star, September 4, 2021*

   Approximately 12,000 of 17,000 Covid-dedicated beds in Dhaka city hospitals remained unused despite prior surge investments.

6. **Beds, doctors crises make services scarce for KMCH patients**
   — *The Daily Star, October 6, 2022*

   Khulna Medical College Hospital operated with 81 out of 288 doctor posts vacant, affecting treatment quality despite expanded infrastructure.

7. **Almost half of approved posts in government medical colleges remain vacant**
   — *Prothom Alo, March 2023*

   2,605 out of 5,589 approved positions in government medical colleges were unfilled, including many senior teaching roles.

8. **Staff shortage hampers healthcare**
   — *The Daily Star, September 12, 2023*

   Tangail General Hospital faced critical shortages with 14 doctors and 73 other staff positions vacant, overburdening remaining personnel.

9. **A health complex in dire need of doctors**
   — *The Daily Star Editorial, February 28, 2024*

   Baniachong Upazila Health Complex had only 4 doctors in place of 17, with vacancies in gynecology, radiography, and pharmacy impairing service delivery.

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These headlines reaffirm the persistence of management failures in the Bangladeshi health sector, where recurring themes—vacancies, under-utilized infrastructure, inadequate planning, and poor coordination—continue to dominate even a decade after earlier reports. The point is again proved that health sector problems in Bangladesh are primarily management problems, not merely medical or budgetary ones.

4. Analysis and Discussions: Field visit and citizen observations

In addition to desk research based on recognized national media outlets, we conducted extensive field visits to several health complexes (names are not mentioned due to confidentiality of particular health complexes and KIs- key informants). We also interviewed patient citizens, onsite at health complexes and offsite elsewhere at convenience

Following is a sample of mismanagement of health care sector problems in citizen life:

- Lack of government initiative in monitoring price of medicine.
- Pharmacies selling illegal medicines is a rampant practice; mobile court operations are seen sometimes; welcomed by citizens but it is irregular and not sustainable. (Drug administration issue)
- Doctors prescribe those company medicines which maintain 'good' relationship with doctors.
- There is an unhealthy competition among pharmaceutical companies to push their medicines to doctors and ultimately to citizen patients.
- Medicine stores sell the medicines without any effective control and monitoring of drug administration and related authority.
- Mobile court of district administration is run suddenly on some days and some retail drug shop owners are punished on the spot for selling unapproved medicines. But there is no systemic mechanism of coordination among the district administration, police and concerned directorate.
- Shortage of doctors or nurses or medical assistants or technicians in different medical centers (Union level Community Clinics, Upazila Health complex, General Hospital)
- Diagnostic equipment like X-Ray machines, are out of order; repairing takes long time even for years; technologists remain idle.
- When machines are repaired, or new machines arrive, technologist's posts are vacant due to transfer or long process of recruitment. When machines and machine handling technologists are there, maybe doctors are not there.
- Doctors drawing salary without attending medical centers or work places.
- Doctors on deputation to district hospital; medical centers remain without adequate doctors.

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- Post vacant in the hospitals; nurses remain unemployed
- Doctors are posted into union medical sub center but there are no office logistics for their sitting or working.
- Using the title of 'Dr.' by untrained and unqualified person citizens going to them unknowingly. It is not clear to citizens how to check the qualification.
- First impression of a health complex is not healthy. Bad impression starts from premises. Patient waiting area, corridors, rooms are not kept tidy. They said, they continually have shortage of cleaning and support staffs.
- Medical officers are busy, consultants are not busy, surgeons are almost idle due to unavailability of medical logistics. Some consultants are deputed to district level hospitals or medical college hospitals to fill the gaps there or for post-graduate training.
- X-ray and other pieces of laboratory equipment are either out of order, or films are in shortage, or technologist post is vacant. So due to lack of any one component of service system, patients have to go to external private lab or clinic for diagnostic tests as prescribed by medical officers and consultant doctors.
- Ambulance is there, driver post is vacant, if driver is there, fuel budget is not allocated. If fuel is there, driver is not there. If everything is there, ambulance is out of order due to maintenance problem. So Ambulance remain idle and driver remain without any work.
- Union health centers are in name only, doctors can hardly go there and sit there because most health centers do not have bare minimum logistics facility for a doctor or even a SACMO (sub-assistant community medical officer) to provide a package medical treatment of patients.

Upazila Health and Family Planning Officer (UH&FPO) is almost helpless because he neither can dictate the consultant doctors who are more qualified by education and post-graduate qualifications, nor he can fill the vacant positions of doctors, medical technologists, or other support staffs according to his need instantly. For filling up the posts to run the health complex as a system, he has to wait for long government recruitment procedures. In the meantime, patient cannot wait and citizens loose the trust on the system. So, the system is there but it does not work at no fault of UH&FPO and or doctors.

5. Consolidated Analysis and Discussion

Medical challenges—such as disease outbreaks or a shortage of trained specialists—are often cited, but deeper examination reveals that even available resources are misaligned or underutilized due to managerial dysfunction. Similarly, while low health budgets are a concern, numerous examples show that existing funds are wasted or fail to translate into service delivery due to poor planning, delayed recruitment, lack of accountability, and mismanagement of logistics. For instance, diagnostic machines remain idle not because of budgetary constraints, but due to the absence of trained technologists or maintenance oversight.

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Doctors complain that they do not have sufficient work environment and living condition in Upazila and even some district level hospitals. Also they say that there are not minimum facilities for their children's education and other social facilities. Citizens complain they do not get service oriented mentality from doctors. Doctors give necessary and unnecessary diagnostic tests and medicines. There are good doctors but negative impression is very dominant.

About medicine, we have a very good drug policy that enabled Bangladeshi pharmaceutical companies excel and even export to international market. But within the country citizens are at the mercy of the pharmaceutical companies combined with weak law enforcement for illegal and outdated medicines. Effective monitoring and controlling mechanism is absent due to poor management control and coordination from Drug directorate and law enforcement mechanism.

Hospitals lie empty while patients flood private clinics, not because there are no buildings or equipment, but because of personnel misallocation and weak service integration. Vacant posts coexist with thousands of unemployed nurses due to weak HR planning and broken recruitment pipelines.

These are problems that reside in how the 'health system' is organized, governed, and led — the core concerns of management. Therefore, to truly reform and improve health outcomes, attention must shift from merely increasing funds or medical capacity to redesigning and strengthening the management systems that determine how healthcare resources are planned, deployed, and held accountable.

6. Policy Implications: Addressing the Management Gap in Health Sector

The persistent nature of service failures in the Bangladeshi health sector—reflected in repeated headlines over the past decade—underscores a crucial insight: the primary challenges are more non-medical in nature, nor are they simply about insufficient funding. Rather, they reflect deep-seated management failures that cut across planning, coordination, implementation, and accountability functions. Following is a set of policy recommendations based on the above analysis and discussion. The categories presented *(strategic human resource planning, operational systems and service integration, regulatory and institutional governance, performance monitoring and management capacity building)* addresses core dimensions of the management failures identified in the study.

1. Strategic Human Resource Planning

A. Integrated human resource planning (HRP) should be introduced to align the supply of health workers with the actual demand across different locations and levels of care.

B. Real-time HR databases can be utilized to monitor the availability, attendance, and deployment of doctors, nurses, and technicians.

C. Strategies aimed at rural retention should be developed, encompassing hardship allowances, housing provisions, educational support for families, and career incentives.

D. A merit-based and transparent recruitment system needs to be established to eliminate irregular hiring practices and to restore institutional credibility.

2. Operational Systems and Service Integration

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A. End-to-end operational protocols should be created to integrate infrastructure, staff, logistics, and service delivery, ensuring the simultaneous availability of machines, technologists, and doctors.

B. Key operational decisions ought to be decentralized to functional management units at district and upazila levels, with clearly defined authority and accountability.

C. Facility expansion, such as the addition of beds, must be accompanied by proportional increases in staffing and operational budgets.

3. Regulatory and Institutional Governance

A. The Drug Administration should be strengthened through enhanced staffing, targeted training, and the implementation of digital systems to monitor drug quality, pharmacy operations, and illegal sales.

B. The mobile court system requires regularization and expansion via coordinated efforts among district administration, police, and the Directorate General of Drug Administration.

C. Licensing and monitoring of medical practitioners must be rigorously enforced, including measures to prevent the illegal use of the “Dr.” title.

D. The Bangladesh Medical and Dental Council (BMDC) should be empowered to take decisive action against quackery and fraudulent medical practices.

4. Performance Monitoring and Management Capacity Building

A. A transition from routine compliance to performance-based accountability systems is needed, incorporating regular monitoring of absenteeism, service quality, and patient feedback.

B. Digital attendance tracking and biometric systems can be introduced to support more effective monitoring of presence and performance.

C. A trained cadre of public sector health managers at middle and facility levels should be developed through specialized education in health management.

D. Citizen satisfaction and service responsiveness may be included as key indicators in the evaluation of health facilities.

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By embedding these reforms within a coherent **management-centered approach**, health sector governance can shift from reactive firefighting to proactive service delivery. Without such a realignment, medical and financial investments will not be effective in terms of producing desired citizen outcomes.

7. Conclusions

There is a management problem at system level in the health sector. Top level management – ministries, secretariats, and DG health has little understanding of nuances of the system and incentive mechanism of bottom level upazila health complex and union health centers. The persistence of recurring failures in Bangladesh's health sector—across both time and geography—demands a strategic shift in policy focus: **from medical inputs and budgets to management systems and accountability**.

There are clearly visible signs of progress in health sector in terms of indicators, physical investments, vaccination programs, and even strategic documents. Said that however, there is a need to be critical about what is missing on the ground at the bottom, where citizens interact with health system on a day to day basis. It is sometimes said in popular media that budget should be increased in health sector. But our core argument from the analysis above is increasing budget will not solve the nature of the problems of Bangladesh health sector. There should be a significant 'management' reforms or improvement of the whole system of resource allocation, incentive system and enabling environment.

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