

GISWatch
10th Edition

GLOBAL INFORMATION SOCIETY WATCH 2016

*Economic, social and cultural rights
and the internet*



ASSOCIATION FOR PROGRESSIVE COMMUNICATIONS (APC)
AND INTERNATIONAL DEVELOPMENT RESEARCH CENTRE (IDRC)

Global Information Society Watch

2016



Global Information Society Watch 2016

Economic, social and cultural rights and the internet

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This work was carried out with the aid of a grant from the International Development Research Centre (IDRC), Ottawa, Canada, as part of the APC project “A rights based approach to internet policy and governance for the advancement of economic, social and cultural rights”.

More information at: <https://www.apc.org/en/projects/internet-rights-are-economic-social-cultural-rights>



APC would like to thank the Swedish International Development Cooperation Agency (Sida) for its support for Global Information Society Watch 2016.



Published by APC and IDRC

2016

Printed in USA

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Global Information Society Watch 2016 web and e-book

ISBN 978-92-95102-70-5

APC-201611-CIPP-R-EN-DIGITAL-260

BANGLADESH

ICTS, HEALTH RIGHTS AND HEALTH FINANCING MODELS IN BANGLADESH



KEYWORDS: **health**

Bytes for All Bangladesh

Partha Sarker and Munir Hasan

www.bytesforall.org

Introduction

The United Nations General Assembly on 16 December 1966 adopted the International Covenant on Economic, Social and Cultural Rights (ICESCR), a multilateral treaty that came into effect in January 1976. It enshrines the economic, social, and cultural rights (ESCRs) of individuals, including the right to an adequate standard of living, the right to an education, labour rights and the right to health. The covenant currently has 160 parties as signatories. Bangladesh ratified the covenant in October 1998. This report focuses on the right to health in Bangladesh in the context of accessibility and affordability. It looks at how information and communications technologies (ICTs) enable a health financing model in support of the implementation of the right to health.

Government health policy

Article 12 of the ICESCR, referring to the right to health, calls on state parties to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” including “conditions which would assure to all medical service and medical attention in the event of sickness.”¹ These conditions, outlined in the comments and subsequent discussion, have been taken to include “economic accessibility”, i.e. health facilities, goods and services must be affordable for all. Payment for healthcare services has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.²

The Bangladeshi constitution refers to ESCRs in Part II, where the rights are described as “fundamental principles of state policy”. The constitution says: “It shall be a fundamental responsibility of the state to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people with a view to securing to its citizens: a) the provision of the basic necessities of life, including food, clothing, shelter, education and medical care.”³ However, Article 8(2) of the constitution specifies that these principles “shall not be judicially enforceable” – in other words, they are not legally binding.⁴

Since the declaration of Bangladesh as an independent state in 1972, the government has focused on primary health care and family planning services, particularly for the rural poor. It has achieved some successes in this. For example, the infant mortality rate has come down from 92 per 1,000 live births in 1990/91 to 38 in 2014. Maternal mortality has come down from 574 per 100,000 live births in 1990/91 to 170 in 2013, with a sharp increase in the percentage of births attended by skilled health personnel (from 5% in 1990/91 to 42.1% in 2014).⁵ With increased access to healthcare facilities, immunisation, nutrition and overall economic development, the average life expectancy in Bangladesh has gone up by around three years, from 67.2 years in 2009 to 70.4 years in 2013.⁶ Most importantly, the gender gap in life expectancy at birth – so prevalent since the country’s independence – has completely disappeared in recent years.

In the absence of a formal health policy, all health-related planning and programming in

1 www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

2 National Human Rights Commission, Bangladesh. (2012). The International Covenant on Economic, Social and Cultural Rights: A Study on Bangladesh Compliance. nhrc.portal.gov.bd/sites/default/files/files/nhrc.portal.gov.bd/page/348ec5eb_22f8_4754_bb62_6a0d15ba1513/International%20Covenant%20on%20Economic%2C%20Social%20and%20Cultural%20Rights%20a%20study%20on%20Bangladesh%20Compliance.pdf

3 Constitution of Bangladesh. bdlaws.minlaw.gov.bd/pdf_part.php?id=367

4 Waheduzzaman, M. (2014). Economic, Social and Cultural Rights Under the Constitution: Critical Evaluation of Judicial Jurisprudence in Bangladesh. *Bangladesh Journal of Law*, 14. www.biliabd.org/article%20law/Vol-14/M.%20Waheduzzaman.pdf

5 UNDP. (2015). *Millennium Development Goals: Bangladesh Progress Report 2015*. www.bd.undp.org/content/bangladesh/en/home/library/mdg/mdg-progress-report-2015.html

6 Bangladesh Bureau of Statistics. (2013). Report on Sample Vital Registration System 2013. www.bbs.gov.bd/WebTestApplication/userfiles/Image/LatestReports/MSVSB_Report_2013.pdf

Bangladesh was guided by the sections dealing with the health sector included in the country's Five Year Plans.⁷ The first National Health Policy of Bangladesh was approved by parliament only in 2000; it was revised in 2011 to reflect the principle that every citizen has the basic right to adequate healthcare.⁸

The government is constitutionally obliged to ensure healthcare for its citizens, and both availability and affordability of medical services are addressed in the policy, foregrounding the issue of equity in health financing. The policy deals with health insurance for employees in formal sectors, and the provision of free medical and health services to poor and marginalised population groups using government resources. The policy highlights the need to maximise the innovative and best use of information technology for the development of the health sector and to ensure healthcare to all.

It encourages local innovative models for health services and talks about an Integrated Management Information System (IMIS) with a computer network extending across the country to support the implementation and monitoring of the policy action plans. The use of "smartcards" for previously underserved groups to enable them to access health services efficiently is also part of the implementation plan.

Health financing solutions

To support the implementation of the health policy, the government's Health Economics Unit announced the Health Care Financing Strategy 2012-2032, which "provides a framework for developing and advancing health financing in Bangladesh." According to the strategy, "The framework and its direction are aimed at increasing the level of funding for health, ensuring an equitable distribution of the health financing burden, improving access to essential health services, reducing the incidence of impoverishment due to catastrophic health care expenditures and improving quality and efficiency of service delivery." The strategy aims to reduce out-of-pocket expenditure from 64% to 32% of total health expenditure, to increase government expenditure on health from 26% to 30%, to increase social protection from less than 1% to 32%, and to reduce dependence on external funds from 8% to 5%.

One of the core aims of this strategy is to provide universal healthcare coverage in Bangladesh by 2032.

The strategy includes three key interventions:

- Design and implement a social health protection scheme, called Shasthyo Surokhsha Karmasuchi (SSK),⁹ with some aspects focusing specifically on those living below the poverty line.
- Strengthen financing and provision of public healthcare services, such as through the use of results-based financing and the scaling up of a demand-side financing programme.
- Strengthen national capacity to design and manage the social health protection scheme, including in financial management and accountability.

The strategy divides the population into three categories:

- Around 47.5 million people who are below the poverty line will receive publicly financed healthcare through a free health protection scheme.
- Around 83.4 million people who are engaged in the informal sector will be under different health financing schemes, including publicly financed health care, community-based health insurance initiatives, and micro-health insurance.
- Around 20.5 million people who are in the formal sector can receive publicly financed healthcare, and can subscribe to other private healthcare coverage and/or social health protection schemes.

The SSK provides a "smartcard" to households qualifying for the benefits. The card includes the names of dependent members in the household. Each household receives benefits for up to BDT 50,000 (around USD 1,000) per year. The health cards provide access to local hospitals and other relevant services. The cards are connected to a database with patient details that can be accessed at SSK centres.

Hospitals treat SSK patients according to standard guidelines¹⁰ and claim reimbursements from the scheme operator based on the designated fees

7 For more on the Five Year Plans, see: www.plancomm.gov.bd

8 National Health Policy of Bangladesh 2011. www.mohfw.gov.bd/index.php?option=com_content&view=article&id=74&Itemid=92&lang=en

9 www.heu.gov.bd/shasthyo.php

10 The treatment guidelines help to calculate and standardise the reimbursement to the hospital. Reimbursements follow a case and diagnosis-based payment system, which will be gradually refined. See: sskcell.gov.bd/PDF/home.pdf

attached to the benefit package. All patient records are maintained electronically, and accounting, claim processing and disbursement happens online, using a mobile network linking SSK, the scheme operator and the local hospital, for efficiency and transparency.

Prior to establishing the SSK model, demand-driven health financing models were already in place in Bangladesh. For example, initiated in 2007, a government-led Maternal Health Voucher Scheme targeted poor women with the aim of providing better maternal health services by reducing financial burdens. The scheme provided eligible women a voucher that entitled them to a package of three antenatal check-ups, safe delivery care in a health facility or at home, and a small gift box. Among voucher recipients, safe infant delivery rates were an impressive 89% compared to 40% in institutional deliveries in 2012.¹¹

Some innovative initiatives have also been launched to try and test locally managed health financing models in small communities. The following examples are worth mentioning.

The Benapole Municipality in Jessore District has introduced a health financing model to provide free health services to its senior citizens (aged 60 and over) who otherwise cannot afford to bear the cost of those services. As part of this model, more than 1,000 senior citizens living in the area have been given smartcards. This gives them access to healthcare facilities and services including examinations and diagnoses by doctors and prescription drugs provided for free or at a nominal cost. Patient records are verified by accessing a database using the smartcard and a fingerprint reader. Our visit to the hospital in the district revealed that the hospital's server is connected to the doctor's office, the emergency unit and the medical diagnosis centre, so that information and instructions from one unit can be accessed by another unit. A good number of patients visit the hospital regularly to access different healthcare services.

The Uzirpur Upazila Health Complex¹² in Barisal District has also introduced a health financing model servicing more than 1,000 patients from extremely poor population groups, including landless people, people with disabilities and the elderly.

The patients are given a smartcard to access different health services, including examinations and diagnoses and free prescription drugs. Their medical details are stored on a database. Patients are verified using secure web-based software and are notified of appointments and of any change in prescription drugs or the treatment procedure via mobile phone text messages. The Upazila Health Complex manages the programme.

The SSK model of health financing is also being piloted in three different local hospitals: the Kalihati, Ghatial and Modhupur Upazila Health Centres in the Tangail district of Bangladesh. Patient registration is captured in a database, and there are plans to distribute smartcards to patients.

Conclusion

Bangladesh has invested “considerable resources in strengthening its management information systems using ICTs,” seeking to ensure that all *upazila* (sub-district) health complexes have access to computers and wireless modems for internet access, and anticipating that the information management system will “use all possible ICT equipment” as a means to gather, channel, process and distribute health information.¹³ Most of the government-run *upazila* health complexes and district hospitals now have mobile phone-based health service call centres where users can call for free 24/7 and get medical advice from a doctor or registered nurse over the phone. A recent study has identified 26 different e-health and m-health initiatives in Bangladesh that are mostly working on delivering health services or managing health information.¹⁴

However, health sector financing in Bangladesh continues to face three main challenges: the inadequate allocation of funds for health; inequity in access to health services because of inadequate financing mechanisms; and an inefficient use of existing resources. In general, Bangladeshi public health expenditure patterns appear to be regressive – allocating more resources to richer districts than the poorer ones.¹⁵ The World Health Organization

11 Ahmed, S., & Khan, M. (2009). *A maternal health voucher scheme: What have we learned from the demand-side financing scheme in Bangladesh?*

12 *Upazila* is a geographical region in Bangladesh used for administrative or other purposes. They function as sub-units of districts. https://en.wikipedia.org/wiki/Upazilas_of_Bangladesh

13 Ministry of Health and Family Welfare (MHFW). (2008). Health Bulletin 2008. Dhaka: Government of the People's Republic of Bangladesh, Management Information System (MIS), Directorate General of Health Services (DGHS).

14 Ahmed, T. et al. (2014). eHealth and mHealth initiatives in Bangladesh: A scoping study. *BioMed Central*. bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-260#CR35

15 Islam, A., & Biswas, T. (2015). *Health System Financing in Bangladesh: A Situation Analysis*.

recommends a minimum per capita health expenditure of USD 54, but this currently stands at USD 27 in Bangladesh. According to Ravi Rannan Eliya, director of the Sri Lanka-based Institute for Health Policy, universal health care consists of two things, “access to healthcare” and “risk protection” – health care should not make people poorer. “On that outcome Bangladesh is bad,” he said, “[because of] the low level of public spending.”¹⁶

The SSK is a step in the right direction to ensure the right to health for marginalised and vulnerable groups. The use of smartcards and a centralised database are key to this solution – and although the state has not yet attained its 2032 targets, it is currently rolling out pilot models. Nevertheless, a national database of electronic records of patient information along with the digitisation of hospitals and capacity building would be a mammoth task. These pilot initiatives still need to be scaled up in other locations to understand the challenges faced by a national roll-out.

Action steps

Bangladesh needs to take several steps to strengthen the current approach to securing the right to health:

- The government must significantly increase its public funding for health to strengthen the equitable distribution of resources, with a special strategic focus on the poor.
- The government needs to invest heavily in ICT-based health infrastructure to move e-health initiatives beyond the pilot stage. E-health strategies should include smartcards for health services, the digitisation of hospitals, and giving people access to medical services using mobile phones.
- Civil society needs to be more directly engaged in evidence-based research and advocacy in building up the case for health financing to secure the right to health. Currently there is little engagement by civil society on this issue.

¹⁶ Hasib, N. I. (2015, 15 January). Per capita health spending rises in Bangladesh, but concerns remain. *bdnews24.com*. bdnews24.com/health/2015/01/15/per-capita-health-spending-rises-in-bangladesh-but-concerns-remain

Economic, social and cultural rights and the internet

The 45 country reports gathered here illustrate the link between the internet and economic, social and cultural rights (ESCRs). Some of the topics will be familiar to information and communications technology for development (ICT4D) activists: the right to health, education and culture; the socioeconomic empowerment of women using the internet; the inclusion of rural and indigenous communities in the information society; and the use of ICT to combat the marginalisation of local languages. Others deal with relatively new areas of exploration, such as using 3D printing technology to preserve cultural heritage, creating participatory community networks to capture an “inventory of things” that enables socioeconomic rights, crowdfunding rights, or the negative impact of algorithms on calculating social benefits. Workers’ rights receive some attention, as does the use of the internet during natural disasters.

Ten thematic reports frame the country reports. These deal both with overarching concerns when it comes to ESCRs and the internet – such as institutional frameworks and policy considerations – as well as more specific issues that impact on our rights: the legal justification for online education resources, the plight of migrant domestic workers, the use of digital databases to protect traditional knowledge from biopiracy, digital archiving, and the impact of multilateral trade deals on the international human rights framework.

The reports highlight the institutional and country-level possibilities and challenges that civil society faces in using the internet to enable ESCRs. They also suggest that in a number of instances, individuals, groups and communities are using the internet to enact their socioeconomic and cultural rights in the face of disinterest, inaction or censure by the state.

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