Bangladesh pharmaceutical policy and politics

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An analysis of the politics of Bangladesh pharmaceutical policy in the 1980s shows how significant health policy reforms in developing countries depend on political conditions both inside and outside the country. Bangladesh’s drug policy of 1982 illustrates that governments can sometimes change public policy in ways unfavourable to multinational corporations, while the failed health policy reform of 1990 shows that reforms unfavourable to powerful domestic interest groups can be more difficult to achieve, even contributing to a government’s downfall. The case provides evidence of basic changes in how the international agenda for health policy is set, especially the growing role of non-governmental organizations in international agencies and national policy debates. Understanding the political patterns of policy reform in Bangladesh has important implications for strategies to affect health policy in developing countries.

Introduction

In the past decade, Bangladesh has received considerable international attention for its national pharmaceutical policy. The policy was rapidly introduced in 1982 as a major reform and achieved immediate recognition for its radical objectives. The policy was hailed by some observers as innovative and courageous, and was assailed by others as repressive and counterproductive. Then, in the late 1980s, the same national government failed in its efforts to introduce a new health policy, contributing to the regime’s downfall in 1990 and leading to the drug policy’s subsequent review and possible revision.

The Bangladesh experience illustrates several patterns in the political economy of health policy in developing countries. It shows how significant reforms depend on political conditions both inside and outside the country — an intersection between domestic and international political economies. Second, the case shows that governments can sometimes achieve public policy changes that are unfavourable to multinational corporations, but that policies unfavourable to powerful domestic interest groups can be more difficult to achieve, even contributing to a government’s downfall. Third, the case provides evidence of fundamental changes in how the international agenda for health policy is set, especially the growing role of non-governmental organizations in international agencies and national contexts. Understanding these political patterns of policy reform in Bangladesh has important implications for strategies to affect health policy in developing countries.

Pharmaceutical problems in Bangladesh

In the early 1980s, Bangladesh ranked as the world’s second poorest country, with average per capita income of US$130, and with about 95 million people in a land area of 144 000 square kilometres,1 giving it the highest population density in the world. About 90% of the population lived in rural areas, with illiteracy at 70% of the adult population. Persistent health problems were reflected by an infant mortality rate of 110 per 1000 live births.

At the same time, Bangladesh confronted multiple problems in its pharmaceutical system, similar to those found in many developing countries. The problems affected all aspects, including consumption, prescription, distribution, production, and government procurement.

From the perspective of consumption, a large portion of the Bangladesh population had limited access to modern drugs, with estimates varying from 30% of the population2 to 85%.3 In 1981, the national market consisted of about US$75 million in allopathic drugs, less than 0.1% of the total world drug market4 for about
1.9% of the world’s population. These figures indicate that the Bangladesh market represented a tiny share of global pharmaceutical sales, suggesting that most multinational drug firms did not put much emphasis on it in their corporate strategies. The figures, however, underestimate the level of consumption of pharmaceuticals per capita in Bangladesh, compared to other countries, unless corrected for cross-national price differences.5

In the early 1980s, the market in Bangladesh included about 3500 brands of pharmaceuticals,4 with various problems in the patterns of pharmaceutical consumption. A market survey for 1978 was reported to show that about one-third of the total value of drug consumption was accounted for by ‘vitamins, iron tonics, cough and cold preparations, “tonics and restoratives”, “volume restorers”, enzymes and digestants, antacids and psychotropic drugs’.6 One of the few population-based studies of pharmaceutical consumption in Bangladesh showed 57 purchases per 1000 people per week in a rural community (Matlab), with antibiotics the most frequently purchased category (28OJo); 95OJo of consumption occurred from pharmacy purchases. This study reported that antibiotics were ‘rarely obtained in the correct dose and they were often prescribed for illnesses or age groups for which they were not indicated’.7 In addition, patients consumed these products with little information on proper usage or contraindications.

Problems also existed in the distribution system, with distinct differences between the public and private pharmaceutical systems. In the public system, drugs were free but not widely available, while in the private system drugs were more readily available but not affordable for perhaps half the population. According to an international evaluation, the primary health care system in Bangladesh provided only about 10OJo of the needed drugs and covered only ‘a small fraction’ of the rural population.2 The range of public sector problems included: poor logistics and storage, problems in the motivation and supervision of health workers, inadequate drug budget, leakage into the private system, poor diagnostic and therapeutic skills of health workers, and a low overall government health budget (about US$1 per person in the early 1980s). According to a 1990 government report,9 ‘Free health care has in reality amounted to NO health care while doctors are known to divert patients to private clinics with which they are often directly connected’ (emphasis in original). The report stated that even when public hospitals had stocks of medicines, patients were commonly asked to purchase products from nearby private pharmacies because of economic connections between doctors and the pharmacies.

Inadequate supplies in government facilities were due in part to drug costs. One study found that drugs represented a high-cost input for medical services compared to labour, and that drug costs substantially reduced the public sector’s price advantage over the private sector.5 For a government clinic to supply the desired level of drugs would require the approximate equivalent of salaries for two paramedics for one year.

In the private sector, most dispensing was done by drug sellers at the 14 000 licensed pharmacies.
In the early 1980s, maximum retail prices were declared guidelines of Government to provide set by the Ministry of Commerce rather than the basic needs of life to the majority of the people Ministry of Health, but with little effective enforcement of price controls at the retail level. Bangladesh thus had no effective public controls through the production and/or importation of over drug prices or dispensing practices in the private market.

Pharmaceutical production also presented problems. Among developing countries, production capacity varies from those with no manufacturing capacity at all, especially in Africa, to those with some domestic formulation (such as Kenya and the Dominican Republic), to those with an ability to produce most intermediates, export drugs, and carry out research and development (including Egypt, Indonesia, Brazil, Argentina, Mexico and India). In the early 1980s, Bangladesh belonged to the middle category of countries with some capacity for formulation but with little else. Eight multinational firms manufactured 75% of all products (by value), 25 medium-sized local companies produced an additional 15% of the market, and 133 small companies were responsible for the remaining 10%. The government provided no effective quality control supervision for local manufacturing processes or for final products sold on the market. In the early 1980s, Bangladesh imported about US$30 million of raw materials and about US$12-15 million of finished drugs.

Finally, problems existed in government procurement practices. The high percentage of imports placed a high demand on the government health budget and on the limited foreign exchange available. These limitations created conflicts in allocating scarce government resources for drugs versus other expenditures, among various drugs, and between imported versus domestic drugs.

The drug policy
On 27 April 1982, Bangladesh’s new military government formed an Expert Committee on Drugs, consisting of eight members. Two weeks later, on 11 May, the committee presented its report, with 16 criteria unanimously agreed upon as guidelines to reorganize the country’s pharmaceutical sector. While ‘keeping in view the health needs of the country’, the report stated its overall objective as follows: ‘Consistent with the declared guidelines of Government to provide basic needs of life to the majority of the people through austerity and to improve the economy of the country, wastage of foreign exchange through the production and/or importation of unnecessary drugs or drugs of marginal value have to be stopped’.

The report then appended a list of drugs to be removed from the market, based on the committee’s evaluation of all registered and licensed pharmaceutical products manufactured and imported in Bangladesh. This report became the basis of the new national policy.

The Bangladesh Drug (Control) Ordinance of 1982 was issued soon thereafter, on 12 June. The policy applied WHO’s concept of essential drugs to both private and public sectors for pharmaceuticals in Bangladesh (an essential drugs list had been used since 1978 for procurement by the government’s Central Medical Stores). The policy’s basic strategy was to exclude all non-essential drugs from the country, rather than to promote essential drugs in the public sector while allowing the coexistence of a broader private market. The policy created a restricted national formulary of 150 essential drugs and 100 specialist drugs, with 12 at the health post level, 45 for primary health care, and the full list at tertiary hospitals. The act banned about 1700 drugs from production or sale in three categories: 299 harmful drugs that were to be destroyed within three months; 127 drugs that required reformulation within one year, due to unnecessary, unscientific or harmful ingredients; and 1240 drugs that did not conform to the 16 basic principles and had to be withdrawn within 18 months.

The ordinance also included measures to promote local manufacture and to restrict foreign firms within Bangladesh. For instance, if products were produced by local firms, multinationals were not allowed to import similar drugs. The policy also imposed restrictions on transfer prices, requiring that they be similar to international competitive prices.

Bangladesh’s new drug policy arose within a particular political context. On 24 March 1982, Lieutenant-General and Army Chief of Staff HM Ershad had overthrown the government and seized power, declaring martial law later that day. To explain his actions, Ershad declared that ‘economic life has come to a position of col-
lapse, the civil administration has become unable
effectively function, wanton corruption at all
levels has become a permissible part of life...[the] law and order situation has deteriorated to
an alarming state...[and there has been] bickering for power among the members of the ruling
party. Ershad convened his expert committee on
drugs about four weeks later.

A key architect of the new drug policy was Dr
Zafrullah Chowdhury, hero of Bangladesh's
independence war, a recipient of the Ramon
Magsaysay Award, and a grassroots develop-
ment worker. In 1972, Dr Zafrullah had founded
the Gonoshasthaya Kendra (or People's Health
Clinic) outside Dhaka to provide home health
services to the rural poor through village-level
female health workers, with support from several
UK-based agencies, including War on Want,
Christian Aid and Oxfam, and from NOVIB, a
Dutch donor. Then, in 1979, with external aid
and loans from Bangladesh banks, he established
a company to produce essential drugs for
primary health care at low prices. Under
the government of President Ziaur Rahman
(1975-1981), Dr Zafrullah pushed for a national
pharmaceutical policy based on essential drugs,
but without success.

Ershad's rise to power created favourable
political conditions and incentives for the enact-
ment of a new pharmaceutical policy. First, the
policy embodied a populist strategy of basic
needs (through reduced prices of essential drugs)
to appeal to Bangladesh's rural poor, who con-
tinued to be bypassed by development efforts
despite nearly US$13 billion of aid funds com-
mitt ed in the country in the first decade after in-
de p endence in 1971. In addition, the drug
policy created a political alliance with one sector
of local industry and with a number of promi-
nent left intellectuals, symbolized by Dr
Zafrullah's reputation as a development activist
and a freedom fighter. Even some individuals
who opposed the Ershad government, such as the
President and Secretary General of the Dhaka
University Teachers Association, publicly an-
nounced their support for the drug policy.

The policy articulated a vision of self-reliance
and priority provision of basic national needs and an
attitude of proud defiance against the multi-
nationals - a stance of economic nationalism.
Finally, the policy generated international
legitimacy through its support by international
agencies and non-governmental development
organizations (NGOs).

The new drug policy received an immediate and
hostile response from the pharmaceutical in-
dustry. Domestic firms in the Bangladesh phar-
maceutical industry association (Bangladesh
Aushad Shilpa Samity, or BASS) purchased full-
page advertisements in the Bangladesh press to
oppose the drug policy. International firms did
the same, arguing that the new policy would
disourage foreign investors, would result in
more harm than good for public health, and
would not achieve the goals of increased
availability of medicines. Ultimately, the interna-
tional industry argued, the policy would result in
decisions by companies to halt all pharma-
ceutical production, including that of essential
drugs, and to leave Bangladesh. Attacks on the
drug policy continued from The Pulse, a medical
newspaper in Bangladesh, which denounced the
policy as 'unimaginative, ill-conceived and
hasty', releasing 'evil forces' in the market, put-
ting additional burdens on the common man,
'delaying recovery from diseases' and 'prolong-
ing suffering of the patients'.

Pressure on Ershad's government also came
from foreign governments, which asserted that
the policy would discourage private investors
from entering or staying in Bangladesh. Ambas-
dassadors from the United States, West Ger-
many, the United Kingdom, and the Netherlands
individually visited the Health Minister and the
Chief Martial Law Administrator to express their
displeasure. In addition, the US ambassador
helped to arrange for a visit of experts from the
Pharmaceutical Manufacturers Association and
from companies in July 1982. The importance of
foreign aid in Bangladesh (providing about 80%
of the government's development budget in the
early 1980s) gave these official complaints addi-
tional significance for the new government.

The Bangladesh Medical Association (BMA)
quickly emerged as a vocal opponent to the new
drug policy. The BMA reportedly agreed with
the policy's ultimate objectives but not with its
formulation process, criticizing the committee's
lack of consultation with the BMA. The BMA
criticized the methods used to review all drugs
on the market in a two-week period and also attacked the involvement of foreigners from NGOs in design of the drug policy. According to Dr Zafurullah Chowdhury, however, one person in Ershad’s expert committee on drugs (Humayun KMA Hye) was also a member of the BMA’s pharmaceutical subcommittee, and the other subcommittee member was consulted in the formulation process, although the General Secretary of the BMA was not officially consulted because of his connections with a multinational pharmaceutical company. Following these conflicts, the BMA refused to discuss the policy’s implementation after its announcement in June 1982.

The World Health Organization and international consumer groups, on the other hand, praised the drug policy. WHO Director-General Halfdan Mahler supported the policy during a visit to Dhaka in September 1982, stating, ‘I take this opportunity of congratulating our host country on its courage in starting to put its drug house in order along the lines recently endorsed by the World Health Assembly’. International consumer groups provided more active and consistent support for the policy. In 1986, the International Organization of Consumers’ Unions published a document that commended the drug policy and the government leader who supported it, ‘General Ershad of Bangladesh is one of the few leaders to have acted on this international consensus of health experts’. Praise came as well from international medical journals, especially *Tropical Doctor* and the *Lancet*.

While the Bangladesh government persisted with the main thrust of its drug policy, some changes were introduced in response to complaints and pressure from industry and foreign governments. Soon after adopting the policy, the government established a Review Committee of six military doctors who submitted their report in August 1982. Although never made public, the report apparently criticized several aspects of the drug policy. Subsequently, the government made a number of concessions to industry in formal amendments to the policy, which included: permitting some banned products back on the market, extending the time periods for implementation, introducing an appeals process, and altering the list of allowed products.

**Accomplishments of the drug policy**

Evaluating the Bangladesh drug policy is not easy, due to the heated controversy that arose nationally and internationally. Various organizations, including the Bangladesh government, foreign industry groups, international agencies, and consumer groups, have published reports that evaluate the policy and its consequences. While these reports have differed on many points, they also agreed on a number of specific accomplishments and problems. This section, and the following, identify areas of agreement among these evaluations as a method of assessing the policy’s consequences.

For consumption, the drug policy had two important and immediate consequences. First, it eliminated the importation, sale, and production of drugs declared to be dangerous or useless. While groups differed in their assessment of the costs (and desirability) of removing so many drugs from the market, most groups agreed that the policy succeeded in achieving this goal to a large degree.

Second, the policy reduced the cost of essential drugs within Bangladesh (with savings to consumers, government, and foreign exchange reserves) by decreasing import prices and the value of imported finished products. Significant control was achieved over increases in drug prices during the 1980s. Overall retail prices of drugs rose by only 20-25% between 1981 and 1991, due primarily to two factors: controls over transfer prices and sources of raw materials, and increased competition among manufacturers. Responsibility for setting maximum retail prices for drugs shifted to the Drug Administration, and some prices increased (reflecting the Taka’s depreciation) while others declined (reflecting decreased material costs).

For production, the policy succeeded clearly in promoting domestic production and in promoting essential drugs production within Bangladesh. Nationally owned companies produced 35% of all drugs (by value) in 1981, rising to a high of 67% in 1988, then declining to just over 60% in 1989 and 1990. Similarly, essential drugs rose to nearly 80% of all local production (by value) in 1990 (for 73 items), up from 30% in 1981 (for 45 items) (see Figure 1).
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All groups agreed that the new drug policy provided a great boost to the local pharmaceutical industry. The Bangladesh pharmaceutical industry association even reversed its initial opposition to the policy, and in 1986 purchased newspaper advertisements in support of the policy when the Ordinance was being considered for ratification by Parliament. Even though 145 local firms had a total of 864 products banned by the policy, the industry adapted to the new local circumstances (and new benefits). The value of locally produced drugs (in Taka) nearly doubled between 1981 and 1986, with an average growth rate of about 14% a year throughout the decade. One local company reportedly increased its production 60 times between 1981 and 1985. UNICEF supported local production through its local tenders purchasing products for Drugs and Dietary Supplement Kits, even though costs were somewhat higher than international procurement through UNIPAC (due in part to UNICEF tax exemptions) and despite some problems in quality control of the product and packaging, and in the capacity of local companies to fill orders on time.

The new policy also had important trade and foreign exchange consequences. The value of imported final products remained more or less constant in local currency (see Figure 2) and declined in dollar value (from US$17.5 million in 1981 to US$8.9 million in 1990). Imports of raw (and packing) materials rose, however, from US$35.5 million in 1981 to US$51.7 million in 1990, reflecting the local industry’s restriction mostly to formulation and its continued high dependence on foreign supplies.

In sum, the local industry gained a much larger share of the domestic pharmaceutical market, and by the mid-1980s wanted to protect that new share and protect the return on investments made to produce essential drugs. In 1991, the top three firms in pharmaceutical sales were all Bangladeshi-owned, in contrast to 1981, when the top five firms in sales were all multinational corporations. The economic benefits of the drug policy to the Bangladesh private sector created an important source of political support for the policy’s continuity.

Conditions also improved in the government’s procurement procedures. As part of the drug policy, responsibility for local tendering shifted from the Ministry of Commerce to the Central Medical Store and a new system was established for reviewing and deciding on tenders. About 70% of government procurement came from the parastatal Essential Drug Company Limited, with the remainder through open tender.

Internationally, the Bangladesh drug policy achieved political importance far beyond its economic significance. For some consumer groups, the policy represented what should be done in all countries to control the private sector,
especially multinationals, for pharmaceuticals and other products as well. For the international pharmaceutical industry, the policy represented what should not be done in any country, especially the adoption of an essential drugs list for the private sector. And for the WHO, the policy represented concern that public controversy with the private sector in specific countries could affect the organization's international credibility, particularly with major financial contributors such as the United States.

Problems with the drug policy

For consumption, major problems remained in access to pharmaceuticals that appeared on the allowed list. A sympathetic evaluation of the drug policy by WHO, DANIDA (the Danish aid agency) and SIDA (the Swedish aid agency) in 1984 concluded: 'The new policy has . . . not yet significantly improved the availability of essential drugs to those most in need.' In 1988, a government representative publicly stated in a WHO publication that problems in access remained. A sympathetic evaluation in 1992 stated that public sector health facilities still confronted acute drug shortages, due to governmental budgetary constraints, limited revenues at health facilities, and inadequate supply control systems. Problems also existed in completely removing banned products from the market, both over the counter and, more commonly, under the counter. A report by the International Organization of Consumers' Unions recognized the existence of a black market in banned drugs, but stated that this problem appeared to be in decline.

The Chairman of the Expert Committee, Dr Nurul Islam, responded by pointing out the lack of scientific basis for the criticism and by noting the common availability of all sorts of banned consumer goods in Bangladesh. No authoritative study seems to have been carried out to assess whether smuggled drugs have increased or declined since 1982, although industry sources claimed that these increased as a result of the drug policy, and the Bangladesh-India border is notoriously porous. (Experience in other countries with products banned as useless or dangerous suggests that if a product is banned while a strong demand persists, then smuggling is likely to increase, especially if effective border controls do not exist.)

Problems also persisted in prescribing patterns. Even when patients were correctly diagnosed by a physician, they still often received inappropriate prescriptions. These prescribing patterns were related to continuing problems in the availability of scientific information and in the incentive structure of the dispensing system, neither of which was changed significantly by the drug policy. According to informal reports, some physicians continued to prescribe banned
drugs and would direct patients to specific private pharmacies where smuggled products were sold at inflated prices. The persistence of inappropriate prescribing habits also resulted from the government's reluctance to introduce public education and physician education programmes on 'rational' prescribing, and from the BMA's resistance to incorporating such programmes in medical education. The controversy that erupted over the policy's formulation contributed to problems associated with its implementation.

Prescribing patterns based on appropriate medical practice also created problems of access to some specialized drugs not on the allowed list. Examples of such products were diagnostic dyes used in cardio-catheterization and specific products for diabetes or cardiovascular diseases. In some cases, doctors doing specialized procedures directly sold the products at high prices. In other cases, economically well-off individuals began importing their own drugs through informal channels.

Reflecting these problems in access and prescribing, an essential drugs project (sponsored by DANIDA and SIDA) was initiated in the early 1980s to improve the processes of getting 'good' products to needy people, by building up the distribution system, improving quality control, and changing prescription behaviour in the public system. However, the project was halted in the late 1980s at the government's request because it was perceived as externally imposed and not integrated into government systems, and therefore not politically acceptable in Bangladesh. UNICEF is currently implementing a similar project, called Improvement in Drug Management, which is intended to support the drug policy's objectives, with particular attention to problems of access in the public system and problems of prescribing patterns.

Different groups also agreed that problems persisted in the quality of pharmaceutical products available in Bangladesh, such as the inadequate control of traditional medicines. The number of manufacturing units for traditional medicine increased sharply in the 1980s and various Ayurvedic medicines of questionable value persisted in the market. Stricter controls over drugs considered useless and harmful in the allopathic sector may have contributed to an increase in products of dubious quality in the traditional medicine sector. On the other hand, the drug policy represented the first official regulatory control of traditional medicines in Bangladesh, including the development of registration criteria.

Problems in quality control among pharmaceutical producers have been reported by various sources. Manufacturers were reported to have inadequate quality control facilities, with outdated or nonfunctioning equipment. DANIDA and SIDA reported that some local producers, especially the small-scale manufacturers, 'are without any quality control system'. Problems were also reported of spurious drugs that resembled banned products in name and packaging. In one tragic case, a local company used a poisonous chemical, diethylene glycol, to sweeten pediatric paracetamol syrup, resulting in acute renal failure and the death of over 250 children. In addition, serious problems have been found in tetanus vaccine produced in Bangladesh, including reports of no potency in three consecutive lots, lack of records on distribution, and no national control authority to certify vaccine safety or potency; in 1992, tetanus vaccine production was suspended and the immunization programme returned to the use of imported vaccine. These production quality problems could reflect a trade-off in the implementation of the drug policy, between increasing local production and maintaining product quality, as well as a trade-off between price and quality for products manufactured by small companies.

Various evaluations concurred that the government has not exercised effective quality control over producers, due in part to weak organization of the Drug Administration. This government agency was responsible for the regulation of drug manufacturers and the drug market, yet it had only 35 inspectors for the entire country in 1992. The introduction of a limited national formulary, reducing the number of products for analysis and simplifying the analytic procedures (since, for example, combination drugs were not allowed), should have resulted in some improved efficiencies in the Drug Administration but, overall, it did not receive sufficient capacity-building to administer the drug policy fully and effectively.
Finally, problems occurred in the implementation of key regulations of the drug policy. Controversy arose in the Drug Control Committee over whether the policy was intended to restrict registration to a limited number of essential drugs as an exclusive list or to provide preferential treatment to essential drugs while allowing registration of other ‘non-essential’ drugs. This controversy led to legal action that challenged the restrictive interpretation of the registration policy and contributed to administrative delays in drug registration and appeals. Administrative problems also occurred in the implementation of price controls. In one survey, actual market prices were found to exceed the official prices in Dhaka by 10-30%, with even higher prices in more remote areas. These price control mechanisms also resulted in complaints from drug manufacturers about inadequate profits, administrative delays in responding to rising material costs, and inequities between large and small producers with different quality products.

Bangladesh’s experience illustrates several lessons about pharmaceutical policy. First, it shows that pharmaceutical policy combines health policy and industrial policy, often with conflicting objectives, as has been shown for other countries. The Bangladesh drug policy probably succeeded more clearly as industrial policy, in promoting the economic condition of local manufacturers through a hidden subsidy, than as health policy, where its impact on improving the health status of the local population has been ambiguous and difficult to measure. Questions could also be raised about its success as industrial policy, considering the quality problems of domestically produced drugs and the overall strategic desirability of promoting the pharmaceutical industry versus, say, the textile industry in Bangladesh. Second, the experience supports two propositions about the use of state power in pharmaceutical policy: that it is easier to exclude ‘bad’ products than to get ‘good’ products to people, especially in rural areas, and that it is hard to get rid of all ‘bad’ products on the market, especially when a strong demand continues from prescribers and patients. Finally, the experience shows how improvement in pharmaceutical policy can be limited by the existing health system and health policy. Indeed, increasing awareness about these constraints contributed to efforts at broader health system reform in Bangladesh.

From drug policy to health policy

In late July 1990, the government of General HM Ershad proposed a new health policy that promised radical changes in Bangladesh’s health system. The proposed policy emerged from a four-member committee established in February 1987 called the Health Care System Improvement Committee, which included Dr Zafrullah Chowdhury of Gonoshasthaya Kendra. A separate committee, formed under the additional secretary of the Ministry of Health and Family Planning, was also convened in the late 1980s to consider a national health and population policy for Bangladesh, including 17 members with a representative from the physician’s association. After discussion at the Cabinet level in 1990, the report from this second bureaucracy-based committee, which apparently recommended mostly incremental changes, was ‘suppressed’, while the report from the Improvement Committee, which advocated more transformative changes, was selected as the basis for a national health policy. The Improvement Committee’s approach to health policy was adopted even though some ministers (according to later reports) were concerned that strong resistance could develop.

The health policy proposal, as presented to Parliament and published in the press, sought to ensure preventive and curative health care for all citizens and make the public health system more accountable at all levels. The policy specified 16 objectives, with particular attention to the provision of health care, sanitation, nutrition, and family planning services for the most disadvantaged groups in society. The document then proposed 14 structural changes in the organization of the public health system including: free services for the most vulnerable groups and graduated fees for the better off; a new system of medical audits to improve accountability for medical stocks and funds, and to evaluate the work of medical personnel; plus a decentralization of the health system, with full authority at the local, district and regional levels for enforcement. The document’s third section, with 13 measures on manpower, proposed a ban on private practice by all academic staff and...
junior doctors (with various benefit increases as compensation) and limited private practice for Senior and Chief Consultants.

Ershad's political objectives for his health policy resembled those for his drug policy. He was seeking to: a) win support for populist proposals that would help the poor of Bangladesh, as an important material and symbolic constituency, to achieve international recognition from progressive consumer and development groups; and b) to reform the health system so as to improve health care and also make the drug policy more effective. Ershad may also have been seeking to implement a decentralized health system to establish his political party (Jatiya Party) in grassroots organizations and thereby allow him to hold on to power. He had tried a similar strategy with the legal system, without success.

But efforts to introduce the new health policy brought unintended political consequences that contributed to the resignation of Ershad's government. When Ershad announced the new policy in a television speech in July 1990, the BMA declared an 'instantaneous strike' for 72 hours and soon thereafter extended the strike to 15 August. The BMA demanded that the government withdraw its policy proposal and declared that if the government did not comply then all government doctors would resign on 15 August. In response to this threat, a compromise was reached to form a committee to review the proposal.

In the autumn of 1990, protests against the government continued, building on two years of opposition activity. Street protests by student groups broke out on 10 October, increasing violence throughout urban Bangladesh, with rising military and police repression of political opposition, resulting in scores of deaths (figures range from less than 30 to more than 100). During this period of disruption, several offices of the Gonoshasthaya Kendra were burned down, perhaps in reaction to Dr Zafrullah's association with Ershad. Then, on the morning of 27 November, the joint secretary of the Bangladesh Medical Association, Dr Shamsul Alam Khan Milon, was killed, which galvanized strikes by doctors in Dhaka and elsewhere. That evening, Ershad imposed a national state of emergency in the midst of strikes by journalists, lawyers, doctors, teachers, road transport workers, and civil servants. The opposition then called an indefinite strike (hartal) from 2 December. The next day, senior army personnel forced Ershad to resign, rather than resort to widespread military repression.

The attempt at health policy reform contributed to Ershad's downfall for various reasons - in sharp contrast to the drug policy reform which seems to have strengthened Ershad's regime. First, in 1990, the Bangladesh government confronted increasing domestic and international pressures on both economic and political issues, while in 1982, when the drug policy was enacted, Ershad was at the start of his rule and hopes were strong that he might bring order to Bangladesh and promote development.

Second, the proposed health policy affected the privileges, powers, and income of the medical establishment more directly than the drug policy did. The health policy had important economic implications for those doctors who depended on substantial income from private practice, which helped mobilize the BMA into active opposition against Ershad; at the same time the policy alienated younger doctors who worked at the Upazilla level, proposing to make them accountable to the Upazilla chairman. The comprehensive health policy thus managed to antagonize all segments of the medical profession, without creating a core group of physician supporters. The drug policy, on the other hand, created opposition from multinational corporations that sustained economic losses (even though most foreign companies continued to operate in the growing Bangladesh market), but it also created support from domestic companies that reaped great benefits (and coopted their initial opposition to the policy).

Third, in 1990, Ershad confronted an unstable political situation, from eight years of accumulated enemies. Various factions in the student movement joined together in their opposition to Ershad and provided an increasingly mobilized resistance with growing support from the professional middle class. The BMA's alliance with this growing coalition against Ershad contributed to the legitimacy of the movement. The combination of economic
distress, political instability, and increasing interest group mobilization persuaded the military to withdraw its support from Ershad.

The interim president who replaced Ershad was the country's Chief Justice, and the president of the Bangladesh Medical Association ranked among the six key advisors in the interim government responsible for the health portfolio. Among the interim president's first official actions was to repeal the proposed health policy, the main concern of the BMA. The health advisor subsequently instituted a committee to review the drug policy and also initiated a committee to investigate Gonoshasthaya Kendra. Following Bangladesh's parliamentary elections on 27 February 1991 (which one member of the NGO observer team called 'successful free and fair elections'), a new government was installed.

The new government continued to give the drug policy official scrutiny, and on 4 March 1992 established a 15-member review committee, including multinational and national commercial interests but no consumer representatives. Domestic pressure to revise the drug policy came from the Bangladesh national industry, which sought to loosen or remove price controls on drugs. External pressure also increased, not only from multinational firms but also from a World Bank unit, which in April 1992 sought to persuade the government of Bangladesh to revise its drug policy in a more market-friendly direction, through deregulation, by removing price controls, import controls, and product limitations. UNICEF, on the other hand, sought to support the drug policy's main objectives and structure.

In November 1992, the policy review committee submitted a revised draft policy to the government for review. Then in mid-January 1993, representatives from traditional medicine systems (Homeopathic, Unani and Ayurvedic) challenged the policy process in court for excluding them from the review committee and for recommending a separate drug policy for traditional medicines. The Bangladesh High Court subsequently decided to suspend the review committee. Although no decision was reached about the 1982 policy, observers expected that some revision was still likely.

**Conclusions**

Bangladesh’s contrasting experiences with its drug policy in 1982 and its health policy in 1990 illustrate a number of lessons about health policy reform in developing countries.

First, the cases show how the health policy agenda in Third World countries is increasingly shaped by an interaction of domestic and international political forces. Ershad’s introduction of the drug policy required consideration of both domestic and international factors. In order to achieve his domestic political goals, he had to risk antagonizing the international pharmaceutical industry and several Western governments. His domestic goals included populist political objectives (providing lower priced drugs for the poor), economic political objectives (winning support from the domestic pharmaceutical industry), symbolic political objectives (creating the symbol of an external enemy), and broader legitimacy (gaining domestic and international recognition for his innovative policy).

To achieve these objectives, Ershad collaborated domestically with the respected development pioneer and freedom fighter, Dr Zafrullah Chowdhury. Dr Zafrullah’s collaboration, in turn, gave credibility to Ershad within the international development community. The choice of a national essential drugs policy gave Ershad’s government high visibility at the World Health Organization, where the topic had become a major issue in 1981 with the formation of a special programme reporting to the Director-General and with a dynamic leader seeking to implement the policy in developing countries. The WHO programme had close ties with DANIDA, which was working in Bangladesh on pharmaceutical issues. The Bangladesh drug policy also connected with an international network of consumer groups that came together in 1981 as Health Action International ‘to promote the safe, rational, and economic use of pharmaceuticals worldwide’. Finally, the multinational pharmaceutical industry felt defensive on essential drugs issues in the international arena, which gave the Bangladesh policy heightened visibility around the world. In short, Ershad’s decision to enact a drug policy in 1982 responded to positive political incentives on both domestic and international levels.
A second important lesson of the Bangladesh experience is how political conditions can create opportunities for health policy reform. The drug policy reform shows that it is possible for a poor country, under certain political conditions, to exercise significant leverage over multinational corporations and impose severe regulatory controls, despite the many relative weaknesses of poor countries compared to these firms. National public interests, defined by the government in power, can sometimes take precedence over multinational private interests. Ershad could introduce the drug policy by declaration, because of his position as Chief Martial Law Administrator, and could implement the policy quickly, because of his relatively strong control over Bangladesh government and society at the start of his regime. This high degree of power, however, often declines over time. Subsequent bargaining and negotiation can loosen the restraints (as Ershad did in the summer of 1982), while the development of strong domestic constituents (the private drug sector in Bangladesh) can prolong a policy’s existence. In the long term, policy reforms may be reversed, since foreign companies may be reluctant to leave and may wait (and work) for a change in government or a change in policy (as seemed likely in Bangladesh in 1993). Drastic policy reforms created by political conditions are susceptible to redesign and reversal by subsequent political changes.

Third, the case shows the political limits of seeking radical changes in policy, illustrated by the failure of the proposed health policy. The new health policy posed serious economic and power implications for physicians at a time when Ershad was much weaker politically and economically. The Bangladesh Medical Association became actively mobilized in seeking the policy’s reversal and Ershad’s removal. This example supports the generalization found in rich countries that a government can change the method of paying physicians only when the physicians agree. The case raises the question of whether Ershad could have passed a different version of his health policy reform if he had adopted another strategy - through greater collaboration rather than sharp confrontation with the BMA. The contrasting examples of the drug policy and health policy illustrate the importance for policy makers of carrying out systematic political assessments of proposed decisions to strengthen the probabilities of enactment and implementation.

Fourth, the case of Bangladesh’s drug policy reflects the expanding role of NGOs in shaping national and international policy agendas in the health sector. From the early 1970s, networks of non-governmental organizations have grown internationally and have assumed more influence in international agencies and national contexts. Examples include the movement for accountability on pharmaceutical products and essential drugs, as well as activities on infant formula, pesticides, other banned and restricted products, and hazardous waste exports. Policy issues are no longer decided solely through interactions among governments or between different sections of national or international organizations. The NGO international networks are affecting many policy decisions, and the new influence is generating unease within international agencies, private corporations, and national governments. The Bangladesh case illustrates how, under one set of political conditions, a national NGO leader with international linkages gained significant influence in policy formulation (for both drug and health policies), and how such influence declined (with some backlash) when political conditions changed with Ershad’s downfall.

Fifth, the Bangladesh case of health policy reform raises broader questions about the relationship between health policy and political change. In Bangladesh, a military dictator used pharmaceutical policy in order to create political support and regime legitimacy from international organizations and domestic constituencies. An authoritarian regime adopted what were internationally recognized by some groups as desirable policies and used them as ‘soft options’ to garner both domestic and international support. The case illustrates that health policy reform can produce political success without necessarily leading to health success. Indeed, the effective implementation of progressive drug policies may not be possible without more fundamental structural changes in the health system; and seeking those changes can help undermine the political stability of a strong state or even a military dictator.

The Bangladesh case suggests that some policies considered desirable from a public health
perspective may be most effectively implemented by governments with strong state control. An ethical question for public health professionals is whether to work with repressive governments to improve health policies, if the policies will contribute to the government's political stability and thus to the continuation of repression. What level of health benefit justifies collaboration with repressive regimes? Conversely, weak states may find it difficult to introduce and implement policies that would redistribute resources in the health sector to more vulnerable and politically powerless groups. A comparative analysis of pharmaceutical policy reform supports the importance of strong states and suggests that the feasibility of reform depends critically on political conditions, especially political timing and political management of group competition. These factors assisted policy reform for the military coup government in Bangladesh, but also for the democratically elected government in Sri Lanka and the regime brought to power by popular revolt in the Philippines.

Finally, this analysis points to a number of issues, particularly demand and distribution problems which deserve consideration in the ongoing review of pharmaceutical policy in Bangladesh. The selling activities of small drug shops need greater policy attention, including possible incentives and sanctions to encourage appropriate prescription and sales behaviour. The prescribing patterns of physicians and other health-care workers could be addressed through such measures as changes in medical education, medical audits, and postgraduate education outreach. Consumer protection groups could be strengthened, through NGOs, to promote the education of both prescribers and consumers of pharmaceuticals in Bangladesh. The distribution of essential drugs to rural areas could be enhanced through incentive systems and cost-effective procurement. Also, while it may be controversial, innovative ways could be sought to address the consumption desires of the middle class for specialized drugs not on the allowed list but still considered within appropriate medical practice, for example, through the introduction of high duties and prices for non-list drugs, which could then be used to subsidize the distribution of essential drugs to the poor, as a form of progressive taxation.

Designing and implementing policies to address these persistent problems in Bangladesh will require complex negotiations with the interests involved: the national and international pharmaceutical companies, the medical profession, the drug sellers, the NGO community, the government bureaucracy, and the international donors. The challenge emerges as much from problems in identifying the substance of an appropriate pharmaceutical policy as it does from problems in constructing a process that will bring the diverse groups together in agreement.

Endnotes

a The original lists of 45 essential drugs for PHC included 15 products for village health care and 30 products for Upazilla level care. In 1987, the Upazilla list was increased to 58, for a total of 73 essential drug PHC products. Unfortunately, it was not possible to obtain production statistics for a single set of products (such as the original 45 PHC drugs) for the entire time period, resulting in an inconsistent definition of essential drugs for PHC in Figure 1 and probably inflating essential drug production value and percentage after 1987.

b For example, according to anecdotal reports, some products banned by the 1982 drug policy were subsequently manufactured by traditional drug companies and sold in retail pharmacies along with allopathic products.

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