Review article

Healthcare Financing in Bangladesh: Challenges and Recommendations

Hassan MZ[1], Fahim SM[2], Zafr AHA[3], Islam MS [4], Alam S[5]

Abstract:

Bangladesh has achieved remarkable success in improving most of the health indicators over the last couple of decades despite pervasive economic poverty. However, for a sustainable growth health sector should be among the top lists at Government's policy table. Unfortunately, the recent trend in budget allocation portrayed just the opposite and is concerning as expressed by health experts. Over the last seven fiscal years, budgetary allocation for health dropped from 6.2% to 4.3% of total government expenditure. Due to insufficient public spending, out of pocket payment (OPP) is much higher which is about two-third (64.7%) of total health care spending in Bangladesh. Inadequate and inefficient public healthcare and profiteering tendency of the private healthcare sector are two major factors behind such high private spending. Suffering from a massive shortage of health workforce and with such low public funding it would be very difficult for Bangladesh to fight against upcoming challenges like increasing burden of non communicable diseases (NCDs) and emerging threats due to climate change.

Keywords: Healthcare Financing; Health Budget; MDGs; Universal Health Coverage; Bangladesh

Bangladesh Journal of Medical Science Vol. 15 No. 04 October'16

Introduction:

Bangladesh has made substantial progress in most health indicators over the last two decades[1]. Under-5 child mortality decreased significantly from 144 to 41 per 1,000 live births [2, 3] maternal mortality rates have dropped markedly by 66 per cent (194/100,000 live births) and life expectancy jumped to nearly 70 years at birth[4]. Two years back, one of the most prestigious medical journals, the Lancet, published a case-series on Bangladesh's massive success in health and termed it a great mystery in global health[5]. Lancet stated that, despite spending less on health care than other neighboring countries, Bangladesh now has the longest life expectancy, the lowest total fertility rate, and the lowest infant and under-5 mortality rates in South-Asia[5, 6]. Bangladesh is among the only six countries that are on track to achieve MDGs [7].

But much still remains to be done. Still nearly 40% of children whose ages are under five in Bangladesh are stunted and 35% are under weight[8]. One out of every 24 children dies before their fifth birthday, 60 percent of those within the first 28 days of life, many from conditions which would have been easily treatable if they had access to a skilled health workers[9]. Therefore, to sustain the development that Bangladesh has achieved and to get to a middle income status by 2021, health should be given high priority. But unfortunately, in recent years, the health budget reflects just the opposite picture. The sector remains extremely neglected in the budget allocation

1. Md. Zakiul Hassan, Crescent Gastroliver and General Hospital, Dhaka, Bangladesh
2. Shah Mohammad Fahim, Lecturer, IBN SINA Medical College, Dhaka, Bangladesh
3. Abu Hena Abid Zafr
   Crescent Gastroliver and General Hospital, Dhaka, Bangladesh
4. Md. Shoriful Islam, Assistant Professor of Finance, Department of Business Administration, Northern University Bangladesh
5. Shahinul Alam, Associate Professor, Department of Hepatology, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka, Bangladesh

Corresponds to: Md. Zakiul Hassan, Crescent Gastroliver and General Hospital, 25/i, Green Road, Dhaka-1205, Bangladesh. Email: drzakiulbd@gmail.com

of the government. It is unanimously recognized that public spending on health must be increased for achieving the MDGs in developing countries like Bangladesh[10]. However, budgetary share of health sector is going down every year threatening the future of post-MDG goals. The aim of this review is to highlight the healthcare financing features of Bangladesh, identify the potential challenges to achieve sustainable development goals for the country.

Healthcare Financing Features:

In practice, the government of any country has a prime responsibility about the development of health facilities as well as medical system which should be applied through allocating a significant percentage of total expenditures in health sector. Unfortunately, the yearly allocation in Bangladesh is far short of required level set by World Health Organization (WHO) which is at least 15% of total budget of a country[11] . Figure 1 shows the scenario of health allocation in percentage of total expenditure in last seven fiscal years in Bangladesh.

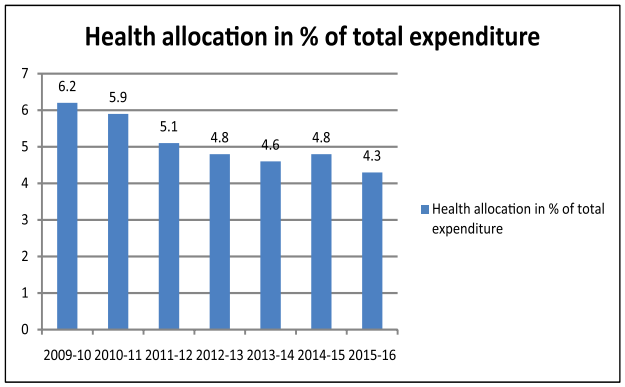

Figure 1: Health expenditure in Bangladesh as a % of total government expenditure during 2009-2016[12, 13]

According to the above mentioned diagram, it can be said that during last seven years, Government health care spending in proportion of total public spending has decreased gradually. Moreover, the fund allocation was decreased with time whereas population as well as different type of new diseases increased within the same time period. In fiscal year (FY) 2009-10, the allocation for health was 6.2% of total budget which dropped to 4.3% in 2015-16 FY[12, 13].

The total health spending in Bangladesh is 3.7 percent of GDP whereas in developed countries, the health sector constitutes nine percent of the total GDP[14]. Figure 2 shows health expenditure in total % of GDP in neighboring countries.

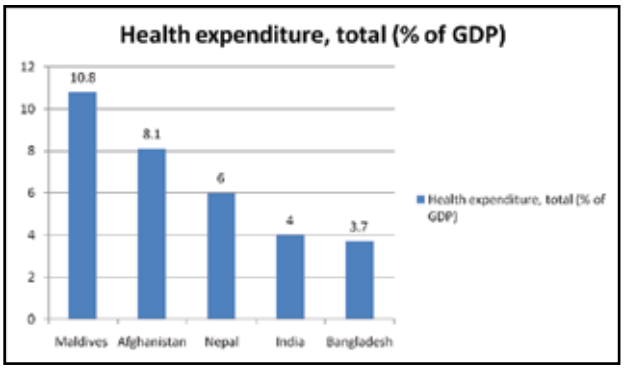

Figure 2: Health expenditure in Bangladesh in total % of GDP[14]

Health spending can be compared with the total GDP and it is remarkably noted that Bangladesh is clearly behind among some other Asian countries in this aspect. From the presented figure, it is observed that Maldives hold the top position and their health expenditure is 10.8% of total GDP. In this case Bangladesh is in lowest position and India use slightly higher percentage than us which is 4%.

The total amount of budget allocated for health in this fiscal year is BDT 12,726 crore[15]. Though the amount is a BDT 1,157 crore hike from the outgoing fiscal year's allocation[16], the sector's share in the total budget has declined 0.51 percent[15]. We can also compare the per capita expenditures for health purpose. Table 1 shows the per capita health spending in neighboring countries.

Table 1: Per capita health spending (in USD) [17]

Country	Per capita health spending (in USD)
Srilanka	102
Bhutan	90
India	61
Afghanistan	55
Nepal	39
Pakistan	37
Bangladesh	32

Bangladesh's per capita health expenditure is $32, which is the lowest in the region compared to India, Afghanistan, Nepal, Bhutan, Pakistan and Sri Lanka[17]. However, the spending is more than three times higher for Sri Lanka and nearest to double in India. WHO recommends a per capita spending of $54 [11]. The government allocation is 700 taka per person per year or 1.92 taka per person per day[18]. With ever increasing health care cost, one can easily realize to what extent the allocated money could help.

The public spending on health is currently only 35.3%, almost one third of total health care spending[19]. In developed countries the picture is just opposite. Table 2 shows the government spending in health in some developed and neighboring countries.

Table 2: Public health expenditure (% of total health expenditure) [19]

Country	% of total health expenditure
Norway	85.5
Japan	82.1
Thailand	80.1
Netherlands	78.8
Canada	69.8
Malaysia	54.8
Sri Lanka	43.9
Bangladesh	35.3

Because public spending is much lower, people have to pay for health from their own pocket (OPP) which is about two-third (64.7%) in Bangladesh. The Global standard for out of pocket payment (OPP) is less than 32 percent[20]. Due to the high OPP, thousands of poor households are being pushed into poverty every year which is called catastrophic expenditure. Studies have shown that 6.4 million (4%) people in Bangladesh get poorer every year due to excessive health cost[21, 22]. People have to borrow money or sell assets to pay for health care. It has also been found that 20 percent of the poorest spend 16.5 percent of their household consumption for health reasons, while 20 percent of the richest spend 9.2 percent [21].

Inadequate and inefficient public healthcare and profiteering in the private healthcare sector are two major factors behind such private spending. As a result the gap between those who can access needed health services without fear of financial hardship and those who cannot is widening[23]. So, despite the rising health care costs in the country, the declining trend of health care allocation is against GOB target to plummet the OPP down from 64% to 32% by 2032[24]. In fact, the OPP will increase further if the allocation is not increased in the budget.

Another important issue can be considered as the budgetary allocation between development and non-development sectors of medical and health care division. For healthcare sector, development budget meant allocation for construction and infrastructural development of hospitals and medical care units, enrichment of modern medical equipments and diagnostic tools, improvement of treatment systems with more effective drugs and interventions etc. On the other hand non-development sector indicates employees' salaries, wages and other operating costs. Last three year's scenario of development and non-development budget in Health sector can be presented with the following table-

Table 3: Allocation of Budget (in % of total) [12, 15]

Healthcare Sector	2013 – 14 (Revised)	2014 – 15 (Revised)	2015 – 16 (Proposed)
Development	**38.24%**	**39.44%**	**41.89%**
Non-Development	**61.76%**	**60.56%**	**58.11%**
Total	**100.00%**	**100.00%**	**100.00%**

From the table 3, it can be said that the allocation for the development sector is lower in comparison to the allocation for non-development sector. Although the table shows an increasing trend of development budget from FY 2013-14 to the running period of time, still it is much lower than 50 percent. Even then a significant portion of development budget remains unspent every year. Over the past seven years it has been observed that the health ministry can utilize only 76% percent of its annual development budget [25].

Despite suffering from acute shortage of resources, government hospitals only utilize a little more than half of their annual budget, forcing patients to seek treatment in the private sector. Government hospitals in rural areas receive their budget near the end of the fiscal year due to bureaucratic tangles and thus do not have much time to spend the money. In addition, there is a core system weakness and knowledge gap. Typically at the ground level, government has made big investment for buying an ambulance but does not have the system for small investment to repair puncture. A 2012 World Bank survey identified, about 10% of installed medical equipments in public health facilities had been unused and another 20 percent had never been installed [26]. This is clearly inefficient use of resources and reflects lack of transparency and good governance. TIB repeatedly reported that the sector has been plagued with corruption and corruption has been institutionalized in all bodies within the sector which is, one of the prime reasons, for under utilization of allocated fund[27]. Another problem is unequal distribution of funds and resources. Figure 3 shows the unequal distribution of budget allocation in seven different divisions, where Dhaka got almost half. But Sylhet and Barisal division jointly received fund less than one-fourth of Dhaka [28] and second largest amount received by Chittagong division which is 18%.

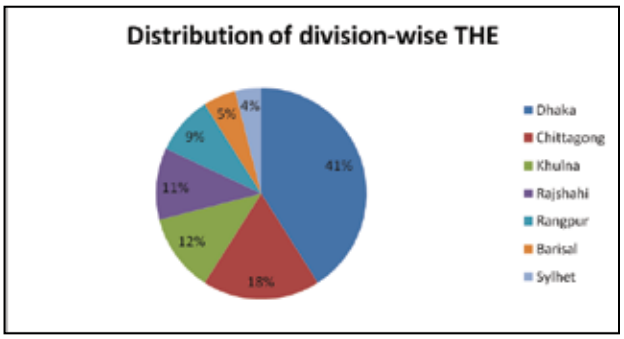

Figure 3: Distribution of Division-wise Total Health Expenditure (THE)

Challenges and Recommendations:

Bangladesh has a massive shortage of skilled health work force. The country has only 0·5 doctors and 0·2 nurses per 1000 people, far less than the minimum standard of 2·28 per 1000 recommended by WHO[29]. Trained and skilled workforce is a key to ensure quality health care for people. Bangladesh has an extensive health infrastructure, but due to shortage of health care workers and logistics, most public health facilities cannot perform optimally[30]. A workforce plan for the short, medium and long term is necessary with a clear strategy to achieve targets within a specified time, addressing both the public and the private sectors. The plan should also address the needs and motivations of the workers, as well as their responsibilities and accountability towards patients.

In Bangladesh, rates of antenatal care use, skilled birth attendance, and facility-based deliveries are lower than those are for neighboring countries. Still home delivery is 63% and delivery with no skill birth attendant is 58%. Delivery at facility among the poorest quintal is only 15% and delivery with skill birth attendant is only 18%. We need to reach this quintal of the population and special fund for mother would help to improve maternal health indicators [9]. In this year Budget, GoB took an initiative for the mothers named 'Maternal Health Voucher Scheme' [15]. It is a good initiative and effective plan to expand this program would bring positive changes in case of maternal health and achieving MDG 5.

We are having an epidemiological shift in disease burden where infectious diseases are taking a back seat and non communicable diseases (NCDs) are coming up[31]. Our health system is not ready for this transition and healthcare is likely to be more costly. NCDs like heart diseases, hypertension, diabetes and cancer are emerging as major health threats and are responsible for 52 percent of the total deaths in Bangladesh[32]. It is high time to plan ahead and allocate enough funds to fight the upcoming NCD epidemic. Moreover, with the increase in life expectancy, aged people would constitute a major part of our population in near future and consequently geriatric diseases would go up. We should have a plan to improve the medical care for senior citizen.

Government of Bangladesh plan to provide 13,861 mini laptops to community clinics [15], But a recent study by World Vision identified several potential barriers to delivering expected healthcare services from community health clinics including infrastructural weakness, irregular medicine supply, a lack of monitoring and negligence in duties of caregivers. None of the community clinics surveyed has electricity connections and in most of those, tube wells do not work and the toilet facility is not available. About 34 percent of the clinics did not receive medicines on a regular basis. Besides, inadequate training for service providers and their limited capacity to deal with things during emergency situation and critical diseases are hindering the optimal services[33]. Therefore, what is needed first is to remove the barriers to improve their performance and strengthen their functional capacity. Due to their proximity to people, we also propose that in addition to the primary health care, the community clinics can serve as a potential platform for preventive service package. Also, we recommend reinforcing the Upazilla Health Complexes and district hospitals to enable them to function as the principal service hospitals for general population.

The provision for free health care services should be expanded. We strongly recommend for free health services for the vulnerable population including ultra poor, pregnant women, under-five children, urban slum dwellers, garments workers, labors and people in hard to reach areas. Under an initiative launched by the United Nations called COIA (Commission on Information and Accountability) for maternal and child health, the MIS started to electronically register and track every pregnant woman and under-five child, using 11 core indicators and this registry can be used for providing free service to these groups. For others, free health cards can be issued. We also advocate to provide free primary and emergency health services to the migrant workers to acknowledge their substantial contribution to national economy with remittance and because most of them cannot afford health care overseas.

Recent Ebola outbreak in Africa highlighted how

vulnerable our health care system is in terms of a pandemic or epidemic threat and it reminds us of the desperate need to strengthen health systems for everyone, everywhere. We recommend investing for strong, equitable health systems to be prepared to fight against emerging threats and increasingly severe natural disasters.

Conclusion:

Bangladesh has achieved many of the Millennium Development Goals (MDGs), but a stronger commitment is needed to achieve the Universal Health Coverage (UHC) [34]. UHC is right to health that means every person everywhere should have access to quality healthcare without suffering financial hardship [35, 36]. It says about reducing the out of pocket expenditure through the cost sharing or pre-payment mechanism. Inadequate funding, inequity in financing and its inefficient use are some of the crucial challenges that should be resolved to ensure quality health for all and establish universal health coverage [37].

Healthcare is not a charity, but a basic human right enshrined in article 15a, 16 and 18 of Bangladesh's constitution[38]. It is recognized by the UN declaration. Bangladesh is also committed to ensure health for all as a signee of Alma Ata Declaration[39]. Therefore to uphold people's right to health GoB should put health as a national priority, allocate sufficient budget for the sector and ensure the utilization of the allocated fund rationally, and these initiatives will help Bangladesh to step forward towards post-MDG goals and achieving universal health coverage.

Conflict of interest:

None of the authors declared any conflict of interest.

References:

1. Ahmed SM, Evans TG, Standing H, Mahmud S. Harnessing pluralism for better health in Bangladesh. The Lancet. 2013;382(9906):1746-55. http://dx.doi.org/10.1016/S0140-6736(13)62147-9
2. The Millennium Development Goals Report New York: United Nations, 2015.
3. Were WM, Daelmans B, Bhutta Z, Duke T, Bahl R, Boschi-Pinto C, Young M, Starbuck E, Bhan MK. Children's health priorities and interventions. BMJ 2015; 351 (Published 14 September 2015) http://dx.doi.org/10.1136/bmj.h4300
4. Health bulletin Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 2013.
5. Chowdhury AMR, Bhuiya A, Chowdhury ME, Rasheed S, Hussain Z, Chen LC. The Bangladesh paradox: exceptional health achievement despite economic poverty. The Lancet. 2013;382(9906):1734-45.http://dx.doi.org/10.1016/S0140-6736(13)62148-0
6. Balabanova D, Mills A, Conteh L, Akkazieva B, Banteyerga H, Dash U, et al. Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening. The Lancet. 2013;381(9883):2118-33. http://dx.doi.org/10.1016/S0140-6736(12)62000-5
7. Bhutta ZA, Chopra M, Axelson H, Berman P, Boerma T, Bryce J, et al. Countdown to 2015 decade report (2000–10): taking stock of maternal, newborn, and child survival. The Lancet. 2010;375(9730):2032-44.http://dx.doi.org/10.1016/S0140-6736(10)60678-2
8. Rahman MM. Is Unwanted Birth Associated with Child Malnutrition In Bangladesh? International perspectives on sexual and reproductive health. 2015;41(2):80-8. http://dx.doi.org/10.1363/4108015
9. Bangladesh Demographic and Health Survey. Bangladesh: Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 2014.
10. The Abuja Declaration: Ten Years On. Geneva: World Health Organization, 2011.
11. Annual Financial Statement (Budget) Bangladesh: Ministry of Finance, Government of the People's Republic of Bangladesh. [Cited July, 2015]. Available from: http://www.mof.gov.bd/en/
12. Year End Report on Fiscal Position, Finance division: Ministry of Finance, Government of the People's Republic of Bangladesh. [Cited July, 2015]. Available from: http://www.mof.gov.bd/en/index.php?option=com_content&view=article&id=226&Itemid=1
13. Health expenditure, total (% of GDP). The World Bank, 2010-2014.
14. Budget Speech 2015-16. Ministry of Finance, Government of the People's Republic of Bangladesh, 2015-16.

15. Budget Speech, 2014-15: Ministry of Finance, Government of the People's Republic of Bangladesh; 2014-15 [cited July 2015]. Available from: http://www.mof.gov.bd/en/budget/14_15/budget_speech/speech_en.pdf.
16. Health expenditure, Per capita (current US$). The World Bank 2010-2014.
17. Mustafa A, Begum T. Universal Health Coverage Assessment People's Republic of Bangladesh. 2014.
18. Health expenditure, Public (% of total health expenditure). The World Bank 2010-14.
19. Expanding Social Protection for Health: Towards Universal Coverage. Bangladesh Ministry of Health and Family welfare, Government of the People's Republic of Bangladesh, 2012.
20. Rahman MM, Gilmour S, Saito E, Sultana P, Shibuya K. Health-related financial catastrophe, inequality and chronic illness in Bangladesh. PloS one. 2013;8(2). http://dx.doi.org/10.1371/journal.pone.0056873
21. Hamid SA, Ahsan SM, Begum A. Disease-specific impoverishment impact of out-of-pocket payments for health care: evidence from rural Bangladesh. Applied health economics and health policy. 2014;12(4):421-33. http://dx.doi.org/10.1007/s40258-014-0100-2
22. Islam A, Biswas T. Health System in Bangladesh: Challenges and Opportunities. American Journal of Health Research. 2014;2(6):366-74.http://dx.doi.org/10.11648/j.ajhr.20140206.18
23. Health Care Financing Strategy 2012-2032. Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 2012-13.
24. Huque R, Mobin S. Change Management and the Health Sector of Bangladesh: A Review of Key Policy Issues.
25. Projecct Performance Assessment Report: Health, Nutrition and Population sector program. The World Bank 2014.
26. Governance Challenges in the Health Sector and the Way Out. Tranparency International Bangladesh, 2014.
27. Bangladesh National Health Accounts Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, 1997-2007.
28. The World Health Report: Working Together for Health. Geneva: WHO, 2006. World Health Organization, 2014.
29. Kalam A, Parvin S. Primary Health Care Expectations and Reality of Bangladesh: A Sociological Analysis of the Selected Two Rural Areas. European Journal of Biiology and Medical Science Resarch. 2015;3(2):25-41.
30. Karar ZA, Alam N, Streatfield PK. Epidemiological transition in rural Bangladesh, 1986–2006. Global Health Action. 2009;2.
31. Riley L, Cowan M. Noncommunicable Diseases Country Profiles 2014. Geneva: World Health Organization. 2014.
32. Community Clinics Survey. World Vision Bangladesh 2014.
33. MDG Progress Report 2015. Ministry of Planning, Government of the People's Republic of Bangladesh, 2015.
34. Kieny M-P, Evans DB. Universal health coverage. Who Emro. 2013;19(4).
35. Garrett L, Chowdhury AMR, Pablos-Méndez A. All for universal health coverage. The Lancet. 2009;374(9697):1294-9. http://dx.doi.org/10.1016/S0140-6736(09)61503-8
36. Adams AM, Ahmed T, El Arifeen S, Evans TG, Huda T, Reichenbach L. Innovation for universal health coverage in Bangladesh: a call to action. The Lancet. 2014;382(9910):2104-11. http://dx.doi.org/10.1016/S0140-6736(13)62150-9
37. Habibullah M. The Constitution of the People's Republic of Bangladesh. Government Printing Press, Tejgaon, Dhaka; 1996.
38. Stanton B, Clemens J. User fees for health care in developing countries: a case study of Bangladesh. Social science & medicine. 1989;29(10):1199-205. http://dx.doi.org/10.1016/0277-9536(89)90363-8