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REVIEW

An Overview of Bangladesh Health Systems Financing

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Abstract

Health financing is fundamental to the ability of health systems to maintain and improve human welfare. Bangladesh has a mixed health system both in financing and in delivery of services. Despite a significant economic improvement, health systems financing does not meet the greater needs of the population. Total expenditure on health as a percentage of GDP was 3.4% in 2012 and 2.37% in 2016.

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Introduction

Health financing is fundamental to the ability of health systems to maintain and improve human welfare. Health financing refers to the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system… the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" [1].

Bangladesh has a mixed health system both in financing and in delivery of services. Despite a significant economic improvement, health systems financing does not meet the greater needs of the population. Total expenditure on health as a percentage of GDP was 3.4% in 2012 [2] and 2.37% in 2016 [3].

Since its independence, Bangladesh has made significant progress in health outcomes. Most of the health indicators show steady gains, and the health status of the population has improved substantially. Healthcare services are provided through public, private for-profit and private not-for-profit organizations. The public sector provides curative, preventive, promotive and rehabilitative services, whereas the private for-profit organizations provide only curative care. NGOs are mostly not-for-profit; they provide outpatient, promotive and preventive services. The Ministry of health and family welfare (MoHFW) is responsible for planning and management of services throughout the country. The government has been pursuing a sector-wide approach (SWAp) since 1998. Developed by the World Bank in 1990, the SWAp was intended to provide a more coherent way to manage government-led sectoral policies and expenditure frameworks, and build local institutional capacities. Under the umbrella of SWAp, three of the programs, Health and Population Sector Program (HPSP, 1998-2003), Health, Nutrition and Population Sector Program (HNPSP, 2003-2011), and Health, Population and Nutrition Sector Development Program (HPNSDP, 2011-2016) has been implemented. At present, the fourth SWAp (HNPSP) is underway to be implemented.

The present government has taken steps to revitalize primary healthcare (PHC) services by establishing one community clinic for every 6,000 populations in the rural areas [4]. The country has managed to develop a nation-wide network of health services infrastructure.

Per capita total expenditure on health expenditure was US $67 in 2011, and total expenditure on health as percentage of gross domestic product (GDP) was 3.4%. The main source of finance for total health expenditure (THE) was out-of-pocket (OOP) spending (63.3%) followed by government spending (23.1%) and external resource (8.4%). Being one of the lower-middle income countries located in SEA with a population of more than 164.6 million (July 2020 est.) and 72.05 years of life expectancy at birth in 2017 [5], Bangladesh is striving to improve its population's health.

The healthcare services in Bangladesh are highly

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centralized, and controlled by the Ministry of health and family welfare (MoHFW) and its two directorates; Health and Family Planning. Total health expenditure (THE) as estimated by BNHA (2015) was Tk. 325.1 billion (US $4.1 billion) in 2012, Tk.153.9 billion (US $2.2 billion), Tk. 81.5 billion (US $1.4 billion) in 2002, and Tk. 46.4 billion (US $1.1 billion) in 1997 [6]. THE has increased by around 14.0% in 2015 in nominal terms and 8.0% in real terms whereas, the THE as a percentage of gross domestic product (GDP) has remained stable in 2015 at around 3.4%. Per capita spending on health was Tk. 2,144 (US $27) in 2012, Tk. 1,576 (US $16) in 2007 and Tk.825 (US $9) in 1997 at 2012 constant price.

According to the system of health accounts developed by Organization of Economic Cooperation and Development (OECD) 2011, disaggregated financing schemes encompass major types of financing arrangements including households' out-of-pocket (OOP) expenditure, and third party payments like social insurance and voluntary insurance [7]. The largest financing scheme for Bangladesh healthcare is the household OOP expenditure. The share of household in the THE was 55.9% in 1997, and has risen to 67% in 2015. Government financing through MoHFW has increased significantly in absolute terms, but as a share of THE public spending has declined from 37.0% in 1997 to 23.0% in 2015 [6]. Voluntary health insurance schemes are primarily in the form of spending to provide or reimburse medical care for employees in formal sectors, and some business entities. The contribution of NGOs' serving households accounts for 2.0% of THE approximately. Development partners' contribution to NGOs is accounted for 8.4% of THE [6].

Households spend over Tk.250 million annually on drugs and health related goods and services. This component has increased from 55.9% in 1997 to 59.9% in 2005 to 63.3% in 2012 and 67% in 2015 [6]. Spending on medical goods comprises the largest share of OOP expenditure. Households spent Tk.134 billion on pharmaceutical drugs, which accounted for 65.0% of OOP in 2012.

Community financing mechanisms and risk-pooling systems are nearly non-existent except in some pockets of NGOs innovation. A few NGOs have started some kind of health insurance component within their package of micro-credit programs. As time passes, Bangladesh has acquired experience in implementing activities under demand-side financing mechanisms, through piloting maternal health voucher schemes in 33 upazilas (Subunits of districts serve for administrative or other purposes. Previously known as Thana or police station) in the country.

In 2015, pharmaceuticals account for the largest amount of spending (43%), followed by providers of curative care (25%) and preventive care (11%). The trends over time show that pharmaceuticals share of spending has increased, while spending on governance, health system and financing administration has decreased.

• Divisional breakdown of total health expenditure shows that Dhaka accounts for highest (46%) while Sylhet and Barisal are jointly lowest (4%) in 2015. Dhaka enjoys highest amount of contribution from both public (36%) and private (49%). • For 2015, per capita health spending on healthcare for Bangladesh is Taka 2,882 ($37). For residents of Dhaka division, it is Taka 3,832 followed by Taka 3,315 in Khulna. Per capita spending by government is around Taka 652 in 2015. The highest level of per capita government spending is in the Rajshahi division at Taka 679 per capita [6].

In Conclusion, the Ministry of Health and Family Welfare (MOHFW) remains the largest contributor for Government schemes. In 2015, MOHFW alone contributed about Taka 96 billion (94% of total public expenditure) while the combined contribution of all other ministries was around Taka 6 billion. For private sector schemes, household accounts for Taka 302 billion (88%) of private expenditure in 2015 followed by financing schemes of the foreign development partners implemented by NGOs. Other private financing schemes, primarily offered by private companies and corporations, accounts for around 2% of total private schemes in 2015. Since 2005, the share of private scheme showed a marked increase largely due to new investments in several large sized private hospitals in Dhaka.

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