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Country Summary Report for Bangladesh

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Acronyms

GDP	Gross Domestic Product
GNI	Gross National Income
HEU	Health Economics Unit, Ministry of Health and Family Welfare
HRH	Human Resources for Health
HPF	Health Protection Fund
MDG	Millennium Development Goals
NGO	Non-governmental organization
OOP	Out of pocket health spending
PPP	Purchasing power parity
MOHFW	Ministry of Health and Family Welfare
SSK	Noncontributory health program for households below the poverty line (Shasthyo Suroksha Karmasuchi)
THE	Total Health Expenditure
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

Preface

In 2011, Japan celebrated the 50th anniversary of achieving universal health coverage (UHC). To mark the occasion, the government of Japan and the World Bank conceived the idea of undertaking a multicountry study to respond to this growing demand by sharing rich and varied country experiences from countries at different stages of adopting and implementing strategies for UHC, including Japan itself. This led to the formation of a joint Japan–World Bank research team under The Japan–World Bank Partnership Program for Universal Health Coverage. The Program was set up as a two-year multicountry study to help fill the gap in knowledge about the policy decisions and implementation processes that countries undertake when they adopt the UHC goals. The Program was funded through the generous support of the Government of Japan.

This Country Summary Report on Bangladesh is one of the 11 country studies on UHC that was commissioned under the Japan–World Bank Partnership Program. The other participating countries are Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam. A synthesis of these country reports is in the publication "Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies," available at:

http://www.worldbank.org/en/topic/health/brief/uhc-japan.

These reports are intended to provide an overview of the country experiences and some key lessons that may be shared with other countries aspiring to adopt, achieve, and sustain UHC. The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments or loss of income when a household member falls sick. Although the path to UHC is specific to each country, it is hoped that countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.

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The Program was led by a team comprising Akiko Maeda, Lead Health Specialist and Task Team Leader for the World Bank, and co-Team Leaders, Professor Naoki Ikegami, Department of Health Policy and Management, Keio University School of Medicine and Professor Michael Reich, Taro Takemi Professor of International Health Policy, Harvard School of Public Health.

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The report was edited by Jonathan Aspin.

Country Summary Report for Bangladesh

Overview

Bangladesh is a low-income country with gross national income of $1,940 per capita in purchasing power parity (PPP) in 2011.[1] It has made great strides in economic and social development outcomes, particularly in health, and is on track to achieving most of the health-related Millennium Development Goal (MDG) targets. Under-five mortality has been cut by half in the last decade (to 46 deaths per 1,000 live births in 2011).[2] It has also strongly invested in and promoted family planning programs since the 1950s. Fertility rates have fallen sharply to 2.2 births per woman in 2011.[3] But despite this drop, its population is projected to grow to 202 million by 2050 (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat 2013). About one-third of the population is still poor. Bangladesh spends about 3.8 percent of GDP on health, while public spending accounts for one-third of total health expenditures (THE). Out-of-pocket (OOP) spending constitutes about 60 percent of THE, with evident implications for financial protection, especially among the worse off. Country basic data is presented in Table 1.

The country faces multiple challenges in improving efficiency and quality across health, human resources for health (HRH) being a key bottleneck at all levels. However, it provides an example of a country that is in the initial phases of exploring mechanisms to improve health services coverage and financial protection to its population, with a commitment to achieving universal health coverage (UHC) by 2032, and one that has innovative approaches to addressing key health care issues, including equity and citizen engagement.

Table 1. Data overview

Population	150.5 million (2011)
GDP	$111.9 billion (2011)
GNI per capita in purchasing power parity (PPP)	$1,940 (2011)
Total health expenditure (THE) as % of GDP	3.8% (2011)
THE per capita	$27 (2011)
OOP health expenditure as % of THE	59.8% (2011)
Public expenditure ratio of THE	38.2% (2011)
Life expectancy at birth	69 years for total population (2011)
Hospital beds per capita	0.3 hospital beds per 1,000 population (2005)

Source: World Bank, World Development Indicators 2013

[1] GNI per capita in current US$ was $840 in 2012.
[2] 53 deaths per 1,000 live births over 2007–11 (Bangladesh Demographic and Health Survey 2011).
[3] 2.3 births per woman over 2007–11 (Bangladesh Demographic and Health Survey 2011).

PART I. UNIVERSAL COVERAGE: STATUS AND SEQUENCING

A. Overview of current status

1. Legal and statutory basis

The government is constitutionally committed to provide its citizens with the basic necessities of life, including food, clothing, shelter, education, and medical care (HEU 2012a). To fulfill this obligation, public primary health facilities are supposed to provide health care free of charge, and are financed through general tax revenue. There is a nominal fee charged for use of tertiary and specialty hospitals. In reality, the majority of Bangladeshis (80 percent) report paying to receive health care (Bangladesh Health Watch 2012).

Apart from public financing through the Ministry of Health and Family Welfare (MOHFW), there are no comprehensive health-financing systems in place that provide coverage for large portions of the population. Rather, there are smaller programs primarily run by nongovernmental organizations (NGOs) that seek to provide affordable access to basic health care, as well as schemes to provide some coverage for civil servants and manufacturing employees. The government has, though, sponsored a Maternal Voucher Program that uses demand-side financing mechanisms to encourage women to use maternal health services.

In recent years, the government has started to explore insurance programs to provide affordable access to health services that were reflected in different strategic documents such as the National Health Policy 2011 and the Strategic Document of the Health, Population and Nutrition Sector Development Program (2012-2016). As a first step in achieving UHC, Prime Minister Sheikh Hasina declared her commitment to UHC coverage for all citizens in her address at the 64th World Health Assembly in May 2011. Following this announcement, the MOHFW, with development partners, began a series of consultations and workshops that culminated in October 2012 with approval of the Health Care Financing Strategy 2012–2032 (HEU 2012a). The document provides a statutory roadmap for Bangladesh to achieve UHC by 2032.

As part of this system, there will be a Health Protection Fund (HPF) that will include a contributory regime for formal sector workers, and a noncontributory health program for households below the poverty line. Initial discussion on the Health Protection draft law of the overall program is currently in development. The intent is for the HPF to be run by an independent parastatal institution. The state is planning to pay the premiums of households below the poverty line but at a cost that the country could afford however, this plan is currently fiscally constrained.

2. Population and services covered by selected schemes

In 2007, around 6.5 million Bangladesh nationals had community-based, micro-insurance coverage (Werner 2009). Most insurance packages include basic health services, such as simple preventative and curative care and referrals to higher-level hospitals (Ahmed et al. 2005). In most cases, the insurers and providers are part of the same organization (Bangladesh Health Watch 2012).

A few private, voluntary insurance programs operate in Bangladesh. Fourteen companies offer health insurance, primarily group plans for office or factory employees (Bangladesh Health Watch 2012). The main component of these programs is coverage for hospitalization, with a maximum benefit limit of approximately $1,800. Private firms make direct payments for medical

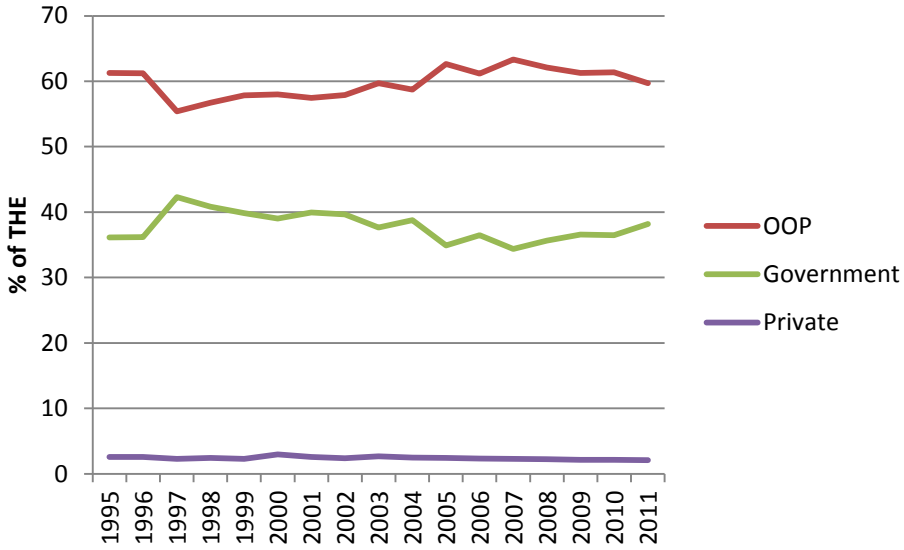
care amounting to about 1 percent of THE; premium payments are an even smaller share of THE (HEU 2010b). The large size of the informal sector, about 87.7 percent of the population, remains a large barrier to expanding the private insurance market beyond its current nascent phase (Maligalig, Cuevas et al. 2009; Bangladesh Health Watch 2012).

The Maternal Voucher Program, a performance-based payment scheme, covers 10.3 million people or around 7 percent of the population (Schmidt et al. 2010; Nguyen et al. 2012). From April 2007 through August 2009, over 304,000 vouchers were distributed, estimated to cover 80 percent of eligible women based on the population and fertility rate (Nguyen et al. 2012). The vouchers entitle women to access free antenatal care, delivery care, emergency referral and postpartum care services, as well as cash stipends to cover transport costs and purchases of nutritious foods and medicines (HEU 2010a).

3. Financial protection and equity

OOP payments account for the majority of THE (Figure 1). In 2011, of THE, 59.7 percent was OOP, 38.2 percent was from government, and 2.1 percent was private (World Bank 2013). Since 1995, OOP expenditure made up an ever larger share of THE, and commensurately government health spending an increasingly smaller share (see Figure 1). OOP payments are not used for prepayment mechanisms, and instead are primarily used in direct spending in pharmacies, drug shops, and for other self-treatment options (HEU 2012a).

Figure 1. Health Expenditure Trends, 1995–2011



Source: World Bank World Development Indicators, 2013

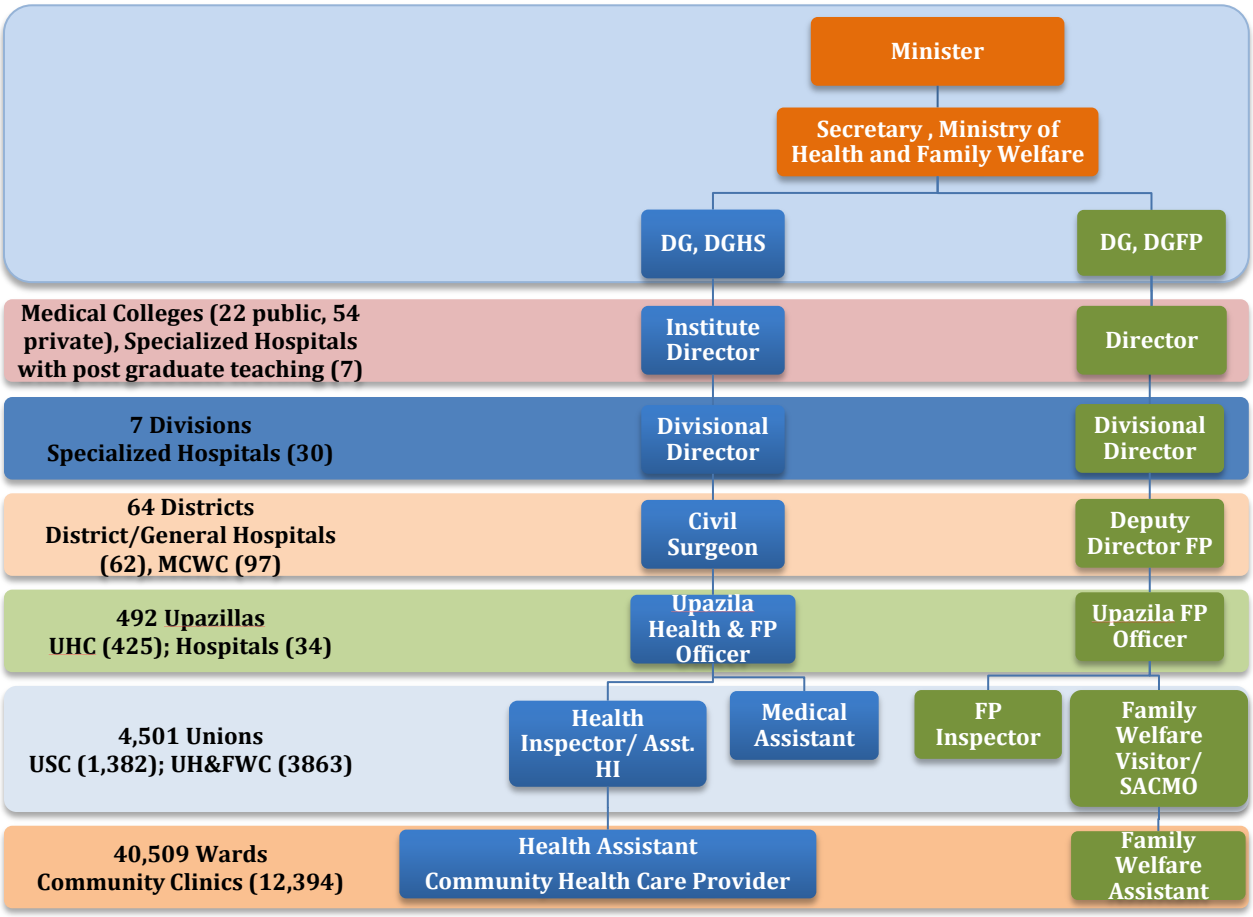
OOP expenditures on health as a share of monthly income are larger for lower- than higher-income households, at 5–10 percent and 3 percent, respectively (World Bank 2010). These high OOP expenditures lead to steep rates of catastrophic health expenditure: 7–25 percent of households experience catastrophic health shocks annually, driving up to 3.8 percent of the population into poverty (5.7 million people) every year (Bangladesh Health Watch 2012).

While all Bangladesh nationals are entitled to receive health care in public health facilities, both resources and supply favors those with higher income, with more money spent in richer districts than poorer ones (Ahmed et al. 2005; HEU 2010b; Bangladesh Health Watch 2012; HEU 2012a). Due to both health-seeking behavior and access, utilization of health services tends to be far better for higher-income groups (World Bank 2010). For example, only 4.6 percent of women in the lowest income quintile had an institutional birth compared with 43.8 percent among those in the highest income quintile (World Bank 2010). Similar trends exist for antenatal care and family planning services (World Bank 2010). Additionally, it was found that in the aggregate more government resources are dedicated to rural areas, expenditure per capita in rural areas was about half that of urban areas (Bangladesh Health Watch 2012). However, the analysis of disaggregated data reveals stark inequities in the urban health care system, and highlights the poor health status of the slum populations. The urban poor populations are particularly vulnerable to the health threats of unmanaged urban growth, including contaminated food and water supply, air pollution, inadequate waste removal, unsafe housing, eviction, and road traffic accidents (Adams et al. 2013).

4. Goal setting and public service delivery system

The public sector health services structure is built on the country's administrative levels (i.e. national, divisional, district, *upazila*, union, and ward), with the MOHFW responsible for the implementation, management, coordination, and regulation of national health and family planning–related activities, programs, and policies. The MOHFW delivers health services directly through its own facilities under the direction of two separate executing authorities, the Directorate of Health Services and the Directorate of Family Planning (Figure 2).

Figure 2. Public service delivery system



Source: MOHFW 2013.

The MOHFW intends to move toward a facility-based delivery system delivered by an integrated team of health and family planning personnel (World Bank 2010). Under this system, the first point of contact with the health system would be in community clinics at the ward level, with referrals to union and *upazila* facilities. Current door-step services would be replaced with fixed-site services.

In urban areas, the Ministry of Local Government, Rural Development and Cooperatives is primarily responsible for all public primary health service delivery. Apart from tertiary-level hospitals and a few Urban Dispensaries, these urban areas do not receive funding from the MOHFW, and health service delivery is paid for by Primary Health Care Projects (USAID 2011).

B. Health financing policies and HRH

1. Financing and payment

THE per capita was $27 in 2011, having more than doubled since 2001 when it was just $11 (WHO 2012). THE as a share of GDP remained relatively stable between 2000 and 2011, with a slight increase from 3.1 percent to 3.8 percent. Government spending on health, including contributions from donors, more than doubled between 2001 and 2007; however, its overall share of THE declined over the same period due to more rapid increases in OOP expenditure (HEU 2010b; World Bank 2010). In 2011, government health expenditure as a share of THE was 38.2 percent, down from 40 percent in 2000. OOP expenditure as a share of THE increased from 57.9 percent in 2000 to 59.7 percent in 2011. Other private expenditure on health as a share of THE was only 2.1 percent in 2011, of which less than 1 percent was derived from payments on insurance. Of THE, external resources accounted for 6.8 percent in 2011 (World Bank 2013).

There is no purchaser–provider split in the public health care system: the MOHFW directly provides care. Budget allocations are made in five-year increments and supported by the Sector-wide Approach program funded by several donors. At *upazila* level, each facility receives equal resources, irrespective of the needs of the catchment population and utilization rates (HEU 2012a). Budgets for higher levels of care are allocated from revenue and development budgets based on the number of beds and staff of each hospital. Health workers are paid a salary set by the Ministry of Finance.

2. Fiscal space

The MOHFW budget for health is divided into “revenue” and “development” components. In 2007, the revenue budget accounted for 55.8 percent of total public expenditure on health and the development budget for 41.2 percent (World Bank 2010). The revenue component is financed entirely by tax and is dedicated in large part to paying the salaries of government health workers. The development component is partially financed by donor assistance and includes capital investments. Donor financing accounted for about half the development budget for health in 2011 (MOHFW 2012). The share of the total government budget dedicated to health has remained below the target of 10 percent (World Bank 2010): in 2010 for example, it constituted only 7.4 percent (WHO 2012).

The government will need to increase its health budget by 17.7 percent a year from 2009/10 to 2014/15 and by 2 percent annually from 2014/15 to 2024/25 if it is to cover 50 percent of the required budget to achieve UHC (Bangladesh Health Watch 2012). Between 1998 and 2007, the average annual growth rate of THE was 11.1 percent and that of government health spending 10.8 percent (HEU 2010b; WHO 2012). Even though the total utilization rate of the government budget is 76.8 percent (HEU 2010b; WHO 2012), which indicates an inability of the government to spend its current budget allocations, fiscal space will remain an impediment for the government in achieving UHC by 2032.

The issue of cost management has not been at the forefront of health spending concerns. However, due to the relatively low level of health spending, achieving maximum value from each taka put into the system is of paramount importance. The government-led poverty reduction strategy highlights the need to improve efficiency in the health sector (Government of Bangladesh 2008). As Bangladesh seeks to channel high rates of OOP expenditure into prepayment insurance mechanisms, it will need to develop appropriate governance and institutional capacity for greater accountability over the use of scarce fiscal resources.

3. HRH policies

The MOHFW recognizes that there is a severe health workforce crisis, as well as the need for comprehensive reform of the system, as noted in the 2008 Health Workforce Strategy (MOHFW 2008; MOHFW 2010). In recent years, the Ministry of Civil Service has increased the number of health workers. However, the ratio of doctors, nurses, and midwives per 1,000 population is still below the 22.8 health workers per 10,000 population estimated by WHO. Further, as of 2012, 44.2 percent of sanctioned positions were vacant (Bangladesh Health Watch 2012). In 2011 there were 43,537 doctors and 15,023 registered nurses in the country, and about 58 percent of doctors were in the private sector (MOHFW 2011). Beyond these absolute shortages, and despite the majority of the population living in rural areas, the majority of health workers are in urban areas (El-Saharty and Ahsan 2011; HEU 2012a). Additionally, about 94 percent of the health workforce comprises unqualified health professionals (Bangladesh Health Watch 2007). Table 2 provides details on the HRH status.

Beyond all these issues, the health sector faces many HRH challenges including an inappropriate skill mix, ineffective deployment, poor quality of education and training, and weak governance. These challenges are exacerbated by the lack of incentives for staff to serve in rural areas or to improve their performance (El-Saharty et al., forthcoming).

The MOHFW now emphasizes training lower cadres of health workers, including medical assistants, health assistants, and community health workers. These health workers are intended to provide services in the communities in which they live, with a focus on rural areas.

Table 2. Status of HRH in Bangladesh, 2010

	Number per 1,000 population	Entry			Exit	
		Qualifications	Government determines the number of new entrants	Number of entrants per year	Number of years of education	Number of newly licensed per year
Physicians	0.295	High school graduate	Yes	4,816	5 years	2,656
Nurses and midwives	0.272	RN: High school graduate	Yes	RN: 2,280	RN: 3 year Midwife: a) RN plus 6 months post-basic certificate; b) 3 year diploma in midwifery	RN: 2,700 Midwife: 569 (post-basic certificate)
Community health workers (2005)	0.331	N/A	No		0	

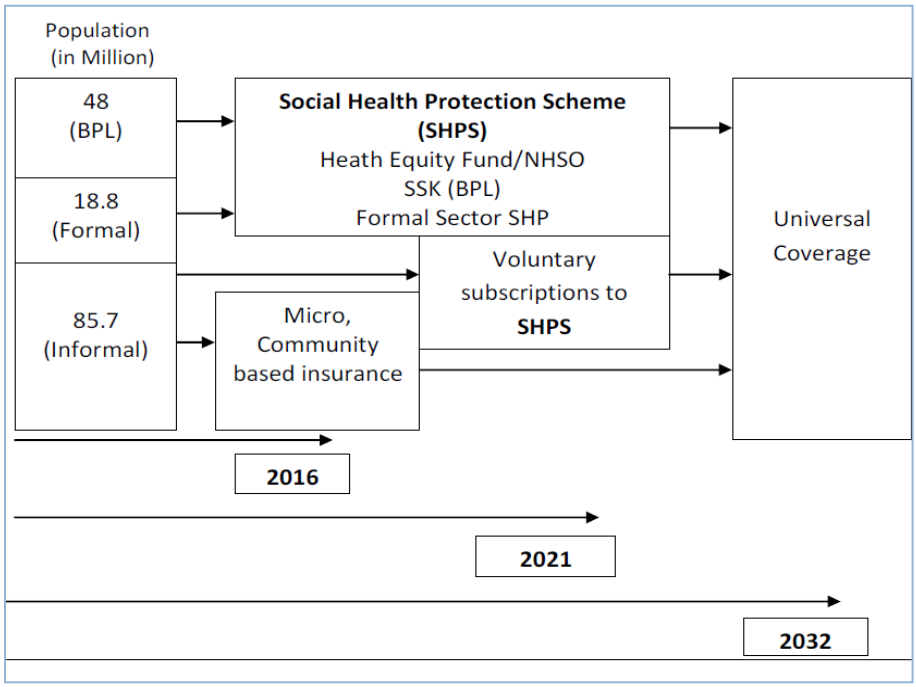
Source: Bangladesh Health Watch 2012 and MOHFW.

C. Sequencing of reforms

1. Timeline

UHC reform is in its nascent phase. The prime minister's 2011 commitment to achieving UHC demonstrates important political will. The MOHFW has articulated its vision to reach this goal through the 2012 Healthcare Financing Strategy (Figure 3). The Strategy has three objectives: (a) to generate more resources for effective health services; (b) to improve equity and increase health care access especially for the poor and vulnerable; and (c) to enhance efficiency in resource allocation and utilization. The strategy grew out of a process in which representatives from academia, research organizations, NGOs, and the public sector provided input. It envisions three phases for UHC.

Figure 3. Sequencing of proposed reforms



Source: HEU 2012a.

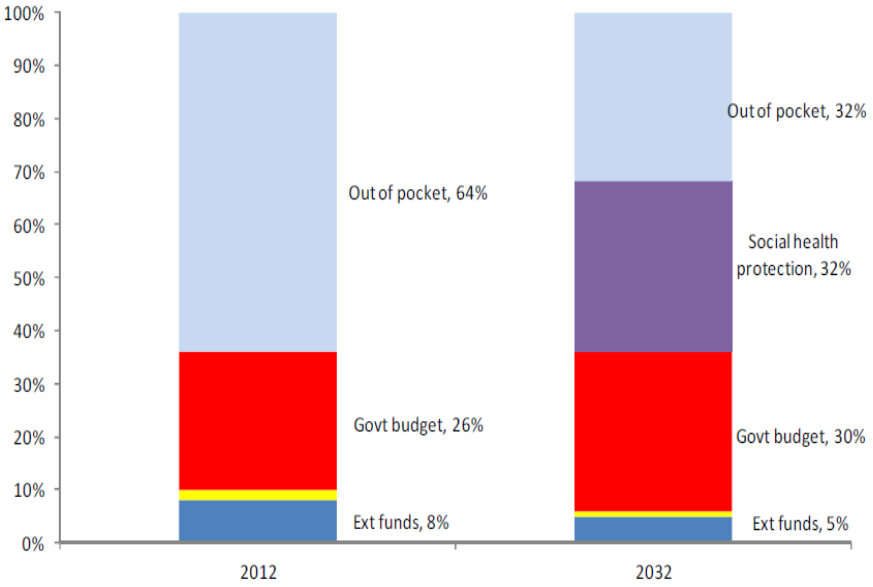
In the initial phase, 2012–2016, it was planned to pilot a noncontributory health program for households below the poverty line, the "Shasthyo Suroksha Karmasuchi (SSK), but implementation was delayed however, it remains a priority program for the government. In the first phase, 2016–2021, the HPF will be launched, with the intent to cover all households below the poverty line (31.5 percent of the population) through a noncontributory regime and formal sector households (12.3 percent of population) through a contributory regime (HEU 2012a). During this interim period, community-based insurance will be promoted for households lacking coverage (56.2 percent of the population). By 2032, the MOHFW hopes to achieve UHC and integrate all households under the national HPF. This plan remains illustrative, with much work needed to make it economically and operationally feasible. Figure 4 depicts the proposed evolution of health financing.

2. Health Benefits Package

Bangladesh, has had rapid advancements in coverage of maternal and child health interventions (Chowdhury, et al., 2013). However non-communicable diseases, treatment of injuries, and high cost diseases have lagged behind (El-Saharty, et al., 2013).

The Health Benefits Package, may initially expand the coverage for an essential set of highly cost-effective interventions that affect the poor that may include the treatment of high cost catastrophic events. These interventions would be publicly financed through a combination of tax revenues and payroll taxes. For the defined benefit package of publicly financed services, there would be no user fees, defined as fee-for-service charges at the point of care.

Figure 4. Proposed evolution of health financing



Source: HEU 2012a, p. 21.

PART II. Lessons to be shared

Having health care access embedded in the Constitution as a right provided important institutional underpinning to UHC Bangladesh, as was the case in a number of other countries. Bangladesh also set explicit target dates for UHC as a way to mobilize political support and keep the country focused on the goal and, though facing significant macroeconomic constraints, made UHC a national objective to be achieved over the long term.

As a strategy to help ensure UHC, Bangladesh is considering introducing the HPF. However, Bangladesh faces challenges on finding the fiscal space to finance UHC policies and programs on a sustainable basis. The country faces macroeconomic constraints and limited government capacity to raise revenues and must rely on external assistance to finance a significant portion

of health benefits at least in the medium term. Bangladesh is implementing a Sector-wide Approach[4] to harmonize external assistance to limit dependency and ensure efficient use of donor assistance. It is also exploring ways to expand its narrow tax base by introducing new payroll taxes under a social insurance program as the financing vehicle for expanding coverage. The government's strategy is to create one common pool under the HPF, which will first introduce a noncontributory tax-funded insurance program for the poor and a contributory scheme for civil servants, financed through payroll taxes and employers contributions. The informal sector will rely on CBHI at a first step, and are expected to join the national insurance program later.

Bangladesh is facing a significant need for an increase in the number of skilled health professionals, representing a critical challenge for the country in the early stages of UHC adoption and implementation and underscoring the need to revisit traditional models of education, deployment, and remuneration. The skewed mix of health care providers—a very high ratio of doctors to nurses—is also an issue: as of 2011, Bangladesh had 43,537 doctors, 15,023 registered nurses, and an extraordinarily large pool of unlicensed and unregulated health workers, which constitute some 94 percent of the overall health workforce. With such an imbalance between skilled nurses and doctors in the context of a broader absolute shortage of trained medical personnel, the country is in dire need of HRH market regulation tools to address its health care personnel needs. The production of a larger workforce of skilled nurses and midwives might be an option that Bangladesh can consider both to meet the country's HRH needs and to ensure that the population receives care from well-trained and qualified health workers.

Due in part to the overall low level of education attainment in the country and to address the skills mix issue, MOHFW emphasizes training lower cadres of health workers, including medical assistants, health assistants, and community health workers to work in the communities in which they live. This program, a potential model for other countries, has had important positive impact, for example, on coverage for tuberculosis treatment. Further developing flexible entry and career pathways for these categories of health workers may become an important HRH strategy to meet the rising demand for skilled health professionals. In Bangladesh physicians tend to occupy positions in urban areas and at private medical facilities. With the government willing to find innovative ways to provide physicians with incentives to be deployed and retained in public rural facilities, it may wish to consider a similar approach.

As Das and Horton (2013) noted in a *Lancet* article, the country's significant advances in health status, including life expectancy, fertility rates, and infant mortality rates, represent not only success but are instructive for the challenges that countries face along the pathway to UHC. Flexibility in policy, investment in innovation, and community engagement are three hallmarks of the approach taken by the country to address its health needs and move toward UHC. The Lancet Commission on Global Health 2035 strongly endorsed the "progressive universalism" approach because of its particular benefits to the poor (Jamison et al. 2013). The Commission suggested two "progressive pathways" to UHC. The first may be more relevant to Bangladesh as it involves "*insurance that covers the whole population but targets the poor by insuring health interventions for diseases that disproportionately affect this group. This pathway would initially finance an essential set of highly cost-effective interventions addressing infectious diseases and reproductive, maternal, neonatal and child health disorders, and it would include an essential package of NCD interventions.*" In Bangladesh, these interventions would be publicly financed

[4] Developed for health in the 1990s in response to widespread dissatisfaction with fragmented donor-sponsored projects and prescriptive adjustment lending.

through a combination of tax revenues and payroll taxes. For the defined benefit package of publicly financed services, there would be no user fees, defined as fee-for-service charges at the point of care without the benefit of insurance. The key advantage of this approach is that the government does not have to incur expensive administrative costs trying to identify who is poor, at least at the start of program implementation. With respect to targeting, Bangladesh should take advantage of two programs supported by the World Bank. The first is the Bangladesh Poverty Database, which is a nationwide poverty registry to be launched in 2015 to serve as an identification system of poor households and is based on a proxy means test methodology. The second is the National Identity Card, which is a computerized smart card issued to individuals under the poverty line.

Bangladesh created an environment for pluralistic reform in which many participants in the health sector, including NGOs and the private sector, were allowed to flourish, contributing to the significant health improvements. Das and Horton (2013) also note the important contribution of investments in research and services innovation—often overlooked in assessments of health care reform. These investments included those not only in innovative approaches to primary care but also in health systems. The positive synergistic nature of innovation and community engagement has been an important factor in Bangladesh: community participation and activism contributed to the keen interest in and support for innovation, and in turn, the innovations "led to community-based approaches and partnerships that enabled the country's locally produced research findings to be delivered at scale" including important innovations in the social and economic empowerment of women (Das and Horton 2013).

Bangladesh's ability to engage and indeed mobilize communities to action is impressive, as is its national commitment to both gender equity (inextricably related to health status and coverage) and UHC. Nonetheless, the health and socioeconomic challenges faced by Bangladesh in its striving for UHC can be addressed through its continued creativity, community engagement, and political commitment to equity. An incremental approach to health care reform and expansion of the health sector in Bangladesh could serve the country well, as it works to address and resolve issues of fragmentation and fiscal space. Bangladesh will have to carefully decide how best to manage its sizable private and NGO sector and provide coverage for a large informal sector. Decisions that are made now will have long-lasting consequences for the institutional structure of the health care and health insurance sectors.

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