Expanding Social Protection for Health Towards Universal Coverage

Health Care Financing Strategy 2012-2032

September 2012

Health Economics Unit
Ministry of Health & Family Welfare
Government of the People's Republic of Bangladesh

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Preface

Bangladesh has achieved considerable success in primary health care services delivery though it has the lowest per capita health expenditure in the SAARC region. However, it is now facing the challenges of increasing health care costs due to rising awareness and diagnosis that enable the treatment of previously untreatable conditions. There is continued attempts at empowering disadvantaged people for accessing to health care which is arguably increasing.

This country has been plagued with the burden of unacceptably high out of pocket expenditure at the level of about 64% of total health expenditure (THE). Government spending stands at around 26% only and there is no mentionable health insurance program. The economically vulnerable population of the country is threatened with impoverishment in case of catastrophic illnesses and the percentage of that population is rather too high. THE level, itself, is also quite low. Only 3.4% of GDP is spent on health. This calls for focusing on the concerns for deepening and broadening the resource base for health in the country.

The health care financing strategy aims to address all these issues in a medium to longer term perspective. In addition to increasing financial resources for health, Bangladesh will require improved ways of organizing resource mobilization, allocation and expenditure in order to obtain the maximum value for money. So as to ensure equitable and sustainable financing and financial protection against health expenditures for the entire population.

The health care financing strategy provides an overview of the vision, and the goals, followed by the strategic objective, each with their associated strategic interventions that respond to the goals of health financing in Bangladesh. It aims to provide the framework and direction for increasing the level of funding for health, ensuring an equitable distribution of the health financing burden, improving access to essential health services, reducing the incidence of impoverishment and catastrophic health care expenditures and improving quality and efficiency of service delivery.

An action plan for possible implementation in the short term has been set out. We believe timely implementation of the action plan following the strategy will strengthen the country's health system.

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Acknowledgments

The Health Care Financing Strategy has been developed over a period of a year since the adoption of Health Policy 2011 and HPNSDP (2011-2016). The development was through a participatory process. That process has been led by Health Economics Unit under the full support and proactive guidance of the Ministry of Health and Family Welfare.

Since the beginning of the development process of the strategy document, Senior Secretary Mr. Md Humayun Kabir actively contributed in framing the outline and in the consultation process.

Mr. Waliul Islam, Lead Consultant facilitated and coordinated the Technical Working Groups (TWG), and organized the regional and national consultations with support from the focal points of the 3 TWGs, Dr. Tanvir M Huda and Dr. Jahangir Khan, from ICDDR, B, and Ms. Nahid Akhter Jahan of Institute of Health Economics of Dhaka University. Members of TWGs, especially Ms. Nargis Khanam of Planning Wing of MOHFW, Dr. Rumana Huque, Associate Professor of Economics, Dhaka University, Mr. Hossain Adib of BRAC, Dr. Nadira Sultana of Access Health International, Professor Sushil R. Howlader of Institute of Health Economics of Dhaka University, Dr. Khairul Islam of Water Aid and Dr. Zahirul Islam and Ms Ylva Sorman Nath of SIDA deserve special thanks for their contributions.

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It is the product of the collaborative effort by many professionals inside and outside of HEU and MOHFW, all the actors in the health care financing strategy development process deserve thanks for their respective contributions.

Acronyms

BNHA	Bangladesh National Health Accounts
BIDS	Bangladesh Institute of Development Studies
BPL	Below Poverty Line
CBHI	Community Based Health Insurance
CMH	Commission on Macroeconomics and Health
CCT	Conditional Cash Transfers
CSR	Corporate Social Responsibility
DI	Data International
DP	Development Partner
DSF	Demand Side Financing
GDP	Gross Domestic Product
GoB	Government of Bangladesh
HCFS	Health Care Financing Strategy
HEU	Health Economics Unit
HFRTG	Health Financing Resource Task Group
HIES	Household Income and Expenditure Survey
NHSO	National Health Security Office
HPNSDP	Health, Population and Nutrition Sector Development Program
HNPSP	Health, Nutrition and Population Sector Program
MDG	Millennium Development Goals
MHI	Micro Health Insurance
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MHVS	Maternal Health Voucher Scheme
NGO	Non-Government Organization
NHA	National Health Accounts
OOP	Out-of Pocket Payment
PBF	Performance Based Financing
PHC	Primary Health Care
PPP	Public Private Partnership
RBF	Results Based Financing
SAARC	South Asian Association for Regional Cooperation
SHPS	Social Health Protection Scheme
SSK	Shasthyo Shuroksha Karmasuchi
TFIPP	Thana Functional Improvement Pilot Project
UHC	Upazila Health Complex
THE	Total Health Expenditure
US $ PP	United States Dollar at Purchasing Parity
WHO	World Health Organization

Executive Summary

The Health Care Financing Strategy 2012-2032 provides a framework for developing and advancing health financing in Bangladesh. The strategy is aligned with the vision of the Health, Population and Nutrition Sector Development Program (HPNSDP) 2011-2016, the universal coverage as defined by WHO, and the National Health Policy 2011 that recognizes the importance of bringing more funds to the health sector and pooling the resources more adequately.

Rising incomes and aging population, with its growing burden of chronic diseases, will progressively add to the demand for complex and expensive health care. At the same time, the impressive performance of preventive and primary care has to be maintained and be available for the population. The high out of pocket spending and the catastrophic impact of the health care, especially on the poor and vulnerable, must be decreased and financial protection for health must be increased. The strategy needs to meet the financing challenges confronting the health sector now and in the future.

The challenges posed by health financing in Bangladesh are many and can be summarized under three broad categories. These are: (i) inadequate health financing; (ii) inequity in health financing and utilization; and (iii) inefficient use of existing resources.

The strategy recognizes the importance of other building blocks of the health system; however, discussions on those and their impact on this strategy have been beyond the scope of this document.

This strategy document has been developed through a participatory process, led by the Health Financing Resource Task Group with the Senior Secretary of the Ministry of Health & Family Welfare (MOHFW) in the chair. Thematic papers on the financing challenges were drafted by technical working groups with representatives from the academia, research organizations, NGOs and public sector; integrating the thematic papers, a preliminary draft was shared with representatives of stakeholders in regional consultation workshops. A national consultation with the principal stakeholders on the redrafted document was held to arrive at the final draft.

The Strategy is designed to address these challenges and presents a compelling case for an increase in public resources dedicated to health while outlining an actionable mechanism to capture private spending and channel it efficiently in prepayment and pooling arrangements. It puts emphasis on extending financial protection to all segments of the population.

The goal of the national health financing strategy is to strengthen financial protection and extend health services and population coverage especially to the poor and vulnerable segments of the population, with the long-term aim to achieve universal coverage. The role of health financing is to : (i) provide all people with access to needed health services (including prevention, promotion,

treatment and rehabilitation) of sufficient quality to be effective; and (ii) ensure that the use of these services does not expose the user to financial hardship.

The 20-year health financing strategy devises ways to combine funds from tax-based budgets with proposed social health protection schemes (including for the poor and the formal sector), existing community-based and other prepayment schemes and donor funding to ensure financial protection against health expenditures for all segments of the population, starting with the poorest.

Recognizing the need for increased engagement and strengthened stewardship role of MOHFW, this strategy document aims at maximizing the complementary role of private sector, both for profit and non-profit, through public private partnership, and continuing the engagement of Development Partners' in financing the health sector. The proposed strategy has designed its interventions and actions targeted to increasing people's engagement and participation.

To begin with, this strategy proposes to cover the poor and the formal sector, including government, private and NGO employees, and progressively extending the coverage to the remaining segment of the population by 2032.

To cope with the challenges and increase financial protection for the entire population and decrease out-of-pocket payments at point of service, the following three strategic objectives are proposed:

- Generate more resources for effective health services
- Improve equity and increase health care access especially for the poor and vulnerable
- Enhance efficiency in resource allocation and utilization

Strategic interventions and supportive actions:

1. Design & implement Social Health Protection Scheme
- Determine institutional arrangements for Social Health Protection Scheme
- Design and implement Health Equity Fund/National Health Security Office
- Implement SSK for BPL
- Design social health protection scheme for above BPL (formal and informal)

2. *Strengthen financing and provision of public health care services*
- Implement needs and performance based allocation
- Scale up/reinforce Result Based Financing (MHVS)
- Retain user fees at point of collection

3. *Strengthen national capacity*
- Support information exchange platform/knowledge hub/resources pool
- Develop the capacity to design and manage the social health protection scheme
- Strengthen Financial Management and Accountability
- Improve monitoring and evaluation
- Introduce mechanisms to support the production of additional key staff (nurses, paramedics and medical technicians)

1. Introduction

The primary goal of any health system is good health of the population, and effective health systems require robust financing mechanisms. Health spending is different from other spending and is characterized by many defining peculiarities. First, healthcare expenses are often unpredictable. It is difficult for most part to predict when one would need emergency or curative care which, in the absence of pre-payment and risk sharing mechanisms (like insurance), makes it very difficult to meet the sudden demand for health expenditures at time of illness. Second, the need for (and value of) routine preventive care - especially for women of reproductive age and children - is highly predictable. Yet, social and economic disadvantages may result in lower access than is desirable. Subsidies or fee waivers then may be called for on economic efficiency as well as equity grounds. Third, illness may adversely affect an individual's economic pursuits and income, which often have a hugely negative impact on a household's ability to manage its daily demand for the most essential goods. To be effective in these conditions, a health care financing mechanism must offer financial protection against ill health and from financial consequences associated with obtaining medical care.

The Government of Bangladesh (GOB) is constitutionally obligated (Bangladesh Constitution, Part II, Article 15) to provide the basic necessities of life, including food, clothing, shelter, education and medical care to its citizens. However, poverty, lack of knowledge, and other barriers keep many people from accessing services essential to maintain health and making healthy choices. One major barrier is financial; a large number of health services in Bangladesh are obtained through out-of-pocket expenditures made at the point where health services are received or medicines are purchased. Globally, such expenditures account for about 32% of total expenditure on health (Xu K et al 2010), but for Bangladesh, it makes up 64% of total health expenditures (BNHA 1997-2007). Such high out of pocket expenditures on health can lead to loss of productive assets (selling items to pay for medicines) and threaten economic survival, especially in countries with high rates of catastrophic illnesses, such as Bangladesh.

Bangladesh has made remarkable progress in expanding coverage for essential public health interventions, such as immunization. These results have markedly lowered maternal and child mortality rates. In contrast, there is very limited coverage of services related to secondary and tertiary care. Only $ 4.2 per person per year is spent on health from the government budget. Out of pocket expenditures on health account for a further $ 10.4 per person per year, but all of it is spending by individual and none of it is pooled. WHO has determined that out-of-pocket expenditures for health care are the least effective way of paying for health services. The net result is that even though the country is doing well across a number of health indicators - based on improving access to essential maternal and child health interventions, free treatment of tuberculosis and other contagious diseases, the total availability of resources for health are few and financial protection for health expenditures is very limited. On average around 15% of total households faced catastrophic health expenditure due to the high burden of out of pocket payments.

The country will require more than just increased financial resources for health; it will require vastly improved ways of organizing resource mobilization, allocation and expenditure in order to obtain the maximum value for money to ensure equitable and sustainable financing and financial protection against health expenditures for the entire population. This is the foundation stone and guiding principle of the proposed health financing strategy.

Bangladesh has grown steadily during the last decade, and economic growth has averaged 5.8% for the past 10 years. During this period, Bangladesh has also begun to experience demographic as well as epidemiological transitions -- with its population slowly but steadily aging, and non-communicable diseases gradually accounting for more and more deaths. Rising incomes and aging population, with its growing burden of chronic disease, will increase demand for complex quality health care. Government should recognize the growing demand for and public expectations of improved health care.

At the same time, the impressive performance of preventive and primary care must be maintained and be available for all segments of the population. This challenge must be met with an innovative and bold health financing strategy, one that makes a persuasive case for an increase in public resources dedicated to health and outlines an actionable mechanism to capture private spending and channel it efficiently in prepayment and pooling arrangements. Financial protection for health must be increased, and the high out of pocket spending and the catastrophic impact of the health care, especially on the poor and vulnerable, must be decreased.

Bangladesh hitherto has not adopted a deliberate health care financing strategy. Health financing interventions and programs are either driven by supply side pressures - salaries for nurses and physicians and medicines and supplies for facilities, while pilot activities are often initiated in response to emergencies or following international trends. A comprehensive health care financing strategy is critical to meet the challenges confronting the health sector now and in the future.

The strategy is fully aligned with the vision of universal health coverage, defined by the World Health Organisation (WHO) as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access" (WHO 2005). The goal of universal health coverage is that no one should die or suffer because they cannot afford health care, and no one should be made poorer because they get sick.

This strategy supports the vision of the HPNSDP (2011-2016), which underscores the importance of seeing "people healthier, happier and economically productive to make Bangladesh a middle income country by 2021." Moreover, the National Health Policy 2011 recognizes the importance of bringing more funds to the health sector and pooling the resources more adequately. An urgent effort is required to strengthen health systems to succeed in improving the health conditions of the people. This is contingent upon spending more (broadening and deepening the resource base); spending better (doing the right things in the right way); and spending on right groups (determining how costs and benefits are to be distributed).

1.1 Scope of the Strategy

Health care financing, although very important and in some cases the main driver, is just one of the several elements that together constitute a complex health system. There are a number of broader development and health system issues critical to the success of the proposed health care financing strategy. Among others, these include social safety nets, human resource management and development, pharmaceutical management and rational use of drugs, adequate health care technology, health information systems, community participation, public private partnership and governance. While this strategy recognizes their importance, addressing these issues or discussing their impact on this health financing strategy are beyond the scope of this document.

1.2 Strategy Development Process

This Strategy document was developed through a participatory process that included a series of consultative workshops and discussions with key informants. Health Financing Resource Task Group (HFRTG) chaired by the Senior Secretary of Ministry of Health and Family Welfare (MoHFW) led the process. Three technical working groups (TWG) based on three thematic areas, namely resource mobilisation, equity and efficiency related to health care financing were formed. Composition of the groups included officials from MoHFW, its Directorates, representatives from professional associations, research and academic institutions, and NGOs. Three theme based papers were produced after review of relevant documents and discussions and consultations within and outside the respective TWG. After a series of joint consultations with all the TWGs, a preliminary draft of the strategy document was prepared integrating those thematic papers. This draft was then shared in 5 regional workshops held in Chittagong, Mymensingh, Sylhet, Rajshahi and Khulna during May-June 2012. A two day redrafting workshop with TWGs was held to incorporate all the comments received from the participants of the regional workshop and some international reviewers. The first draft was prepared, and then was shared in a national consultation held in Dhaka on 24 June 2012. The second draft integrated the comments received from the discussants and participants of the national consultation.

2. Key Challenges in Health Financing

An examination of the financing of the health sector in Bangladesh highlights three challenges currently facing the sector which must be addressed by any health financing strategy. These are: (i) inadequate health financing; (ii) inequity in health financing and utilization; and (iii) inefficient use of existing resources. These are discussed in details below.

2.1 Inadequate Resources in the Health Sector

Bangladesh spends 3.4% of GDP on health, which in per capita terms is US$ 16.2 (US$ 46 PPP, in current dollars) according to Bangladesh National Health Accounts 1997-2007 (BNHA 1997-2007). This compares rather unfavorably with most countries in the region, and is higher in absolute amount only to neighboring Myanmar.

Table 1: Total Health Expenditure (selected countries), 2008 (US$ PPP)

	Maldives	Sri Lanka	India	Nepal	Pakistan	Bangladesh	Mayanmer
Per capita PPP	769	187	122	66	62	46	27
Percent GDP	13.7	4.1	4.2	6.0	2.6	3.4	2.2

Source: WHO Department of Health Statistics and Informatics. "World Health Statistics 2011". Geneva: WHO. http://www.who.int/whosis/whostat/2011/en/index.html. Retrieved 2012-06-12.For Bangladesh figures source is "Bangladesh National Health Accounts (BNHA) 1997-2007", HEU/DI 2010.

The main source of finance for total health expenditure (THE) is out-of-pocket (OOP) spending by households (64%) followed by government spending (26%), and External resources (8%). OOP payments by households for health at the point of service account for 2.2% of the country's GDP. Households' OOP mostly purchase drugs (66%). OOP also includes both formal fees and informal fees. Formal fees are paid at public, private and NGO facilities and also paid to informal providers.

At present, user fees (formal fees) levied at public facilities are nominal and not retained at the facility but rather go to the Government treasury. Some projects such as Thana Functional Improvement Pilot Project (TFIPP) during 1997-2003 piloted retention of user fees at the facilities. However, due to rigid public sector financial management rules[1] this could not continue beyond pilot phase. In government facilities, user fees generate very small levels of revenue. In 2007, only about Taka 109 million was generated from formal user fees, representing only 0.26% of total public health spending in the same year (Begum T, forthcoming). Collection of unofficial or informal fees is common in health facilities in Bangladesh (Killingsworth, et al, 1999), but no estimates of the volume of such fees are available.

Public health spending comprises less than 1% (one percent) of the GDP in Bangladesh. Public health spending as a share of GDP depends on the size of the overall public sector and whether health is a priority for the government. The country has the smallest public sector relative to the size of its economy (16% of GDP) in South Asia[2]. Only 6.3% of the total government budget was spent on health in FY 2009-10 (MOF 2011). Revenue-GDP ratio and Tax-GDP ratio indicate revenue raising capacity of the country. Revenue-GDP ratio is 12% and Tax-GDP ratio is 10%. This suggests limited revenue raising capacity of the government.

1. Policy does not allow for individual Ministries to retain user fees but must be sent back to treasury
2. Source:http://apps.who.int/nha/database/StandardReport.aspx?ID =REPORT_COUNTRY_PROFILE, Accessed on 29 June 2012.

During the second sector program HNPSP (Health, Nutrition and Population Sector Program) the target of 10% of the national budget for health was not realized. The budget allocation request for health stands at 4.87% in 2012-13 (MOF 2012).

Development assistance is an important source of funding for the health sector as it contributes about one fourth of the total MOHFW budget. At the beginning of the second sector wide program HNPSP 2003-2011 (worth US$ 4.3 billion), development assistance was one third of the total program budget, which was reduced to one fourth at the beginning of the third sector program HPNSDP 2011-2016 (worth US$ 7.7 billion).

NGOs' own financing accounts for one percent of total health expenditure (BNHA 1997-2007). NGOs in health sector are financed by donor assistance, own funding generated from community based health insurances (CBHI) or micro health insurances (MHI) and fee for services (Bangladesh Health Watch 2012). External assistance is the major funding source of the NGO sector. According to the BNHA 1997-2007, donor financing for NGOs accounted for about 8% of THE.

In Bangladesh, there are a number of notable and innovative community insurance schemes largely run by NGOs; however these schemes remain limited in scope and coverage[3] (Bangladesh Health Watch 2012). These NGOs in most cases are both insurer and provider. Most of the services offered are primary care, and a few provide secondary and tertiary care. The majority of these schemes are providing subsidized care instead of risk shifting, which is a characteristic of insurance as co-payment exceeds 50% in many cases (Bangladesh Health Watch 2012).

Other sources include private firms and private insurance. Private firms[4] spent BDT 1325 million on health in 2007 accounting for only 0.8% of THE according to BNHA 1997-2007. Private health insurance accounts for an insignificant share (0.2%) in THE; 14 out of the 44 enlisted insurance companies offer some form of health insurance, mostly group health plan for office or factory employees.

Report of the Commission on Macroeconomics and Health (CMH) of WHO (2001) strongly recommended increasing investment in health to promote economic development and poverty reduction. According to the report, the least-developed countries require minimum US$ 34 per capita, to introduce the essential health interventions. According to a recent estimate US$ 54 per capita is required to attain a fully functioning health system and to cover a basic package of services including interventions targeting non-communicable diseases by 2015 (WHO, 2010a). The results of the MDG Needs Assessment and Costing study (2009-15) show that US$ 19 per capita is required to achieve only the health related MDGs during 2009-15 in Bangladesh (GOB, 2009). There is a significant resource gap since Bangladesh spends US$ 16.2 per year per capita on health.

3. Microfinance NGOs introduced health insurance services since the late 1990s and early 2000s. Thirteen of the total 36 include health insurance but have a very small membership (Dror and Preker 2002, Ahmed et al. 2006).

4. Commercial banks mostly private will fall under this source. These banks spent BDT 689 million on health in 2010 as a part of Corporate Social Responsibility (CSR). This amount is 10 times higher than that was in 2007 (Bangladesh Bank 2011). This shows growing contribution of this source.

2.2 Inequity in Health Financing and Utilization

The manner in which "the health system is financed can have a profound effect on individuals' access to healthcare and thus on health, health inequalities, responsiveness and responsiveness inequalities" (Murray et al). In Bangladesh, the main source of financing of health care is out-of-pocket payments. O'Donnell et al (2008) found that in Bangladesh, the better off pay more out of pocket for health care, spend proportionally more of their household resources on health care, and also receive more or better care. The poor pay less and receive less health care since they simply cannot afford to pay and hence do not seek treatment (O'Donnell et al, 2008). Inability to afford health care leads to loss of health and subsequent erosion of earning capacity.

Illness shocks have catastrophic economic consequences through lost earnings besides catastrophic medical spending (van Doorslaer et al, 2007). The estimated income loss due to illness in rural Bangladesh was about one tenth of income of the hard core poor (BIDS 2001). Incidence of catastrophic payment for medical care is high in Bangladesh, with at least 10% of all households spending more than one fourth of their household resources net of food costs on health care. According to BIDS 2006, illness or health shocks pushed 18% of households into poverty.

The success of any health care financing strategy depends not only on how the resources are mobilized but also on how the collected funds are allocated and spent. There are some significant weaknesses in the way MOHFW allocates its resources both financial and non-financial across the different tiers of the health system. Every upazila level facility (sub-district) receives equal amount of resources irrespective of the need of the catchment population and service utilization. Per capita MOHFW spending varies across divisions. According to BNHA 1997-2007, per capita MOHFW spending in 2007 was lowest in Barisal receiving US$ 1.3 for health while it was the highest in Sylhet division receiving US$ 2.4.

Government has appropriately targeted 60-65% of total resources towards upazila and lower administrative levels providing primary care. However, the disaggregated figures of revenues and development expenditures show that in recent years the proportion of development expenditure going to upazilla and lower levels to total development expenditure has decreased from 65% in 2001/02 to 52% in 2007 (HEU 2010). The richest quintile receives more than 30% of the total subsidy. In most cases subsidies to hospital care is pro-rich while non-hospital care is pro-poor (O'Donnell et al, 2007). The pro-poor utilization of outpatient services may be affected also by the reliance of the poor on unqualified private informal providers (O'Donnell et al, 2008).

2.3 Low Levels of Efficiency in Healthcare Financing

Efficiency in healthcare financing comprises efficiency in resource mobilization and efficiency in utilization of existing resources. Resource mobilization through pre-payment mechanisms is more useful for its efficient usage.

Out of pocket payments by the households that account for 64% of total health expenditure (THE). OOPs do not use pre-payment mechanism and are not efficiently used. Pharmacies/drug shops are the major health care provider for Bangladeshi households, accounting for nearly two thirds of their out-of-pocket spending. Private pharmacies effectively partner with a poorly educated population to provide a "Self-treatment" option that is the dominant mode of curative care and an important additional source of sector inefficiency. Unnecessary and even harmful drugs are dispensed without a prescription, frequently in a branded form rather than in an equally effective generic form and in less than the required dosage that leads to the development of drug resistance. These are leading causes of inefficiency (WHO 2010).

Public spending accounts for only 26% of THE, mobilized through taxation (prepayment mechanism). Ministry of Health and Family Welfare accounts for 97% of public health spending and receives around 5.5% of the total government budget. Due to fiscal pressures the 2012-13 budget allocation request for health stands at 4.87%. Every year, a portion of MOHFW budget remains unspent which is reported by successive Public Expenditure Reviews (PER). This reflects weak absorption capacity which is largely due to rigid public sector financial management, an obstacle to efficiency.

The government budget provided to public hospitals is allocated on the basis of number of beds and staff employed. Important factors such as the quality of services, case mix and severity, and other cost factors are not sufficiently considered while allocating budget, which leads to inefficiency and inequity in the health system. Further, budget execution in many hospitals is poor, especially since local hospitals have limited authorization for purchasing goods for hospitals whenever required.

Private health insurance coverage is minimal in Bangladesh. Pre-paid health insurance premiums constitute only a negligible portion of total healthcare expenditure, just 0.2% of THE according to BNHA 1997-2007.

The mix of health care providers and expenditures on equipment, drugs and supplies is far from optimal. The health workforce in Bangladesh currently shows that there are only 0.300 physicians, 0.280 nurses or midwives and 0.020 dentists per 1,000 people in Bangladesh.[5] The shortage of trained medical providers is one of the reasons for the proliferation of untrained informal providers and of pharmacies being the most popular first point of contact for patients seeking medical care. Also, shortage of health workers in general and retention of qualified workers in rural and hard-to-reach areas in particular are acute problems in the health system in Bangladesh. Along with unavailability of

5. For instance, Thailand, a country with universal health coverage, has 0.305 physicians, 1.52 nurses or midwives and 0.070 dentists per 1,000 people.

inputs, inappropriate combination of inputs has been observed in Bangladesh.

Private sector professional providers are often employees in the public health sector. Lack of opportunities for private practices on the part of the public sector health professionals appear as a de-motivating factor for them to stay in underserved areas. Retention of such professionals in rural and poor areas has become a challenge.

Significantly increasing the number of trained medical providers in the system, designing incentive-compatible ways to post these trained providers to rural and far-flung areas, and instituting a system of effective management of absenteeism are some of the issues that need to be addressed in a full-fledged strategy for human resources in health in Bangladesh.

3 Health Care Financing Strategy

3.1 Vision and Goal

The vision guiding the health care financing strategy is to attain sustainable, equitable, effective and efficient health care financing to ensure equal access to quality health services to the whole population of Bangladesh.

The goal of the health care financing strategy is to strengthen financial risk protection and extend health services and population coverage, with the aim to achieve universal coverage.

3.2 Strategic approach

Social protection aims to protect population from major life risks and vulnerability. Health risks such as illness are major life risks. In a low income country such as Bangladesh, illness is one of the major causes of poverty and poverty also poses major health risks. Hence, protecting against catastrophic or repetitive health-damaging events is an important aspect of social protection. Social health protection is based on core values of universal access, solidarity, equity and social justice. Social health protection aims at removing financial barriers to access to health services and protecting people from the impoverishing effects of medical expenses (WHO 2010).

Generally speaking, social health protection instruments encompass three broad sets of interventions undertaken largely by public sector but also by private, voluntary organizations and informal networks (Cook and Kabir 2009). The three sets of interventions include: (i) social safety net programs which are non-contributory such as unconditional/conditional cash transfers, vouchers, in-kind transfers, subsidies; (ii) social sector policy, such as fee exemption at primary health care facility and nutrition interventions; and (iii) state contingent insurance, often contributory, for example, contributory pensions, health insurance and disability payment (Hoddinott 2010).

The 20-year health care financing strategy of Bangladesh covering the period 2012-2032 will combine funds from tax-based budgets with social health protection scheme, existing community-based and other prepayment schemes, and donor funding to ensure financial protection against health expenditures for all segments of the population. The strategic approach will address issues related to roles of various stakeholders, population coverage and financing mechanisms.

Roles of stakeholders

The proposed strategy envisages an increased engagement and strengthened stewardship role of the Ministry of Health and Family Welfare (MOHFW). The Ministry needs to assume diversified roles of steward, promoter, provider, contractor and regulator. It requires developing ethical standards for health service delivery, enforcing patient's charter of rights, formulation of legal and regulatory norms, developing standard treatment guidelines and management protocols for the national health benefit package so as to govern quality, quantity and price, and proactively promoting the case for sufficient resources for the health sector.

Since independence, the health care system has been evolving in response to the changing economic and political conditions. While the health sector is led and governed by the public sector; most health care is provided by the private sector (BBS 2011). NGOs mainly provide primary care through their community based network of volunteers. Large NGOs also provide curative care through clinics and hospitals which is relatively a recent phenomenon. The health care financing strategy aims to maximize the complementary role of the NGOs and the private sector through contracting and Public Private Partnership (PPP).

Development Partners (DP) play an important role by providing financial and technical assistance in the health sector. The proposed strategy envisages continuing DP engagement.

The proposed strategic interventions and actions will be designed in such a way so as to increase people's engagement and participation.

Financing mechanism and coverage

The health financing strategy focuses on addressing issues relating to all health financing functions-resource generation, pooling and purchasing. The proposed interventions and actions will put emphasis on how prepayment mechanisms that include both tax-based finance and other prepayment mechanisms will be collected, how these funds will be pooled and how they will be used to provide or purchase services. Prepayment will include both non-contributory and contributory mechanisms although contributory mechanisms might not generate substantial resources to start with due to the nascent tax base. Publicly provided health services will continue and the government will purchase services from non-state providers through contracting and PPP.

The proposed strategy will start its health protection coverage with the poor and the formal sector. Then it will expand/extend its coverage to informal sector in order to achieve universal coverage.

3.3 Strategic Objectives

To increase financial protection for the entire population, the following three strategic objectives are proposed:

1. Generate more resources for health
2. Improve equity and increase health care access especially for the poor and vulnerable
3. Enhance efficiency in resource allocation and utilization

Strategic Objective 1: **Generate more resources for health:** Issues related to current low levels of health financing can be addressed through an increase in the level and efficiency of the government's budget allocation and by designing and implementing a compulsory Social Health Protection Scheme.

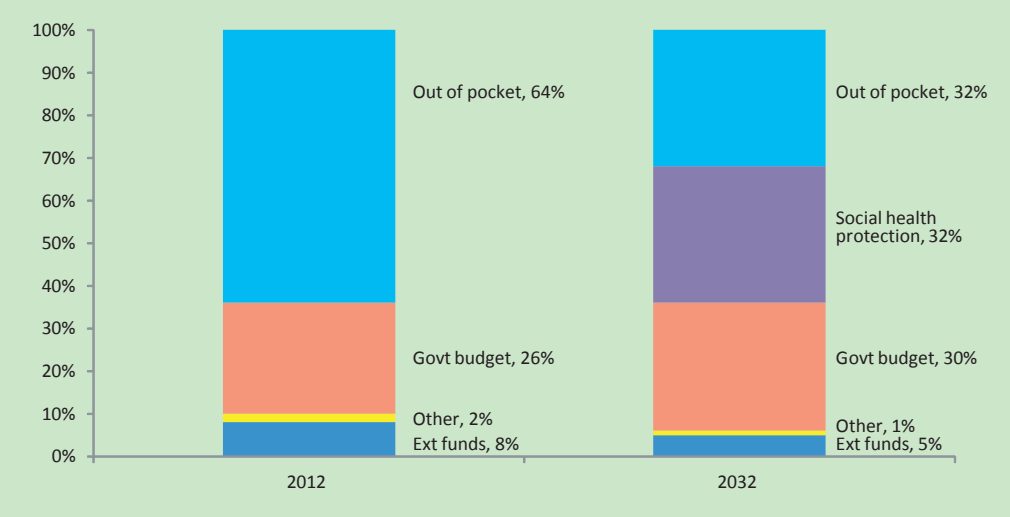
These efforts will be augmented through sustainable, harmonized and aligned DP funding specially for under-funded priorities and neglected health problems.

Considering the limitation of the government budget, extra-budgetary pooled resources from Social Health Protection Scheme and community-based health insurance schemes have the greatest potential to reduce and replace out of pocket payments with prepaid funds. In order to reach a significant share of total health spending, these extra-budgetary pooled resources must grow at sustained targeted rates through the 20- year period.

Strategic Objective 2: **Improve equity and increase health care access especially for the poor and vulnerable:** Equity in financial contribution embraces two critical aspects; that of risk pooling between the healthy and the sick and risk sharing across wealth and income levels. Risk pooling denotes the premise that the contributions for those that are healthy pay for the care of those that are sick, so that individuals who become sick are not struck by a double burden of sickness and financial costs of health care. Over an individual's life span, one is likely to benefit from the financial security of risk pooling when she or he becomes sick. Risk sharing, while similar, refers to the premise that fairness does not mean equal contributions from all, regardless of income or wealth, but that contributions are greater from those who have more financial resources. In practical terms, embedding these notions of fairness in financing is a step towards preventing the catastrophic expenditure of households when one of the members becomes ill. Various risks pooling interventions such as social health protection scheme or community health insurance, effective user fee exemption, etc. will protect patients from the financial risk of seeking or obtaining care.

The heavy reliance on OOP payments, which are inequitable and inefficient, has the most impact on the poor. Thus, the most important objective of the financing strategy is to halve out-of-pocket expenditures for health at the point of service from the current level of 64% of total health expenditure to 32% by 2032. To reach this target, other funding agents must grow faster than out of pocket payments.

Figure 1: Proposed Evolution of Financing Mechanisms



Strategic Objective 3: **Enhance efficiency in resource allocation and utilization:** Efficient allocation and utilization of resources can be achieved through a variety of means, including: (a) resource allocation to production levels linked with needs of the catchment area of the population and with performance; (b) needs based local level budgeting and planning; (c) deconcentration of budget and rationalization of expenditure control; (d) developing financial management (for example, budgeting and accounting) capacities at all levels of health sector, from central to service delivery level; (e) provider payment mechanisms. Innovative health care financing initiatives such as Results Based Financing (RBF), Performance Based Financing (PBF) and PPP can help address the human resource challenges in underserved areas. Reinforcing the Primary Health Care (PHC) through strengthening the referral system in particular will lead to efficiency improvements. Efficiency will be improved by ensuring that (i) each level of care provides the services which it is best equipped to provide, and (ii) expensive secondary care resources are not used to provide services which can be delivered more efficiently and effectively at lower levels of care. This will also reduce the non-healthcare costs of patients such as transportation expenses and other costs incurred by patients if seeking healthcare locally at a close distance from their home.

In the current public health system in Bangladesh, the government is playing the role of purchaser and provider simultaneously. Although for some interventions the government contracts with NGOs to provide TB, HIV/AIDS, nutrition and urban health services, more efforts should be made to strengthen the purchaser role. Efficiency will be enhanced by separating the purchaser from the provider of services, so that providers can focus on effective management of their facilities. This will require increased autonomy for public healthcare providers, so that they have the ability to manage their facilities in the most cost-effective way, under the overall policy direction of the MOHFW. Increasing autonomy is also likely to increase absorptive capacity. Autonomy for hospitals can take different forms: letting them retain revenues from fees, giving them the authority to hire and fire staff, and allowing them to raise funds.

The long term evolution from providing inputs to purchasing services will have several important effects. Firstly, providers will be paid on the basis of type and quantity of services delivered, and the delivery setting (higher at higher levels of the system). As a result, the budget will be largely determined by volume of services and not historical trends. Also, new methods and conditions of payment can be developed in a clear and transparent way, so that the managers of health facilities will know what level of funding to expect for a given level of activity. These changes will facilitate the better planning and management of resources.

3.4 Strategic Interventions

To attain these objectives, two strategic interventions are proposed: the design and implementation of social health protection scheme and the strengthening of financing and provision of the public health services; these interventions will be supported by a third: strengthening of national capacity.

Strategic interventions and supporting actions:

1. Design & implement Social Health Protection Scheme

- Determine institutional arrangements for social health protection scheme
- Design and implement Health Equity Fund/National Health Security Office
- Implement SSK for BPL
- Design social health protection scheme for above BPL (formal and informal)

2. Strengthen financing and provision of public health services

- Implement needs and performance based allocation
- Scale up/reinforce Result Based Financing (MHVS)
- Retain user fees at point of collection

3. Strengthen national capacity

- Support information exchange platform/knowledge hub/resources pool
- Develop the capacity to design and manage the social health protection scheme
- Strengthen Financial Management and Accountability
- Improve monitoring and evaluation
- Introduce mechanisms to support the production of additional key staff (nurses, paramedics and medical technicians)

Design and Implement Social Health Protection Scheme

This intervention will help to achieve all three strategic objectives. The Social Health Protection Scheme is national program with one pool, and one benefit package, first targeting the BPL populations and formal sector with the possibility for the informal sector to join the contributory scheme in a voluntary basis, in a first stage. In a later stage partial subsidy to those in the informal sector and near the poverty line could be introduced. The Health Equity Fund/National Health Protection Office is the pooling and purchasing mechanism of the scheme.

The first step is **determining of the institutional arrangement** for the Social Health Protection Scheme. The next is the **design of Health Equity Fund/ National Health Protection Office.** An autonomous organization, it will receive public, private, and development partners' fund and in addition to financing the Social Health Protection Scheme could provide resources for the existing and proposed interventions focusing on specific groups, conditions and behavior through social health protection scheme and results based financing mechanisms such as DSF (e.g. MHVS), PBF or conditional cash transfers (CCT). Flexible and targeted disbursements by the fund could increase access to quality care, increase financial risk protection, improve efficiency, and increase resources for health.

The next step will be to **implement the Shasthyo Shuroksha Karmasuchi (SSK).** Recently developed SSK by the Health Economics Unit (HEU) of the MOHFW, is a social health protection scheme which is a non-contributory scheme targeting the below poverty line population to provide comprehensive inpatient care. The fourth step is the design of the social health protection scheme for the formal sector (public, private and NGOs), including determination of the benefit package and costing of the package, with the intent of including the non-formal sector over time.

Strengthen financing and provision of public health services

In order to increase access, tax funded primary and preventive care and services will remain free and must be strengthened further improving efficiency and effectiveness. The following three actions are proposed to strengthen financing and provision of public health services.

Implement Needs and Performance Based Allocation: Implementation of needs and performance based allocation will help to achieve strategic objectives relating to equity and efficiency. At present, the allocation of resources from the center to public facilities is done on the basis of static input-based formulas, usually following historical numbers and revenue-expenditure statements. A more results and performance-based allocation system is envisaged, beginning initially with an allocation that takes into account the need of patients. It is based on the needs of the catchment area population. This will integrate into ongoing efforts to promote and support local level planning and management.

Scale-up/reinforce Results Based Financing (e.g. MHVS): Scaling up of Results Based Financing (RBF) such as demand side financing pilot is envisaged to achieve two strategic objectives relating to improving equity and access, and enhancing efficiency. A pathway to improve access and equity is the use of demand side financing schemes such as vouchers for the poor to promote access to selected services, e.g. maternal health services delivered by qualified medical providers. The Maternal Health Voucher Scheme (MHVS) targets the poor pregnant women, which has strong results-based financing elements, is already under implementation.

Retain User Fees: Retention of user fees at the secondary and tertiary level could generate revenue and also improve efficiency and quality of care. This will need flexible public financial management rules and regulations. It is to be noted that primary health care will continue to be free of charge for all and the social health protection schemes will cover the poor.

Strengthen National Capacity

National capacity refers to both individual and institutional capacity in public, private and NGO sectors. Strengthening of national capacity along with a strong stewardship role of the government will be crucial for the successful implementation of this strategy. It considers service provisions and scopes of the health care providers and also explores the mechanism to increase the capacity of the health care financing experts as a necessary condition in terms of number and excellence. The following five actions are proposed.

Support information exchange platform/knowledge hub/resources pool. This platform is critical for a variety of reasons. It will provide a forum for exchanging ideas, best practices and lessons learned from global, regional and local initiatives on social health protection, innovative health financing and the path towards universal health coverage. This forum can also be used for policy relevant research and analysis. The government can set the agenda but research and analysis can be done by the non-public sector. This will enable good analytic work feed regularly into policy thinking and analysis.

Develop the capacity to design and manage the social health protection scheme. To design and manage the social health protection scheme, it will be necessary to assess the existing resources in the relevant areas and also suggest specific policy recommendations which would inform the policy makers about the potential designs.

The government needs to have the capacity to: determine a national health benefit package, develop legal and regulatory norms, standard treatment guidelines and management protocols, ethical standards for health service delivery, enforce patient's charter of rights, accreditations guidelines and mechanism for the private and NGO health provider, and providers payments.

Strengthen Financial Management and Accountability: Financial management capacity is crucial for the implementation and success of the social health protection scheme. Strengthening financial management and accountability at all levels particularly at the facility level will enhance efficiency. It facilitates the public sector in accommodating greater autonomy to facility-level officials for the better management of their routine expenditures and become more cost-efficient. It is also integral to instituting a culture of responsibility and accountability.

Improve monitoring and evaluation: Implementation of social health protection schemes requires a sophisticated information system in place as well as strong system capacity to ensure effective measurement and regulation. Strengthening national capacity in monitoring and evaluation includes developing and enhancing capacity to exercise the stewardship role of developing, validating and adopting sector level indicators. Regular expenditure tracking, such as National Health Accounts and Public Expenditure Reviews, should produce accurate, reliable and timely feedback on performance needed to guide policy and institute changes to achieve the desired goals.

Introduce mechanisms to support the production of additional key staff (nurses, paramedics and medical technicians): To address chronic shortages of key staff, PPP programs providing financial incentives such as scholarship programs for nurses, paramedics and medical technicians will be introduced to increase the supply through accredited private sectors training institutions.

3.5 Population coverage

The entire population of Bangladesh will continue to have access to tax-funded health services provided through the public system and in addition they will benefit from the increased financial protection for health.

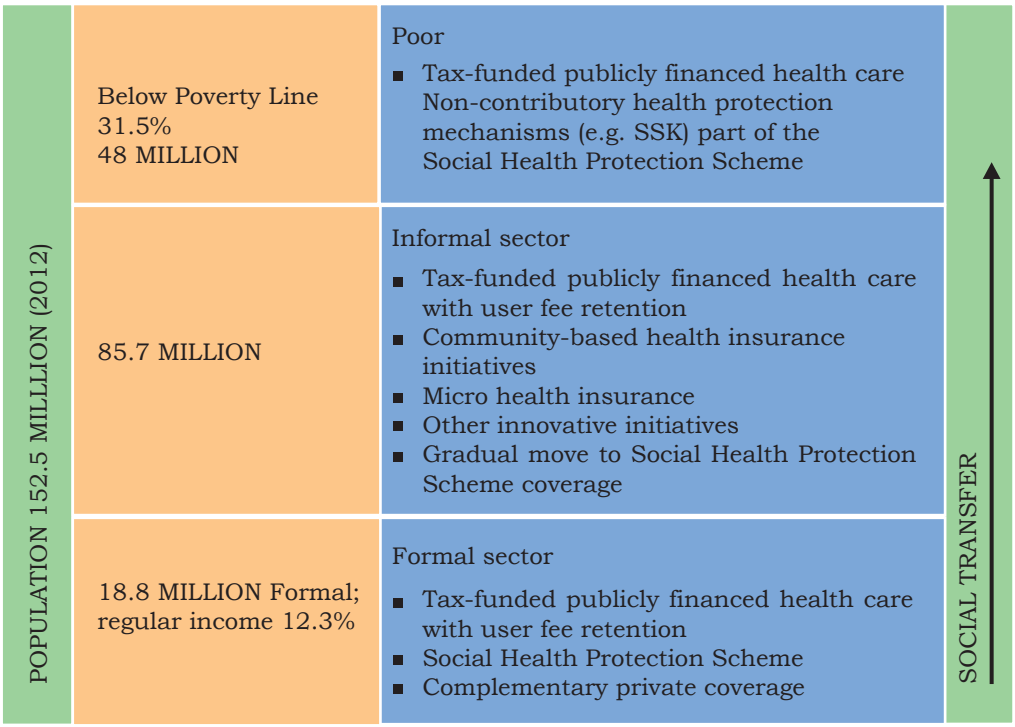
The poorest segment of the population, i.e., those defined to be below the national poverty line (31.5% of the total population according to HIES 2010); will be covered through non-contributory health protection schemes, such as SSK (Shasthyo Shuroksha Karmasuchi). The intent is to provide access to all levels of health care to the population living below the poverty line. The non-contributory health protection mechanisms will be part of the single and national social health protection scheme.

The formal sector (12.3% of total population), which includes some of the higher-income sections of the population, will participate in the future social health protection scheme. This population segment may also purchase health services

directly from private providers and may obtain complementary private health insurance if needed. The formal employment sector of civil servants and private-sector employees will be covered by social health protection scheme with payroll taxes and employer funding. The intent is to eventually cover all Bangladeshi formal and non-formal sector and those under the poverty line under a common scheme.

Another segment of the population has income above the national poverty line, but has only informal employment, irregular income and small levels of disposable income. This group may be able to afford small premium payments for existing or new community-based health insurance as a means to purchase financial protection against catastrophic expenditures that cause impoverishment, but is geographically dispersed, not part of any one organization, and is thus difficult (expensive and challenging) to reach with a formal financing mechanism. The HCFS proposes to explore and study the potential of community based health insurance (CBHI) and micro-insurance to cover this population as an interim measure. Coverage under existing pre-payment scheme will expand, and the gradual expansion of the social health protection scheme will lead towards greater coverage of this segment of the population.

Figure 2: Proposed Population Coverage and Financial Mechanisms



Sources: BBS for total population, BBS 2011 for population below poverty line and Maligaliget al 2009 for size of formal sector

3.6 Sequencing

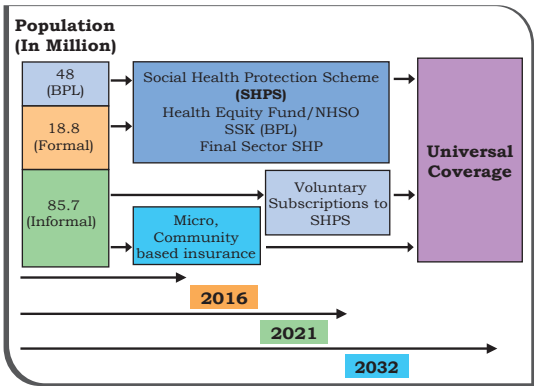
The strategy outlines a path towards financial protection for health to reduce the current high levels of out of pocket payments and catastrophic impact of seeking health care. It will do so in a sequential and realistic manner - covering the poor and vulnerable and the formal sector through a scheme with a common pool with a similar benefit package for risk sharing. The Strategy aims to mobilize additional public and private resources and leveraging them with improved efficiency. As other countries have shown, the path to Universal Coverage can be a long one. The strategy will be implemented in three time bound periods - short term, medium term and long term.

Short term will up to the end of the third sector wide program Health, Population and Nutrition Sector Development Program (HPNSDP) in 2016. The Government will start the SSK pilot - a subsidized health protection scheme for below poverty line (BPL) population in three sub districts immediately. During this period, the key elements of the Social Health Protection will be designed: a) the Health Equity Fund/National Health Security Office, an autonomous agency to handle the financing of the social protection program and b) the mechanism of social health protection for the formal sector (public and private).

Medium term will cover up to 2021 coinciding with the time period of vision 2021 of the Government. The Vision 2021 envisages that Bangladesh will be a middle income country by 2021. SSK for the BPL population will be scaled up. The mechanism for the formal sector will expand and coverage for the informal sector will increase through voluntary subscription to the Social Health Protection Scheme.

In the **long term**, spanning over 20 years up to 2032, the country aims to achieve universal health coverage meaning ensuring access to quality health services and financial protection for its citizens through a complete inclusion of the informal sector in the Social Health Protection Scheme. Sequencing of the various steps as outlined above is extremely important to ensure that the financing strategy meets its objectives. The figure below illustrates this sequencing.

Figure 3: Sequencing in the implementation of the Social Health Protection Scheme.



4. Strategic Level Objectives Indicators

This health care financing strategy is comprehensive as it includes a logical framework and a set of indicators, which define an analytical framework; see Annex B. This framework covers all aspects of health financing; resources mobilization, pooling, and purchasing (allocation). Using this framework the government and the sector stakeholders will be able to assess on-going and proposed health care financing interventions in light of the objectives of improving financial protection for health. If universal coverage is a direction then this health financing strategy is a road map.

Table 2: Health Financing Indicators

Indicator	Definition	Target			
		Current	2016	2021	2032
OOP as % of THE	Out of pocket expenditures as percentage of total health expenditures	64% (2007)			32%
% of prepaid THE by the new health protection schemes	% of new prepayment funds by new schemes and strategies	0%			
% of household facing catastrophic health expenditures	> than 10% of total household expenditures or > 25% of non -food expenditures	15% (2007)			0%
Utilization of services from formal health providers by poor and disadvantaged		TBD			
Health budget as % of national budget		5%	10%	12%	15%
% of unspent budget per year	As percentage of revenue and investment	4%			0.5%
% of population covered by prepayment schemes		TBD	20%		100%

5 The way forward

Stronger health systems play an important role in promoting better health outcomes. Health care financing is one of the six building blocks of health systems. The full impact of the strategy will depend on actions that fall under the other building blocks: human resource development and management, quality of health care services, disbursement of budgetary allocations, information technology, governance and stewardship.

Strategies, no matter how well designed, need significant political commitment and support from the policy makers, implementers at all levels and the general public for their successful implementation. An effective, on-going communication strategy will be required to set out the aims, expectations and results achieved through implementation of the strategy. It is important that this is set within the context of a sound long-term strategy.

Development of the health care financing strategy is the beginning of the journey towards achieving the ultimate goal - universal coverage. Developing a realistic, timebound and measurable implementation plan is the crucial next step.

Bangladesh's goal is to attain Universal Coverage by 2032 by extending financial risk protection and ensuring access to quality service. In some of the countries that have attained universal coverage through social health protection schemes, the process started with the formal sector first, then moved on to cover the poor, and finally those non-poor working in the informal sector. This strategy proposes to cover the poor and formal sector, government, private and NGO employees under one scheme.

Universal coverage is a direction, not a destination. What is important is to begin and take active steps to protect ALL Bangladeshis from the financial risk of seeking or obtaining care.

References

Ahmed MU, Islam K, Quashem MA, and Ahmed N. 2006. *Health Microinsurance: A Comparative Study of three Examples in Bangladesh,* CGAP Working Group on Microinsurance, Good and Bad Practices, Case Study No. 13.

Bangladesh Bank. 2011. *Review of CSR Initiatives in Banks (2010).*

Bangladesh Bureau of Statistics (BBS). 2011. *The Report of the Household Income and Expenditure Survey (HIES) 2010.*

Bangladesh Health Watch. 2008. *Bangladesh Health Watch Report 2007: Health Workforce in Bangladesh: Who Constitutes the Healthcare System?* Dhaka: Bangladesh Health Watch, James P Grant School of Public Health, BRAC University.

Bangladesh Health Watch. 2012. *Bangladesh Health Watch Report 2011: Moving Towards Universal Health Coverage.* Dhaka: Bangladesh Health Watch, James P Grant School of Public Health, BRAC University.

Bangladesh Institute of Development Studies (BIDS). 2001. *Fighting Human Poverty: Bangladesh Human Development Report 2000*

Bangladesh Institute of Development Studies (BIDS) and Chronic Poverty Research Center (CPRC). 2006. *The State of the Poorest 2005/2006:Chronic Poverty in Bangladesh:Tales of Ascent, Descent, Marginality and Persistence.* Edited by Sen B and Hulme D. BIDS and PPRC, University of Manchester

Begum, T. 2011. *Health Care Financing in Bangladesh: A Situation Analysis (draft).* Background paper prepared for World Bank Office, Dhaka.

Commission on Macroeconomics and Health (CMH), WHO. 2001. *Macroeconomics and Health: Investing in Health for Economic Development.* Geneva: World Health Organization.

Cook S and Kabeer N. 2009. *Socio-economic security over the life course: A global review of social protection.* Institute of Development Studies, University of Sussex. Prepared for Ford Foundation's Social Protection Committee.

Dror DM and Preker AS. 2002. *Social Re Insurance A New Approach to Sustainable Community Health Financing.* The World bank and ILO.

GOB.2009. Millennium Development Goals Needs Assessment & Costing 2009-2015 Bangladesh, GED, Planning Commission, GOB.

Health Economics Unit (HEU). 2010. *Public Expenditure Review of the Health Sector 2006/07.* HEU Research Paper 37

Health Economics Unit (HEU)/Data International (DI). 2010. *Bangladesh National Health Accounts (BNHA-III) 1997-2007 (Part 1)* Dhaka: Health Economics Unit, Ministry of Health and Family Welfare with GIZ Bangladesh support

Hoddinott, J. 2010. *Safety Nets and Social Protection: Opportunities for Mutual Learning between Asia and Latin America.* A background paper for the IFPRI and Uiversidad del Pacifico conference "Fostering Growth and Reducing Poverty and Hunger in Asia and Latin America: Opportunities for Mutual Learning", Lima, Pru 22-24 March 2010.

Killingsworth J, Hossain N, Hedrick-Wong Y, Thomas S T, Rahman A, Begum T. 1999.'Unofficial fees in Bangladesh: price, equity and institutional issues'. *Health Policy and Planning,* 14 (2): 152-163

Maligalig D S, Cuevas S and Rosario A. 2009. *Informal Employment in Bangladesh.* ADB Economics Working Paper Series No 155. Manila: Asian Development Bank

MOF. 2011. Monthly Report on Fiscal Position, December FY 2011-12, Macroeconomic Wing, Finance Division, MoF, GoB

MOF. 2012. *Bangladesh Economic Review 2012*, Ministry of Finance, Government of Bangladesh

Murray CJL, Knaul F, Musgrove P, Xu K, Kawabata K. *Defining and measuring fairness in financial contribution to the health system,* GPE Discussion Paper Series: No.24; World Health Organization EIP/GPE/FAR. http://www.who.int/healthinfo/paper24.pdf. Accessed June 16, 2012.

O'Donnell O, van Doorslaer E, Rannan-Eliya RP, et al. 2007. "The Incidence of Public Spending on Healthcare: Comparative Evidence from Asia". *The World Bank Economic Review,* Vol: 21, No. 1, pp. 93-123

O'Donnell O, van Doorslaer E, Rannan-Eliya RP, et al. 2008. "Who pays for health care in Asia?" *Journal of Health Economics* 27 (2008) 460-475

Van Doorslaer E, O'Donnell O, Rannan-Eliya RP, et al. 2007. "Catastrophic payments for health care in Asia". *Health Economics*

World Bank (1993) World Development Report 1993 Investing In Health, Oxford: Oxford University Press

World Health Organization (WHO). 2010. *The World Health Report: Health Systems Financing: The Path to Universal Coverage.* Geneva: World Health Organization

World Health Organization (WHO). 2010a. *Responding to the challenge of resource mobilization -mechanisms for raising additional domestic resources for health.* World Health Report, Background Paper 13. WHO

World Health Organization. 2011. *World Health Statistics* 2011.

Xu K, Saksena P, Jowett M, Indikadahena C, Kutzin J and Evans DB. 2010. *Exploring the Thresholds of Health Expenditure for Protection against Financial Risk.* World Health Report 2010 Background Paper No 19.

Annex A: NHA Data

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Health Expenditure in millions of current Takas											
Total health expenditure (THE)	48699	53602	59433	65497	74193	82978	89709	102229	117085	138955	160899
General government expenditure on health (GGHE)	17682	18341	19292	20217	23128	25223	24810	29316	29918	38696	41318
Ministry of Health and Family Welfare (MOHFW)	16979	17611	18508	19456	22339	24405	23955	28446	29012	37690	40096
Other Ministries	702	730	783	761	790	818	855	870	907	1005	1222
Private expenditure on health	31018	35261	40142	45280	51066	57755	64900	72913	87166	100259	119581
Out of pocket expenditure (OOP)	27573	31055	35071	38719	43456	48944	54461	61078	74506	86419	103459
Non-profit institutions (e.g. NGOs)	548	685	849	1019	1260	1265	1422	1579	1765	1954	2092
Other private sector (e.g. private firms)	597	646	534	964	691	774	1013	1021	1161	1356	1639
Rest of the world funds/external resourcs to NGOs	2300	2875	3688	4578	5659	6772	8004	9235	9734	10530	12391
Health Expenditure in millions of current US $											
THE	1140	1179	1237	1302	1375	1445	1549	1734	1907	2071	2331
GGHE	414	403	401	402	429	439	428	497	487	577	599
MOHFW	398	387	385	387	414	425	414	483	473	562	581
Private expenditure on health	726	776	835	900	946	1005	1121	1237	1420	1495	1732
Out of pocket expenditure (OOP)	646	683	730	770	805	852	941	1036	1214	1288	1499
Rest of the world funds/external resourcs to NGOs	54	63	77	91	105	118	138	157	159	157	180
Health Expenditures ratios											
THE as % of Gross Domestic Product (GDP)	2.7%	2.7%	2.7%	2.8%	2.9%	3.0%	3.0%	3.1%	3.2%	3.3%	3.4%
GGHE as % of THE	36%	34%	32%	31%	31%	30%	28%	29%	26%	28%	26%
OOP as % of THE	57%	58%	59%	59%	59%	59%	61%	60%	64%	62%	64%
Rest of the world funds/external resourcs to NGOs as % of THE	5%	5%	6%	7%	8%	8%	9%	9%	8%	8%	8%
Health Expenditures per capita											
THE per capita in Purchasing Power Parity $	20	21	22	24	27	29	30	33	37	43	46
THE per capita in US$	9.2	9.4	9.7	10.1	10.6	10.9	11.5	12.6	13.7	14.7	16.2
MOHFW per capita in US $	3.2	3.1	3.0	3.0	3.2	3.2	3.1	3.5	3.4	4.0	4.0
OOP per capita in US $	5.2	5.4	5.7	6.0	6.2	6.4	7.0	7.5	8.7	9.1	10.4
Macroeconomic Data											
Gross Domestic Product (GDP) in billions of current Takas+	1807	2002	2197	2371	2535	2732	3006	3330	3707	4157	4725
Exchange Rate (Taka per US $)	42.7	45.46	48.06	50.31	53.96	57.44	57.9	58.94	61.39	67.08	69.03
Population (in million)	124	126	128	129	130	133	135	138	139	141	144

Source: Bangladesh National Health Accounts (BNHA -III) 1997-2007 (Part 1), Research Paper 39a, 2010, Health Economics Unit

Annex B: Strategic Matrix

The Vision is to attain sustainable, equitable, effective and efficient health care financing for a healthier population
The Goal is to strengthen the financial risk protection, and extend population and health services coverage, with the aim to achieve universal coverage
Strategic Objectives
• Generate more resources for health • Improve equity and increase health care access especially for the poor and vulnerable • Enhance efficiency in resource allocation and utilization
Strategic Interventions
• Design & implement Social Health Protection Scheme • Strengthen financing and provision of public health care services • Strengthen national capacity
Indicators
• OOP as percentage of THE • % of households facing catastrophic health expenditures • Utilization of services from formal health providers by poor and disadvantaged • Health budget as % of national budget • % of Unspent national budget per year • % of population covered by pre-payment schemes

Annex C: Glossary of Terms[6]

Benefit package: a minimum set of services that are offered to an insured person within a level of contribution.

Catastrophic health expenditure: A situation where a household spends on health more than 40% of its income after paying for subsistence needs, e.g. food. It can be caused by catastrophic illness, either high cost but low frequency event or by low cost and high frequency events.

Conditional Cash Transfers: Monetary transfers to households over a certain time period when complying with certain health behaviors.

Contracting (or contracting-out): The process in which a legal agreement between a payer and a subscribing group or individual such as purchasers, insurers, takes place which specifies rates, performance covenants, and the relationship among the parties, schedule of benefits and other pertinent conditions.

Contributory scheme: This terminology is often used for social security systems where members regularly contribute to a particular social security scheme in order to have clearly defined social benefits such as old age pension, health services, maternity allowance and other monetary allowance in the event of disability or death. Noncontributory social security scheme refers to social assistance programs as well as services funded directly by the state budget or other public sources.

Demand-side interventions are interventions influencing demand for health services at individual, household or community level.

Effectiveness: The effect of the activity and the end results, outcomes or benefits for the population achieved in relation to the stated objectives. It is an expression of desired effect of program, service intervention in reducing a health problem or improving an unsatisfactory health situation.

Efficiencies (allocative and technical): a difference is made between technical efficiency which is concerned with using given resources to the maximum advantage; and allocative efficiency which relates to achieving the right mixture of health care programs to maximize the health of society. For technical efficiency one can think about the numerous empty beds in the numerous hospitals, indicating that respective human and financial resources are not used to full extent while for allocative efficiency one may consider low delivery of non-integrated preventive services.

Equity: The absence of systematic disparities in health between social groups who have different levels of underlying social advantage or disadvantage - that is, different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged such as by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group at further disadvantage with respect to their health.

- Horizontal equity: Equal payment for households in the same circumstances such as the same income.
- Vertical equity: Persons with greater need should be treated more favorably than others. The extent to which unequal households pay unequal share.

6. Glossary adapted from Draft Health Financing Strategy, Laos PDR, 2011-2015, Ministry of Health Lao PDR, Department of Planning and Finance, Version 19August 2011

Formal sector: Enterprises, which are registered and licensed to conduct business and whose employees earn regular salaries and wages.

Gross Domestic Product (GDP): The total value of goods and services produced within a country each year.

Health equity funds: third party system that reimburses health care providers for services rendered to eligible population.

Health insurance: Financial protection against medical care costs arising from disease or injury. The reduction or elimination of the uncertain risks of loss for the individual or household, by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member.

- Community based health insurance (CBHI): A micro-insurance scheme managed independently by community members, a community-based organization whereby the term community may be defined as members of a professional group, residents of a particular location, a faith-based organization etc.

- Micro insurance: Small-scale, local and independently managed scheme often set up because people are unwilling to trust in larger schemes. Most of the micro schemes are weak to deal with unpredictable large expenses.

- Social health insurance: Compulsory health insurance, regarded as part of a social security system, funded from contributions - often community rated- and managed by an autonomous yet state/ parastatal legal entity.

- Private health insurance: A health insurance scheme often characterized with the following features: voluntary, managed outside the social security system with risk-rated or community rated premiums, managed by an independent legal entity (an incorporation, organization, association or foundation) not by a state/quasi state body, operating for profit or non-profit.

- Voluntary health insurance: Health insurance that offers benefit to its members entitled on a voluntary basis, which can be managed by a private, public or quasi-public body.

Informal sector: Enterprises, which are not registered and licensed to conduct business but do so in an entrepreneurial, independent manner, and whose earnings are not reported or declared as part of a payroll process. Compared with wage-earning workers in the formal sector, the informal sector has more labor-intensive mode of production. Informal production units typically operate at a low level of organization, with little or no division between labor and capital on small-scale labor operations. Their existence is based on casual employment, kinship or personal and social relations rather than contractual arrangements with formal agreement.

National Health Accounts (NHAs): It provides a framework and methodology for measurement and presentation of information on total national health expenditure including public and private sources of funds. NHA tracks financial resources from sources, to providers and functions. It is important because, health systems are complex and policy makers need tools to analyze health financing - how much resources are used in a health system, what resource allocation patterns, use and options exist.

Out-of-pocket expenditure or payment: payments paid directly by patients (as private entities as opposed to a public entity) to health care providers at the time of receiving health services without recourse to reimbursement.

Pre-payment mechanism: a method of paying for the cost of health care services in advance of their use. A method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions, including those contributions that are made to a health fund by employers on behalf of their employees.

Provider payment methods (or mechanisms): Ways or means of paying health care providers such as on a capitation, case-based, fee-for-service or other basis (see also individual definitions).
- Prospective payment: Payment based on a formula that allows service providers to agree the total amount of funding in advance and then payments against that amount are made on a monthly basis.
- Retrospective payment: Payment based on services actually delivered in accordance with a fee schedule that is determined in advance.

Purchaser: This entity not only pays the premium, but also controls the premium amount before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

Resource allocation: The process by which available resources are distributed between competing uses as a means of achieving a particular goal.

Regressive financing: financing whereby the better-off pay a smaller share of their income compared with the poor for accessing health care.

Safety nets: A system that would allow economically and socially deprived citizens to continue to receive social services through free services, subsidized care, social insurance and social assistance. The system should assure that citizens retire with dignity and income - pension benefits; citizens are insulated from the loss of income due to economic forces out of their control - unemployment benefits; citizens not bear the full risk and costs for illness and injury - health benefits; and citizens are provided social welfare support.

Social health protection schemes: includes all kinds of health financing protection mechanisms, from tax-based financing, statutory social health insurance to private health insurance, health equity funds, community-based health insurance, and various fee exemptions for health services.

Supply-side interventions: interventions that address aspects inherent to the health system that hinder service provision

Universal coverage: implies access for all to appropriate promotive, preventive, curative and rehabilitative services at affordable costs.

User charges (or fees): Payment for goods and services according to price list or fee schedule.
Vouchers: a voucher entitles its holder the use of specific health services without paying the respective user fee at selected health providers as the voucher can be exchanged for a specified amount of money by the provider upon receipt.