Editorial

Tapering Healthcare Budget is a red alert for LMIC countries: The example from Bangladesh

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Introduction:

Bangladesh, an LMIC country listed by the WHO, despite having constitutional obligation to ensure the treatment of its' citizen when diseased, improve nutritional status and further amelioration of public health facilities, invests significantly low amount in healthcare, which in terms of GDP is only 0.9%. However, the country has made remarkable progress in reducing the maternal and under-five child mortality over the past couple of decades. Compared to neighboring countries, Bangladesh has set an example in mounting Healthcare Access and Quality Index. Unfortunately, all these achievements have been faded due to existence of a paradoxical health system which is staggering badly from the poor funding, lack of efficient and proper management, and top-to-bottom irregularities.

Bangladesh Jatiya Sangsad (The national assembly of Bangladesh) has passed the national budget worth Taka 4,64,573 crore for the fiscal year 2018-2019 setting the GDP growth target at 7.8 per cent in a bid to further alleviate poverty, reduce inequalities and bring basic and qualitative changes in living standards of people in its' las tbudget session in June 2018. The Minister of Finance of the Government of the People's Republic of Bangladesh (GoB), Mr Abul Maal Abdul Muhith rolled out in his budget speech to build a prosperous, happy, healthy and peaceful nation. (Reference: The 10th consecutive budget

of the current government at the Bangladesh Jatiya Sangsad proposed on Thursday, 07 June 2018).^{1,2}

A study undertaken by the icddr,b found that the out of pocket (OOP) health expenditure pushes four to five million Bangladeshi people into poverty each year. This is a great concern to the nation as a whole. Always a healthy nation produces healthy citizens for future endeavors. In his last budget speech, Minister of Finance Mr. AMA Muhith did not mention any specific plan to address the high expenditure issues. He spoke of building new hospitals, medical colleges and recruitment of the doctors, nurses and midwives. He proposed allocating Taka 23,383 crore for the health sector this fiscal year³.

However, compared to the total volume of the budget, the share of the health sector has decreased from last year's allocation of 5.39 percent to 5 percent this year.

Country's Overall Situation:

Dr. Rashid E Mahbub, Chairman of National Health Rights Movement, said that, the health budget for the next fiscal year was much lower as World Health Organization (WHO) recommends it to be 15 percent of the total budget. "With the cost of all healthcare services growing, it is very likely that the out of pocket health expenditure would go up," said Dr. Rashid. Dr. Mahbub Elahi Chowdhury, Acting Director and Scientist of Universal Health Coverage Programme at the icddr,b, said that, Bangladesh has a good healthcare infrastructure

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up to the rural level; there is also a good number of doctors and nurses. But these resources are not properly being utilized. Here we find lacks in the operation for which the total goal is being threatened and unsuccessful that means monetary problem is not the main constraint³⁻⁵. Allocation of small amount of money to meet managerial and operational logistic expenses can help to improve this scenario dramatically.

There have been four rounds of NHAs in Bangladesh since 1997. The recently completed BNHA-IV covers 1996/97–2011/12 and it is based on the System of Health Accounts (SHA) 2011 framework. BNHA-IV estimates total health expenditures (THE) at 3.5% of GDP (BDT 325,094 million) and a relatively low per capita THE at BDT 2,144 (US\$27). Health expenditure estimates presented above show that urban THE is proportionately higher (at 33%) compared to the urban share of the population (23%). Government financing is 17% of urban THE while it is 26% of rural THE. Urban household OOP health expenditures is proportionately higher at 68% of urban THE compared with rural at 61% of rural THE.⁶

According to Bangladesh National Health Accounts 1997-2015, OOP health expenditure (private/personal spending) in Bangladesh is 67 percent, which is more than double the global average of 32 percent.^{1,3} Now the question arises, how money is going to be utilized. “Will the hospital management be better? Will the private sector be better regulated?” Rashid said. He also added that the government proposed reducing import duty on the raw materials for some medicines, but people won't be benefitted from this measure unless the price of medicine is regulated. And, “Improving governance is the key to providing quality and affordable healthcare to the people of the country.”^{1, 3}

Rising incomes and aging population, with its growing the burden of chronic diseases, will progressively add to demands for complex and expensive health care. At the same time, the impressive performance of the preventive and primary care has to be maintained and need to be kept available for the population. The high out of pocket spending and the catastrophic impact of it, especially on the poor and vulnerable, must be decreased and financial protection for the health must be increased. The strategy needs to meet the financing challenges confronting the health sector now and in the future⁷.

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 resources⁷.

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 document⁷.

According to the National Health Policy (NHP) 2011 of Bangladesh, a Healthcare Financing Strategy 2012-2032 was undertaken by Government of the People's Republic of Bangladesh (GoB) to reduce OOP to 32% within 2032, which suggested substantial raise in budgetary allocation in health every year. But the real scenario is the exact opposite. For the past several years, the percentage of budgetary allocation for health has become static in between 4% to 5%, whereas the recommended level by the WHO is at least 15% for the least developing countries like Bangladesh. Again, more than half of this inadequate budget is allocated for non-development sector. Almost half of the budgetary fund for health sector is allocated for Dhaka Division only; the rest half is allocated for the other seven administrative divisions.⁸ Study shows that, almost one-third of the medical equipment installed in the public healthcare facilities remains unused and or even uninstalled thereof with the caregivers.⁹ They are noticed carelessly fallen abandoned hither and thither without any concern of the authority.¹⁰

National Concerns:

In our country, historically, supply-side financing of the health care services has been the backbone strategy for improving the access of the poor households to essential health care services. Public sector subsidies did not reach the target groups, while mix of subsidized services has not always been the most-appropriate. The better-off groups have received the much greater share of public subsidies in health through the secondary and tertiary health care centres. More than two-thirds of the total expenditure on health is privately financed through out-of-pocket payments. Of the remaining one-third (public financing), about 60% is financed by the Government from tax revenues and the other 40% through international development assistance. Since most of the health care expense is privately borne, ability to pay is a vital determinant of access to the facilities.^{10, 11}

Reviews to Find out Means & Ways:

Bangladesh is one of the 57 countries suffering badly from strong and dedicated health workforce crisis around the territory. Most of the health workforce is clustered around Dhaka, the capital of the country and in other urban areas. The number of caregivers in peripheral healthcare settings is extremely inadequate. The patient load in all levels of public hospitals is massive. Every day, on an average, 200 patients visit the OPD in Upazilla Health Complex, the primary healthcare centers at the sub-district level. The number is almost 600 in district level hospitals and around 2000 in Medical Colleges and other tertiary level hospitals. According to World Bank only one hospital bed is allocated for 1667 people. Contrary to these facts, 34% of the total govt. posts in health sector are vacant, claims the government report. These discrepancies could be met up by following the NHP-2011, which suggested sufficient allocation and efficient use of funds in health sector.⁸

The NHP-2011 also addressed the issue of maternal and child malnutrition and vouched for financial measures to be taken to combat the issue. According to Bangladesh Demographic and Health Survey 2014, 36% of the under five children in Bangladesh are stunted, 33% are underweight and 14% are wasted. Prevalence of Low Birth Weight due to malnourished mother is 43% in Bangladesh. Unfortunately, the suggestions of the NHP to raise allocation for these issues are not reflected in the budget.⁸

Bangladesh is experiencing the epidemiological shift of disease burden from infectious diseases to NCD's. 52% of the total death per year is due to NCD's like cardiovascular diseases, hypertension and its complications, diabetes etc. Also, Bangladesh is in the midway of its demographic dividend period. Low fertility rate combined with higher life expectancy is driving the country towards a rise in the younger population. UNDP reports predict that, this rise will reach its peak in 2030 resulting in highest number of working age population in the history. Financial risk protection for this large working age group is of paramount importance for future economic growth of the country. By 2050, the median age of Bangladeshi people is predicted to be 40 which is 26 now. This means a coming surge of geriatric and other non-communicable diseases are on its way as NCD's constitutes 87% of the disease burden in population older than 60 years. Besides, emerging health related threats due to climate change

are also a matter of great concern, to combat which innovative financial initiatives are to be undertaken¹².

Bangladesh is committed to ensure UHC to achieve SDG 3. However, low budgetary allocation for health by the GoB, inequitable distribution and inefficient utilization of resources, high OOP, rapid privatization of healthcare services leading to rise of treatment cost, rising burden of non-communicable diseases, increasing mean age resulting in a risk of increase in geriatric problems, health hazards likely to be emerged from the effects of climate change are the main obstacles of the country towards achieving UHC. The country needs to find out the innovative healthcare financing system, introduce public health insurance schemes, initiate special compensatory schemes for the ultra-poor, destitute and hard to reach population and for the garments workers, emigrant workers and their families as well. Involvement of health economists and public health experts in District and Upazila levels could prove to be fruitful in implementing these policies.⁸

Development Partners:

There are a lot of UN Agencies, International NGOs/Foundations; Foreign Government Agencies have been actively participating in health sector development activities of the Ministry of Health & Family Welfare, Government of Bangladesh since inception of the independence as development partners. They are providing grants in research, implementations, treatment, purchasing instruments as well as infrastructural developments. The contributions are provided both in cash and kinds. Total DP contribution to the development budget is about 61.29% which is very significant.¹³⁻¹⁵

Bangladesh's average per capita health expenditure is nearly US\$32, which is the lowest in the regional concerns compared to India, Afghanistan, Nepal, Bhutan, Pakistan and Sri Lanka.⁷ However, the actual expenditure is more than three times higher than that of Sri Lanka and nearest to double in India. The WHO recommends a per capita spending of minimum US\$54 in our country. Bangladesh Government allocation for budget year 2018-2019 is very insignificant per person which cannot meet the need of proper health care. With the ever increasing health care cost, one can easily realize to what extent the allocated money could help the ailing person. Helps from the Development Partners are keeping us in this a little better shape.

The consequences of excess OOP expending are enormous with the different scenarios. Some households cannot utilize formal healthcare at all due to excess OOP payments, or they may receive partial care and thus aggravate the disease condition, causing the disease to become a chronic situation. Sometimes the households compelled to sell their movable and immovable properties to manage the treatment costs, which in turn make them poorer. Due to excess health expenditures, the households may need to ration their food items, and thus may become malnourished. OOP health expenditure may affect education, causing children to drop out of school. Moreover, OOP payments may mislead planners and the policy makers to miscalculate poverty status.¹⁰

Conclusions:

Bangladesh is a global development success story: economic growth has averaged 6% since 2003 poverty has halved between 1990 and 2010. Whilst economic growth has led to some development through the agricultural productivity, garment and pharmaceutical exports and remittances, Bangladesh still has 37 million people living in poverty, with 21 million of those living in the extreme poverty. Bangladesh is also highly vulnerable to the natural disasters such as floods, river erosion and cyclones etc. each and every year. Unstable politics and poor governance risk slowing things down, as do social problems like the violence against women, early marriage and signs of rising extremism.¹⁶

Why Health Budget is becoming Poorer?

Analyzing the scenarios side by side, as Bangladeshi we feel proud of seeing the national budget has been growing much bigger over the years but at the same time it is our great concerns that the MoHFW portion is becoming smaller in terms of its proportion (as percentage on total budget). Could we assume that we are fulfilled in the health aspects, and became healthy? We expect to keep on our sustainability as a whole at this moment.

We are very sorry to regret that out of time constraints, we could not be able to take consent(s) from the concerned authors under reference which could be obtained in due course. We also express our deep concerns on those which are quoted but not even acknowledged inadvertently.

Authors Contributions

Conception and design: SI, AR

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Critical revision of the article for important

Intellectual content: SI, AR, TAB

Final approval of article: TAB, AR, SI, AAM

Statistical expertise: NA

Collection and assembly of data: NA

Abbreviations:

BNHA	Bangladesh National Health Accounts
DP	Development Partners
JS	Bangladesh Jatiya Sangsad, Dhaka-Bangladesh
LDC	Least Developed Country
LMIC	Low and Middle-income Countries
NCD	Non-communicable Disease
NHP	National Health Policy
OOP	Out-of-Pocket
SDG	Sustainable Development Goals
THE	Total Health Expenditures
UHC	Universal Health Coverage

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