Commentary

Health Financing in Bangladesh: Why Changes in Public Financial Management Rules Will Be Important

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INTRODUCTION

Bangladesh has achieved remarkable improvement in health indicators since its independence in 1971, despite poor economic conditions. It achieved Millennium Development Goal 4 on child mortality and progressed substantially toward Goal 5 on maternal mortality, even with health system bottlenecks such as weak governance, insufficient health financing, and limited capacity to address local need.1 In a country with a history of adopting low-cost strategies with high health impact,2 focusing on primary health care—even with limited resources—was the single most important factor in these achievements.

More recently, Bangladesh has committed to achieving the Sustainable Development Goals and universal health coverage. Continuous economic growth in Bangladesh has increased the buying capacity of the population, and increasing income levels and education have led people to seek more and better quality health care.2 Such growth does not come without complications, as can be seen in the changing burden of disease from communicable to noncommunicable diseases,3 high disease burden among the urban population, and increasing out-of-pocket expenditures on health.

Total health expenditure in Bangladesh in 2015 was 2.9% of gross domestic product, one of the lowest allocations in the world. At the same time, out-of-pocket expenditures represented 67% of total health expenditure, which is one of the highest proportions in the world.4 Annually, about 4% of households are pushed into impoverishment due to high out-of-pocket expenditures on health.5 Bangladesh’s Health Care Financing Strategy 2012–2032,6 established by the Health Economics Unit of the Ministry of Health and Family Welfare (MOHFW), sets a target of reducing out-of-pocket expenditures on health to 32% of total health expenditure and identifies several health financing reforms to move the
country towards universal health coverage. This strategy proposes three strategic objectives: (1) generate more resources for effective health services; (2) improve equity and increase health care access especially for the poor and vulnerable; and (3) enhance efficiency in resource allocation and utilization. Work toward these objectives has already begun: The Health Economics Unit has designed and piloted a social health protection scheme, while the seventh Five Year Plan (FY2016–FY2020) of the government of Bangladesh (which is the overarching development plan for Bangladesh covering 13 sectors) and the fourth Health, Population and Nutrition Sector Programme of MOHFW (which is the sector-wide approach for the health sector) highlight the importance of and commitment to implementing the health care financing strategy.

HEALTH SERVICE DELIVERY STRENGTHENING, HEALTH FINANCING, AND PUBLIC FINANCIAL MANAGEMENT

In this commentary, we discuss two specific issues in health financing that are underscored in the health care financing strategy and that can be addressed through better public financial management (PFM): inefficient resource allocation and impediments to local use of locally generated funds. Resolving these issues will improve efficiency in the health system, which in turn will support policy advocacy for increasing the budget allocation for the health sector in Bangladesh. Concerns about accountability and transparency in the use of funds will have to be simultaneously addressed, because good governance will need to go hand in hand with improved health financing to enable overall health system strengthening. Improvement in governance ecology in the health sector in Bangladesh will influence the level of efficiency gain associated with any PFM reform. PFM plays an important role in fiscal discipline and efficient allocation of resources to priority needs. However, outdated or weak PFM practices limit the efficiency of budget formulation and execution and health care service delivery, hampering the system’s ability to provide desired health outcomes. This commentary is not proposing significant changes to the entire PFM function; rather, we suggest some specific rule changes that are likely to have important implications for the Bangladesh health sector.

This would not be the first time that Bangladesh has made changes to its PFM system. Some major PFM reform programs have been undertaken since 1996. The most notable was a change from a single centralized accounting office for all PFM-related work to separate offices for each ministry, with extension-of-delegation rules. The other successful reforms introduced a flexible “medium-term budgeting framework” into the national budgeting system and established links between the expenditure framework and the budgetary framework.

At the request of and in partnership with the Health Economics Unit, the World Bank is conducting a diagnostic study on PFM to identify and document PFM issues as they relate to public health service delivery and implementation of the health care financing strategy. The objectives of this study are to identify PFM reforms required for implementation of the health care financing strategy and to inform the Ministry of Finance (MOF) and PFM stakeholders on specific PFM barriers and inefficiencies within the Bangladesh health sector, with possible options for addressing them. The assumption is that removal of identified constraints would yield significant welfare gains. The study will provide an understanding of what elements of PFM and health financing are critical for effective and efficient service delivery in the health sector. This study will provide recommendations to address PFM-related issues in the health sector and will provide evidence necessary to realize the proposed changes discussed in this commentary: need-based resource allocation and use of locally generated funds at the health facility level.

NEED-BASED RESOURCE ALLOCATION

Bangladesh’s public health care system follows a traditional method of resource allocation from the national to the local level: Facilities get resources based on their number of beds and previous funding history, rather than on any needs-based criteria (such as population size, disease burden, bed turnover rate, etc.) or performance-based criteria. The result is inefficiency in allocation. Budgets and expenditures end up not being linked to population size, the number of patients treated, or health indicators. To improve allocation efficiency, the resource allocation method and budgetary rules will need to be changed to reflect the needs of the facilities and the populations. Several allocation criteria have been considered and modeled. Exploratory studies have been conducted in Bangladesh for different methods of resource allocation, including geographic-based allocation, need-based allocation for health care facilities, and allocation based on regional poverty status.

For the health sector, however, any PFM reform must also provide for adequate delegation of authority at the local level. Making this change will require the agreement of officials from various ministries, including the MOHFW and MOF. It will also require the sensitization and buy-in of key
stakeholders at the national and facility levels, given that there are bound to be some losers as certain facilities or districts initially receive reduced allocations based on the reform. The selling point for all is that, after demonstrating increased efficiency through this change, the MOHFW can then advocate for increased budget allocation to the health sector, which eventually will benefit everyone. It is clear that the change process will take time and will require sustained effort on the part of the MOHFW to ensure appropriate awareness and to take action. In addition to the resource allocation mechanism, the system will need to have strong governance in place for efficient management of those resources.

USE OF LOCALLY GENERATED FUNDS AT THE HEALTH FACILITY LEVEL

Historic PFM rules in Bangladesh require any funds collected at the local level to be deposited in the government treasury. This is true for all government sectors, unless an exemption is provided. Thus, any fees collected at the health facility level, such as for diagnostic services or ambulance rental, can only be used by the health facility after the MOHFW establishes a concurrence with the MOF and receives an approval for exemption. Altering PFM rules to make these funds locally available or to increase the autonomy of facilities would improve efficiency and quality of care while enhancing the sense of ownership at the facility level. Modification of restrictive PFM rules at the national and local levels would be essential, because funding could come from both sources. Strong governance systems, with accountability, would be a prerequisite to ensure efficient use of locally generated funds.

Ethiopia’s revenue retention and use program, in place since 2011, offers a good example for Bangladesh. Under the program, public health facilities are allowed to retain and use revenue collected from user fees as an addition to the regular budget. Health facility governing board members manage the funds to improve quality and ensure availability of all supportive services. This revenue retention program is being implemented in parallel with programs to establish and operationalize health facility governance and strengthen public financial management. In 2016, over 90% of health centers and 95% of hospitals in Ethiopia were retaining and using their revenues. This is becoming an increasing source of funding for health facilities, accounting for about 28% of health center budgets and 30% of hospital budgets between 2011 and 2016.\textsuperscript{14,15}

In Bangladesh, a recent example is also available. One of the national-level tertiary hospitals, Bangabandhu Sheikh Mujib Medical University, was given autonomous status in 1998 (related to setting up of the medical university from an existing postgraduate hospital) and has been allowed to retain collected revenues, though studies are not yet available on the anticipated results of improved service quality.

THE WAY FORWARD

To implement the health care financing strategy (which needs to be a priority) and to address the two health system bottlenecks discussed above, Bangladesh will need to change PFM rules and procedures as well as tackle other systemic challenges. Modifying PFM procedures is a long-term process that needs to start now, requiring strong political will as well as improved governance system in the health sector in Bangladesh. Any changes in PFM, with an eye to improving health financing and health outcomes in Bangladesh, will have to carefully consider financial control and ensure transparency and accountability.

DISCLOSURE OF POTENTIAL CONFLICT OF INTEREST

No potential conflicts of interest were disclosed.

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