
# Social Protection in Action: Building social protection floors for all

## Country Brief: Bangladesh

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## Extending Social Health Protection in Bangladesh: Accelerating progress towards Universal Health Coverage

### 1. Introduction

Since the establishment of Bangladesh's first Constitution in 1972, the improvement of health care and nutrition has been established as a priority, with the state primarily responsible for ensuring the provision of health services as a basic necessity. [1] The statutory public health system therefore provides all citizens with a range of services, with only nominal user fees charged to patients. In practice, however, the system is struggling to provide adequate levels of care, with many sick people being left untreated (WHO 2015). Private facilities have mostly filled the gaps, resulting in a high share of out-of-pocket (OOP) health spending, and hence limited financial protection for the population.

To date, national development policies have not given sufficient weight to the health sector, resulting in few systematic improvements. Consequently, both the allocation and the level of government expenditure on health is low relative to the services promised, accounting for just 5.4 per cent of the overall government budget and 0.95 per cent of GDP. Despite these challenges, the government aims to achieve full universal health coverage (UHC) by 2030. This would require public spending on health to substantially increase, which currently accounts for only 17 per cent of cumulative spending on health. In addition, the large share of the informal economy in Bangladesh will require tailored revenue raising mechanisms to ensure the financial sustainability of the social health protection system.

### 2. Context

The current health system in Bangladesh developed from a system of government-owned and government-funded health care services, which was primarily established during British colonial rule. In recent decades, the public health sector has undergone several changes, including the introduction of a sector-wide approach and an essential service package for primary health care. The National Health Policy 2011 articulated several goals, including increasing the health

[1] Bangladesh Constitution of 1972, reinstated in 1986, with amendments through 2014, available at: https://www.constituteproject.org/constitution/Bangladesh_2014.pdf?lang=en

budget every year, ensuring free treatment for the poor through the provision of health cards, and introducing social health insurance for formal sector employees, and for other population groups in the long term (Bangladesh Ministry of Health and Family Welfare 2011a). The 7th Five-Year-Plan (2016–2020) promoted the piloting of risk-pooling mechanisms such as social health insurance, and the implementation of the national Health Care Financing Strategy (General Economics Division 2015). These issues have also been emphasized in the 8th Five-Year-Plan (2020–2025), which has focused primarily on addressing COVID-19 and other infectious diseases.

Long-term efforts to strengthen the Bangladeshi public health system are set out in the Health Financing Strategy 2012—2032, which aims to reduce OOP expenditures from 64 per cent to 32 per cent between 2012–2032; increase government expenditure from 26 per cent to 30 per cent; reduce the share of external funding from 8 per cent to 5 per cent (all three indicators are relative to total health expenditure); and increase social protection coverage from less than 1 per cent to 32 per cent (Health Economics Unit 2012).

To realize these goals, in addition to the national health service, a number of schemes are being piloted by the government, often through official development assistance. Specifically, Shasthyo Shuroksha Karmasuchi (SSK), a government-financed and administered social health protection scheme that targets the population below the poverty line, was launched in 2016 (Islam, Akhter, and Islam 2018). Furthermore, the Maternal Health Voucher Scheme (MHVS), a non-contributory demand side financing scheme covering 53 upazilas (sub-districts), was launched as a pilot scheme in 2007 (Ahmed, Begum, and Smith 2019). To address a lack of social health protection schemes available for government employees in Bangladesh (Molla and Chi 2017), a government-employee contributory scheme is also being designed (Rahman et al. 2018), and several initiatives are being implemented in the garment industry. Some community-based health insurance (CBHI) schemes have also been implemented, without achieving considerable pooling (Islam, Akhter, and Islam 2018). All of these schemes are currently implemented at a very small scale, and are consequently not discussed in this profile, which focuses on the National Health Service.

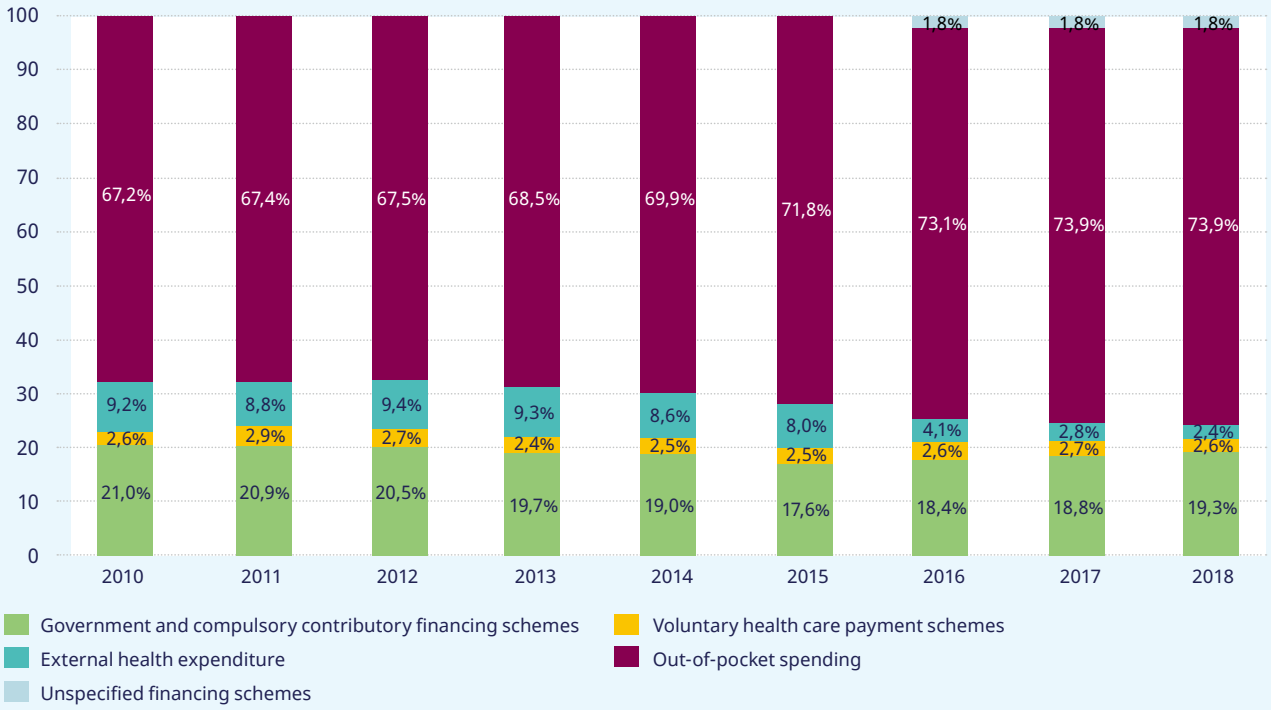
# 3. Design of the social health protection system

- Financing

In 2018, per capita spending on health was US$41.9, equal to 2.34 per cent of GDP (WHO n.d.). Although government expenditure on health care has increased nominally in recent years, its share in overall health spending continues to decline (Mustafa et al. 2018). OOP expenditures accounted for 73.9 per cent of current health expenditure in 2018, while government schemes and compulsory contributory health care financing schemes accounted for 17 per cent, external health expenditure accounted for 6.8 per cent, and voluntary health care payment schemes accounted for 2.3 per cent (WHO n.d.). Notably, there are no dedicated tax sources for the public health system. Recurrent expenses of the Ministry of Health and Family Welfare (MOHFW) are primarily funded through general government revenues, while development budgets are used predominantly for investments and technical assistance (Mustafa et al. 2018).

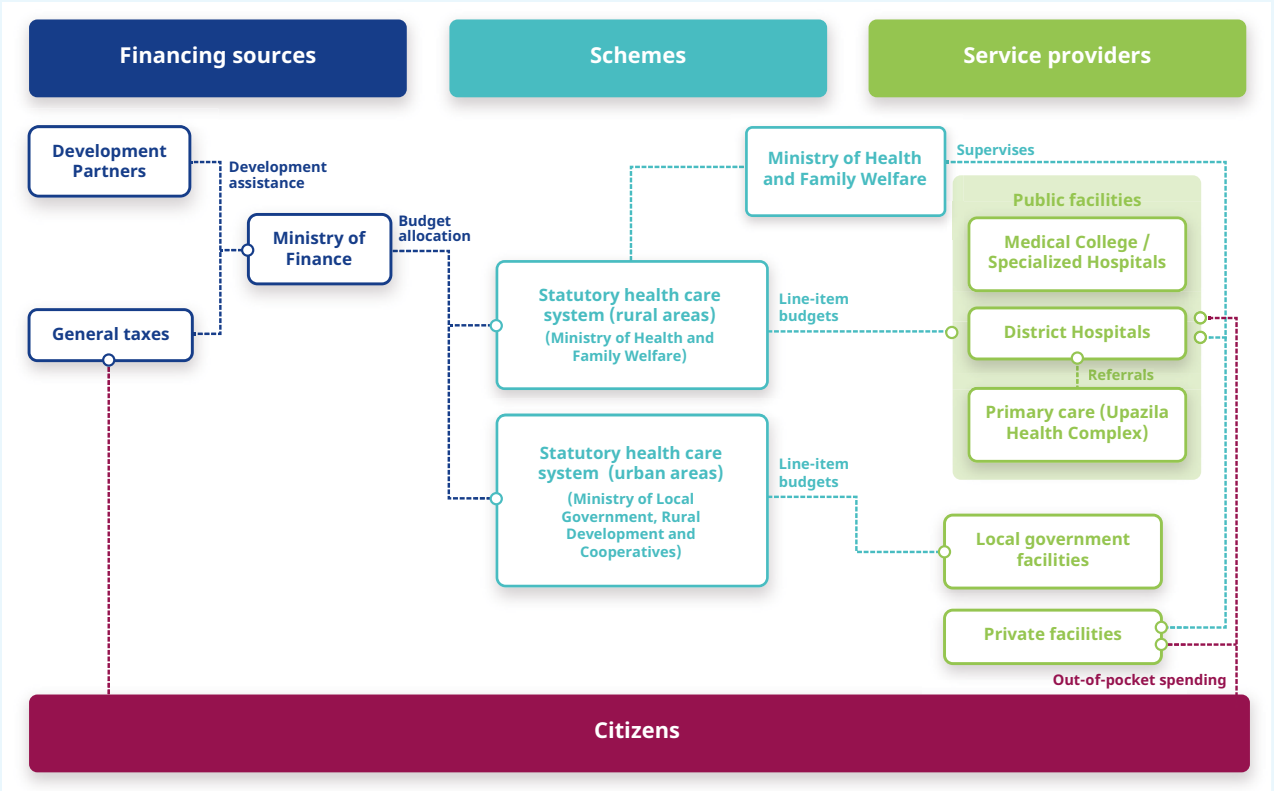
As part of the "Sector Wide Approach" (SWA) implemented in Bangladesh in 1998, several international donors participate in a health sector programme, which involves a pooled funding mechanism (OECD 2006). The participating development partners provide sector-wide support, with contributions made directly into a government account at the central bank and subsequently distributed by the government to implementing agencies through regular budgetary channels. This funding mechanism has been noted to reduce duplication and allow the government to exercise greater control over funds (WHO 2015).

## ▶ Figure 1. Analysis of total health expenditure in Bangladesh




Source: Adapted from WHO Global Health Expenditure Database.

## ▶ Figure 2. Overview of main financial flows of the social health protection system in Bangladesh




Source: Authors

- Governance

The public health system in Bangladesh is highly centralized. The MOHFW is responsible for all institution-based health care delivery in the country and manages the public system of general health, family planning and nutrition services in rural areas throughout the country. According to the City Corporation Act 2009 and the Municipality Act 2010, local government institutions (LGIs) take formal responsibility for primary health care in urban areas.

- Legal coverage and eligibility

In principle, the national health service covers all citizens, and public health facilities are accessible to all citizens irrespective of social status, race or religion.

- Benefits

The MOHFW published its most recent essential health service package (ESP) in 2016. It defines the minimum set of services that must be provided by public facilities to meet a certain level, and lists some additional services that may be provided by facilities if their infrastructure allows for it (Bangladesh Ministry of Health and Family Welfare 2016). The ESP covers interventions for five core service areas: (i) maternal, neonatal, child and adolescent health care; (ii) family planning; (iii) nutrition; (iv) communicable diseases; and (v) non-communicable diseases. In addition, some "common conditions" are covered, including eye, ear and skin conditions, dental care, emergency treatment, and geriatric care. In terms of non-clinical support services, the ESP includes laboratory, radiology and pharmacy services. Drugs listed on the Essential Drug List, as well as medical supplies should in theory be provided free of cost to patients, though supplies are limited.

- Provision of benefits and services

All public health facilities in the country provide care through the statutory health system. By law, public facilities provide services with a nominal user fee charged to the patient. [2] Specifically, 10 Bangladeshi Taka (BDT), equivalent to US$0.12, is charged for outpatient visits (Mustafa et al. 2018). In wards, hospital beds are provided for free, but users may opt to pay an extra BTD150 per day for a shared room, or BTD600 for a private room.

Basic primary care is provided at the ward level (by community clinics) or at the union level (by union sub-centres, union health centres and family welfare centres). Comprehensive primary care is provided at the upazila level at upazila health facilities. Secondary care is provided at upazila health complexes, district hospitals and general hospitals. Lastly, tertiary care is provided by medical college hospitals and specialized institute hospitals. However, there is no structured referral system, and patients with minor ailments may present for treatment at higher-level facilities directly (WHO 2015).

Over the years, budget allocation for primary care facilities has been undertaken centrally by the MOHFW, using indicators such as the number of inpatient beds, bed days and allocated staff size (Evans, Grant, and Pharm 2017). However, since 2019 the Medical and Surgical Requisite (MSR) budget has been allocated based on outpatient visits, number of beds, bed days and bed utilization rate. The 3rd Health, Population and Nutrition Sector Development Programme acknowledged the need for budget allocations based on more relevant data, such as the extent of poverty, disease incidence, population, and local topography (Bangladesh Ministry of Health and Family Welfare 2011b). These needs are also highlighted in the 4th Health, Population and Nutrition Sector Programme (HPNSP) 2017–2022.

Private health care provision represents the largest share of health care services in the country, with over 70 per cent of health facilities and 62 per cent of hospital beds in the country classified as private as of 2019 (Bangladesh Ministry of Health and Family Welfare 2020). The private health provision sector is implemented by a strong and well-organized not-for-profit sector led by NGOs focusing on primary care, as well as a fast-growing for-profit sector concentrated in curative care in urban areas (Rahman 2020). Detailed statistics on the number of NGO-led facilities compared to for-profit facilities are unavailable. However, birth registries from 2018 indicate that 8.5 per cent of all deliveries took place at NGO hospitals, 21.1 per cent were at other private facilities, and the remaining 70.4 per cent were at government facilities (Bangladesh Ministry of Health and Family Welfare 2020). It is, however, likely that these rates differ between types of health service.

[2] Details of hospital user fees published by the Ministry of Health and Family Welfare, available at: http://hospitaldghs.gov.bd/wp-content/uploads/2019/11/Hospital_User_Fees.pdf

# 4. Results

- Coverage

The statutory public health system was established in order to fulfil the government's responsibility to provide health services to the whole population. Although the design of the system (including the services covered and eligibility criteria) is comprehensive, as a result of significant inequalities in the geographical distribution of public facilities, the Bangladeshi health care system has been unable to provide effective financial health protection to all citizens. The WHO's "UHC service coverage index" assigned a score of 48 (out of 100) to Bangladesh in 2017. While this is two points above the score received in 2015, the government is unlikely to reach its own target of 80 by 2025 and 100 by 2030, unless larger reforms of the public health sector are enacted (Government of Bangladesh 2020).

- Adequacy of benefits/financial protection

At 73.9 per cent, the level of OOP spending in Bangladesh is among the highest in the world, indicative of the limited financial protection provided by the national health system (Ahmed, Begum, and Smith 2019). Government social health protection schemes, of which the statutory health system is the main component, covered less than a fifth of all health expenditure in recent years (refer to figure 1). The increasing reliance on OOP spending indicates that access to health services is not equal across the population, meaning that improvements in health outcomes (discussed below) may not necessarily hold for all population groups.

Over the years, income inequality linked to OOP spending on health care has increased (Molla and Chi 2017). A study of the projected achievement of UHC indicators by 2030 found that wealth-based inequities in access to antenatal care, postnatal care, delivery care, adequate sanitation and care seeking for pneumonia, which are already considerable, are projected to persist for all indicators (Rahman et al. 2018). The same study estimated that the incidence of catastrophic health expenditure would increase from 17 per cent to 20 per cent between 2015 to 2030. During the same period, the study predicted that impoverishment would increase from 4 to 9 per cent (Rahman et al. 2018).

These challenges are particularly acute for workers in the informal economy, most of whom lack job security, social and legal protection. Workers in the informal economy represent 85.1 per cent of the labour force in Bangladesh, accounting for an estimated 51.7 million people in 2017 (Oliveira Cruz, Islam, and Nuruzzaman 2019). This group is more likely to work in hazardous and exploitative environments, with greater vulnerability to loss of income when ill. Informal economy workers are also less likely to seek formal health services, and more likely resort to informal health providers or self-medication through pharmacies and drug sellers compared with workers in the formal economy. Although medical supplies and essential drugs should be provided free of cost, facility supplies of drugs are often inadequate (WHO 2015). As a result, patients often have to purchase drugs from private pharmacies out of pocket. Additionally, there is evidence that in some facilities, unofficial fees are charged (Killingsworth et al. 1999), and there is a degree of socioeconomic inequity in the utilization of services at public facilities, with influential individuals able to access services more easily.

- Responsiveness to population needs
    - Availability and accessibility

Since independence, Bangladesh has made concerted efforts to expand the geographical coverage of health services to rural areas, with an important share of public resources allocated to rural facilities, and health cadres dedicated to mitigating the lack of skilled health professionals in rural areas. Despite these efforts, human resource challenges remain a constraint to equitable service provision, with only 6.73 physicians, 2.26 community and domiciliary health workers, and 0.029 dentists per 10,000 people reported in 2019 (Bangladesh Ministry of Health and Family Welfare 2020). The majority of secondary and tertiary hospitals are concentrated in urban areas, though MOHFW-operated primary health facilities are scarce. As such, most LGIs have not fulfilled their assigned responsibility of providing primary care in urban areas. Due to these access barriers and geographical disparities, several studies have identified inequities in health indicators across social, economic and demographic dimensions in Bangladesh, including gender, economic status

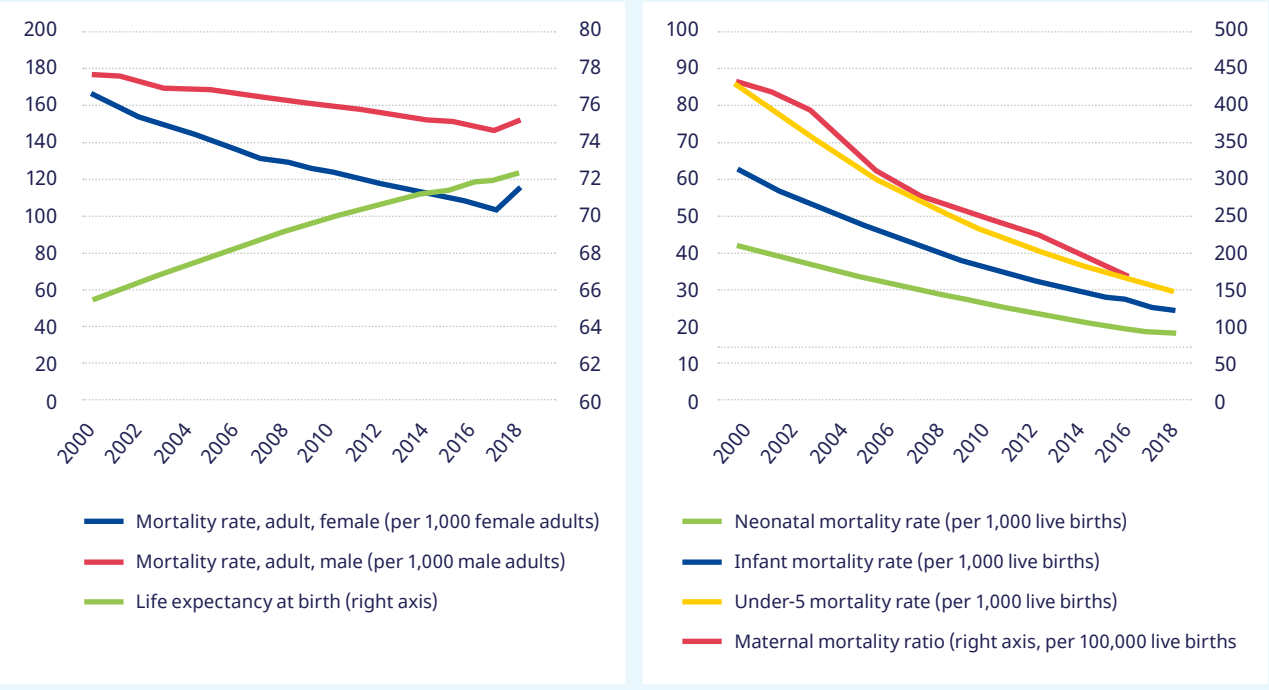
and education level (Joarder, Chaudhury, and Mannan 2019; Hamid et al. 2014).

- Quality and acceptability

Insufficient staffing of the public health system in Bangladesh has led to large numbers of vacant posts in all tiers of the health system, which significantly impacts quality of care at all levels. Limited infrastructure, combined with limited capacity of medical workers compounds this. As noted above, primary care in urban areas is largely neglected due to the fact that responsibility to provide care falls on LGIs, despite the fact that more than 80 per cent of funding for health is allocated to MOHFW. With the exception of child immunization, preventative care in Bangladesh is notably lacking, due to the fact that the public health system is focused primarily on curative care. These deficiencies are driven in part by the fact that the public health sector has insufficient capacity to efficiently spend allocated budgets. Another factor affecting quality of care is the fact that hospitals' organograms are outdated and unresponsive to modern demands.

Despite challenges related to quality and scope of services, Bangladesh has seen improvements in its health indicators over the past decades, especially when it comes to maternal, newborn and child health (MNCH). Figure 3 shows that the mortality rate of adults (aged between 15 to 60) has reduced for both males and females, although progress has been less pronounced for males. Correspondingly, life expectancy at birth increased from 65 in 2000 to 72 in 2018. An analysis of MNCH indicators suggests that the positive trend in overall health outcomes is persisting, with significant reductions to child and neonatal mortality as well as maternal mortality. The relatively strong improvements of MNCH indicators may result from combined efforts of the public and not-for-profit health sectors, which expanded the number of health cadres providing prevention and follow-up services. Targeted demand-side initiatives, such as the aforementioned MHVS scheme, may also have had a positive impact in this regard.

**▶ Figure 3. Bangladesh health system outcomes (left: general outcomes; right: MNCH outcomes)**




Source: Adapted from World Bank World Development Indicators.

## 5. Way forward

For Bangladesh to achieve its target of full and effective UHC by 2030, major reforms must be made to the public health system in a short amount of time. These efforts will need to be accompanied by a significant amount of additional government investment in health to reinforce the supply and quality of public health care provision. To ensure sustainable financing for health, methods to raise revenues for social health protection, with a view to urgently reduce OOP levels, would need to be established, including through greater allocation of general revenues to health, as well as new earmarked revenues. In light of this need, addressing informality will be key to expanding the tax base in Bangladesh. A gradual move away from input-based line-item payment systems and towards outcome-based payment systems may also aid in reducing health system inefficiencies.

Covering a portion of the cost of the health care services that are predominantly provided in the private sector will also be necessary. In this respect, evaluating the success and applicability of pilot projects for the whole country will be a useful first step, after which, successful pilots could be incorporated into the statutory health care system at National level, thereby expanding effective coverage and strengthening social health protection in Bangladesh.

## 6. Main lessons learned

- Although a comprehensive tax-funded health system exists on paper, in practice, its utilization and effectiveness are insufficient to guarantee health coverage without hardship. An administrative structure in which urban and rural facilities are managed by different ministries with unequal budgets, further complicates coverage expansion.
- The large proportion of the Bangladeshi population working in the informal economy, which significantly limits the tax base, poses a significant challenge to raising the revenues needed to guarantee the right to social health protection. Notably, an estimated 51.7 million people, or 85.1 per cent of the national labour force made their living in the informal economy in 2017.
- The development of the social health protection system has not been sufficient to achieve UHC in Bangladesh due to limited infrastructure, as well as a lack of qualified medical workers. Focus should be placed on strengthening health care delivery, improving quality of care and tackling inequalities in access to care.
- Targeted social protection mechanisms have shown some promise in increasing access to health care and utilization of essential health services for specific population groups. For example, the MHVS, a non-contributory financing scheme covering maternal health, and providing cash incentives to pregnant mothers to promote safe deliveries, has contributed to improved utilization and reduced OOP for the services covered. However, issues relating to the design of the scheme, such as payment methods, has led some facilities to provide services that may be medically unnecessary, such as C-Section operations, in order to receive higher payments.

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