

Research Report 167

**Not Quite, Not Enough:
Financial Allocation And The
Distribution Of Resources In The Health Sector**

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Chapter 1

INTRODUCTION

I.1 Setting the Agenda

It would be misleading to give the impression that it is only direct health care provision that can promote sustained progress in health improvement. Yet, the factor that most directly related to health status and remain of prime importance in determining the health outcomes in a population is the practical effectiveness of the health care system. The World Bank (1993) reports that about one-third effect of economic growth on life expectancy comes through the poverty reduction two-thirds comes from increased public spending on health.

In Bangladesh although considerable progress has been made so far in making provision for health care services to the people, field level information indicates that a meager 12 per cent of the total health care used by rural people is delivered by the government health care facilities. The remaining 88 per cent is supplied by the private sector dominated by untrained or quack practitioners. More ominously, the government sector share in the total health care has declined substantially over the past decade from 20 per cent in 1984 to 12 per cent in 1995 having adverse effect on the use of quality health care by the rural people with such effect being greatest on the poor, women, and the children. However, the situation could have been even more intolerable had there been no government facilities in place (Begum 1996).

The supply-side limitation to meet the health care needs of the people while may account for this poor and deteriorating performance of the public sector, there are indications also that the services originating from this sector lack adequate demand. The problems, however, vary between tiers of the service provision. The district level hospitals are generally overcrowded with capacity unequal to demand. But the government facilities at the lower levels are characterized by under-utilization. This is mainly due to lack of people's confidence in the Upazila Health Complexes (UHC). Among various reasons the primary ones giving rise to no-confidence are: poor quality of care provided by them, inadequate supply of drugs and other necessary prerequisites for treatment, unhealthy and unprofessional attitude and practices of health care providers working there, poor managerial practices, and above all, the unwillingness of doctors to serve in the rural areas causing frequent absence of them in the health centres (GOB 1990; Begum 1988). A BRAC (1990) study observed that the doctors deployed in the countryside, unsupported in isolated position are dangerously inexperienced and have little real use.

The correction of this situation evidently requires more resources but it hardly requires any mention that a poor country like Bangladesh will find it extremely difficult to devote the amount of resources that would be required to achieve results significantly better than that currently exists in the health sector. According to recent studies (Kawnine 1995; 1996) the massive efforts made to combat the problems of health sector including the \$ 640 million Fourth Population and Health Project is sufficient neither to meet future needs not planned services.

For development of health sector the scarcity of resources however, is a major headache not only in Bangladesh but in most developing countries and a primary concern in all of these countries has been to mobilize more resources for the health

sector. The increase in public sector expenditure on health while is an important way to improve the access of people to the health care services, it is not the only way to do so. Another alternative to increase the sectoral efficiency is to ensure that the resources that are made available to it are put to best possible use so in order to achieve best possible health results. In other words, even without the increased public spending on health, efficiency of the sector in improving health status of the people can be increased substantially through prudent intra-sectoral allocation and better management of resources available. Thus, the total health expenditure while is important, the nature of expenditure too counts a lot, and it counts sometimes even more in giving the poor and the needy an access to health care services (Rahman and Ali 1996).

I.2 Objective and Scope

The present exercise seeks to examine the macro allocation of resources flows to the health sector in Bangladesh including intra-sectoral distribution of that resources. This will facilitate our understanding with regard to the nature of current resource use and will help thereby to identify the potential opportunities for improving the sectoral impact on health status. The paper also intends to examine the incidence of benefit of public expenditure on health that accrues to people of different economic strata with a focus on rural area.

The first part of the exercise viz. the review of financing the health sector and the health sector spending will be carried out using macro level fiscal information as provided by the Ministry of Finance and the Annual Development Plan (ADP) documents published by the Ministry of Planning. It does not require any mention that the data from these sources, at least in published form, are not readily available at suitable levels of disaggregation, restricting the scope of analysis at desirable length. We, therefore, tried to dig some unpublished background data pertaining to Annual Development Plan (ADP) for examining the intrasectoral allocation issues. The first part is presented in Section II. The second part indicating incidence of benefit of public health expenditure is analysed using combined information collected from the macro budgetary data and 62-village surveys carried out under the Analysis of Poverty Trends (APT) project of BIDS and is presented in Section III. Summary and concluding observations of the study are provided in Section IV.

Chapter 2

MACRO REVIEW OF PUBLIC HEALTH SPENDING

II.1 Allocation of Resources to Health

Allocation of resources to health can be judged from various angles. The indicator may be expressed as percentage of Gross Domestic Product (GDP), as proportion of total public spending measured in relation to revenue (current) and development (capital) expenditures; it is also useful to quantify it in terms of real per capita spending.

Data on the first indicator viz. on total health expenses including private, public, and NGO expenses are not available. This is primarily due to non-availability of the information on private or household expenses, on health constituting major part of the total expenses. Yet, as an World Bank (1993) estimate indicates including public, household, and NGO expenses Bangladesh has spent in 1990 about 3.2 per cent of the Gross Domestic Product (GDP) on health (World Bank 1993). The share has not changed much thereafter. It was estimated to be 3.1 per cent of the GDP in 1994/95 (Kawnine et. al., 1997), and a similar figure was suggested by Rabbani et. al., (1997) for 1995-96. Thus, despite being poor as far as the Bangladesh's potential ability to devote more resources to health is concerned there seems some scope for it. According to World Bank (1993, Table –A8) report, India with real per capita income not much different from Bangladesh spent 6 per cent of the GDP to health in 1990, Nepal spent 4.5 per cent, Sri Lanka 3.7 per cent, and China 3.5 per cent.

There is no much information on expenses on health at household level. A recent study (Rabbani et. al. 1997) suggests that such expenses by the household amounted to Tk. 3789.4 crore during 1995-96. This was around 2.3 per cent of the GDP. Of this, 73 per cent expenses was made by the rural households and 27 per cent was made by urban households. In the health care cost medicine constitutes the single largest item of expenditure and account for about 63 per cent of the total health care costs incurred by the household at national level. of the remaining 37 per cent expenses, travel account for 10 per cent, medical tests for 9 per cent, surgical operation related expenses 3 per cent, and physician's fee 15 per cent. Although medicine cost is the predominant item of expenditure both in rural and urban areas, its relative share is higher in the former (66 per cent) than in latter (54.4 per cent). Interestingly, these two areas do not differ much for the component of 'travel cost' and 'physician's fee' but they differ remarkably for cost on medical tests and that surgical operation. The urban expenses on the former is about twice higher (14 per cent) than that of rural area (7.4 per cent) while in case of surgical operation the proportion urban expenses is about thrice higher (6.3 per cent against 2.1 per cent).

The public sector expenses on health for recent years since 1980/81 are presented in Table 1 and they are presented in terms of per cent of GDP. As evident in these figures the share of publicly funded health in total GDP has been all along less than 1 per cent. Throughout 1980s till 1991/92 the share was indeed around 0.6 per cent with some year to year fluctuation. It then made a visible jump to a figure of nearly 0.8 per cent in 1992/93, increasing to 0.86 per cent in 1993-94. It then remained same (0.86 per cent) in 1994/95.

Table 1
Public Sector Spending as Per Cent of GDP

Period	% of GDP
1980-81	0.56
1981-82	0.58
1982-83	0.57
1983-84	0.59
1984-85	0.63
1985-86	0.56
1986-87	0.56
1987-88	0.61
1988-89	0.58
1989-90	0.59
1990-91	0.62
1991-92	0.60
1992-93	0.77
1993-34	0.86
1994-95	0.86

Source: Various Statistical Year Books

As expected the expenditure on health (Table 2) is very low in per capita terms also in Bangladesh. Indeed, as an estimate indicates (World Bank, 1993) Bangladesh as regards modern drugs spends less per head of population than almost any other country. The per capita public spending on health in current price in 1994-95 is estimated to be only Tk. 85 and was about Tk. 14 in 1980-81. Hence, there has been nearly 6 times increase in per capita public health spending during the last 15 years. In constant price the situation however, is much less impressive. The real increase has been only in the order of two times. A detailed scrutiny of the trend reveals that in early years of 1980s viz. upto 1983, there has been no real increase in per capita public health expenses. In all these years it has been Tk. 22 (in 1984/85 constant price). It then rose to Tk. 24 in 1983/84 and, with some irregularity in trend, rose to Tk. 29 in 1991/92. In 1992/93 it made a big jump to Tk. 38 and increased further to Tk. 43 in 1993/94 and to Tk. 45 in 1994/95. As these figures indicate, the health sector expenses received a relatively increased attention in 1992-94 period. Indeed, social sector as a whole including education and health received higher attention for resource allocation during that period (Sen 1996).

Table 3 presents the proportion of public expenditure spent on health in different years. As shown in the Table whatever expenditure is made by the government in a year in the country taking revenue and development expenditures together, roughly 3 to 4 per cent of it is spent on health. During the first half of the eighties the public expenditure on health showed an upward tendency. The health sector share in the total public expenditure was 3.4 per cent during 1980/81. It rose to 5.5 per cent in 1984-85 and after 1985 viz. in later half of the eighties declined again, and much less than 4 per cent of the total expenditure was made on health during 1985/86 to 1990/91 period. This may be the initial expenditure-reduction effects of

the structural adjustment that was carried out in those years. In early 90s, the expenditure on health increased again albeit only to reach a figure of 4 per cent.

Table 2

Estimated Per Capita Public Spending on Health (Actual)
(Including revenue and Development Expenditure)

(In Tk.)

Period	At Current Price	At Constant Price (1984/85 = 100)
1980-81	14.4	22.0
1981-82	16.3	22.5
1982-83	17.7	22.5
1983-84	22.0	24.5
1984-85	26.3	26.3
1985-86	25.5	23.2
1986-87	30.0	24.6
1987-88	35.2	26.8
1988-89	36.2	25.6
1989-90	40.4	27.3
1990-91	47.6	29.3
1991-92	49.2	29.1
1992-93	64.2	37.9
1993-34	76.3	43.1
1994-95	84.7	45.3

Source: Estimated from Expenditure Figures quoted in Chowdhury and Sen and Population Figures in BBS Statistical Yearbook.

Table 3

Public Expenditure on Health (Actual)

Period	% of Expenditure Made on Health		
	Total	Revenue	Development
1980-81	3.4	6.1	1.9
1981-82	3.7	5.7	2.4
1982-83	3.8	4.9	3.0
1983-84	4.3	7.0	2.6
1984-85	5.5	7.1	2.7
1985-86	3.8	5.2	2.3
1986-87	3.6	6.3	0.9
1987-88	3.8	6.4	0.8
1988-89	3.4	5.2	1.0
1989-90	3.4	5.4	1.0
1990-91	3.6	5.5	1.1
1991-92	4.0	5.6	1.9
1992-93	4.6	6.4	2.2
1993-34	4.0	6.7	1.3

Source: Chowdhury and Sen (1997).

The share of health sector in the total revenue expenditure is noticeably more than that in the development expenditure of the country. During the 1980s and early 90s this sector's share in the revenue expenditure varied between 5 to 7 per cent while corresponding share in development expenditure varied between less than 1 to 3 per cent.

An over time comparison indicates that both revenue and development expenditures on health increased during the first half of the 1980s, the figure reaching a level of 7 per cent for the former and 3 per cent for latter in 1984/85. Both the shares declined in the second half of the 1980s, but the drop was more marked in the case of development expenditure (from 3 per cent in 1982/83 to 1 per cent in 1989/90, while it was less than 1 per cent in 1986-88). It is striking that the share of health sector in development expenditure has been kept at a very low (1 per cent) level throughout the later half of the eighties — a period roughly coinciding with the initial years of structural adjustment.¹ The situation improved somewhat during the early years of 1990s, a period coinciding again with ESAF.² During 1990/91 to 1992/93, for instance, public health expenditures in both revenue and development budgets increased although the overall level on both counts remained below the level achieved during 1983/84-1984/85. However, it is to note that the somewhat encouraging trend observed for development expenditure during the brief spell of 1991-93 could not be sustained subsequently. By 1993/94, the figure dropped substantially to 1.3 per cent. This has happened primarily due to the fact that the government withdrew substantially from the health development expenditure in those years although project aid increased for the same (Table 5).

In short, despite some signs of improvement and recovery during the particular spells, the record of the entire decade preceding 1993/94 (the last year for which data are available) was dismally poor in terms of sectoral allocations for health. This cuts both revenue and development expenditures although the trend of decline was more pronounced for the latter viz. development expenditure (Table 3).

The public health expenses in absolute amount underscore some of these features more clearly (Table 4). In 1984/85 constant price, the health expenses increased during 1980-85 period. It was Tk. 197 crore in 1980/81 and Tk. 256 crore in 1984/85. It then declined substantially during 1985-87, increased again in 1987/88, and declined in 1988/89. Since 1989/90 it had been making a monotonic increase with progress being quite pronounced during the 1991/92 to 1993/94 period. The pace of progress evidently slowed down by 1994/95 and it seems that the quantum increase in revenue expenses noted for 1992/93 was largely an outcome of rescaling of the national pay scale in that year.

Interestingly, the two categories of expenditure — the revenue and the development did not moved in the same direction over the recent years. Of the two, the revenue expenses have been privileged category increasing steadily in real terms during the 1980-95 period (with the exception of 1988/89). The increase in it was spectacular during 1992-94, with some decline in 1994/95. In contrast, the development expenses on health (in 1984/85 constant price) experienced a decline

¹ Note that the SAF-Structural Adjustment Facility-supported by the World Bank and IMF-spanned roughly the period between 1987 and 1990.

² Note that the ESAF-Extended Structural Adjustment Facility-supported by the World Bank and IMF-spanned roughly the period between 1990 and 1993.

throughout the 1980s till 1991/92 (Table 4). Note that the development expenses even in current prices did not show any clear trend during that period. The situation, however, changed for better in subsequent period starting from 1992/93 by a considerable margin.

Table 4

Public Expenses as Health in Current and Constant Price (1984/85 = 100)
(Tk. in Crore)

Period	Total Expenses		Revenue Exp.		Development Exp.	
	Current Price	Constant Price	Current Price	Constant Price	Current Price	Constant Price
1980-81	129.22	197.0	68.07	103.8	61.15	93.2
1981-82	149.25	205.8	80.03	110.4	69.22	95.5
1982-83	167.07	212.8	93.18	118.7	73.89	94.1
1983-84	209.65	233.2	138.84	154.4	70.81	78.8
1984-85	256.43	256.4	163.42	163.4	93.01	93.0
1985-86	260.96	237.6	182.85	166.5	78.11	71.1
1986-87	304.11	249.5	227.95	187.0	76.16	62.5
1987-88	364.22	277.6	275.92	210.3	88.30	67.3
1988-89	382.04	270.3	295.58	209.1	86.46	61.2
1989-90	434.86	293.3	332.37	224.2	102.20	69.1
1990-91	521.95	321.8	368.02	226.97	153.93	94.9
1991-92	549.29	325.0	405.56	240.0	143.73	85.0
1992-93	730.39	431.6	515.24	304.5	215.15	127.1
1993-34	887.38	500.9	603.40	340.6	283.98	160.3
1994-95	1005.21	537.9	628.38	336.2	376.83	201.6

Source: Current Price is taken from Ministry of Finance; Grants and Appropriation (different volumes) and factors for adjusting the current price for constant price are taken from the Bangladesh Bureau of Statistics.

The distribution of the health sector expenditures into revenue and development expenses reveals that the weight of these two types expenses in total public expenditure was almost equal during 1975-83 period. Subsequent to that, the situation changed dramatically and from 1983/84 the revenue expenditure started outgrowing its “development” counterpart. This tendency persisted till 1992/93 when the share of revenue expenses was 74 per cent and that of development expenditure 26 per cent. This was probably due to the fact that increased development activities with a lag put pressure on revenue expenditure as well, as recurrent costs of facilities created thus are to be borne by the Government under revenue head. The share of revenue expenditure in the total public health expenditures showed a declining trend since 1992/93 and in 1994/95 it stood at 62 per cent with development expenditure being 38 per cent (Table 5). Thus, although both revenue and development expenditure during 1992-95 period made an upsurge, the increase in latter was relatively more. Indeed, as noted before the revenue expenses on health in real term declined in 1994/95 but development expenditure increased substantially (Table 4).

Table 5

Distribution of Total Expenditure on Health into Revenue and Development Expenditure and the Share of Government and Project Aid (PA) in the Development Allocation

Year	Distribution of Total Expenditure		Distribution of Development Allocations into	
	Revenue	Development	GOB	P.A.
1975-76	4.9	51.0	-	-
1976-77	50.3	49.7	-	-
1977-78	49.5	50.5	-	-
1978-79	55.4	44.6	-	-
1979-80	54.9	45.1	-	-
1980-81	53.0	47.0	.76	.24
1981-82	54.0	46.0	.76	.24
1982-83	56.0	44.0	.67	.33
1983-84	66.0	34.0	.67	.33
1984-85	64.0	36.0	.46	.54
1985-86	70.0	30.0	.46	.54
1986-87	75.0	25.0	.70	.30
1987-88	76.0	24.0	.56	.44
1988-89	77.0	23.0	.53	.47
1989-90	76.0	24.0	.38	.62
1990-91	70.0	30.0	.47	.53
1991-92	74.0	26.0	.56	.44
1992-93	70.0	30.0	.47	.53
1993-34	68.0	32.0	.41	.59
1994-95	62.0	38.0	.37	.63

Source: Distribution of Expenditure during 1975/76 – 1979/80 is based on allocation and for remaining years it is based on actual expenditure.

As mentioned before, GOB represents the major provider of resources in the health sector. While it is responsible for the entire revenue expenditure, supplies a substantial part of the development expenditure too. Assuming that the actual development expenses from government and the external sources have been proportional to the allocations made under these heads viz. Government and Project Aid (PA), then the estimates indicate that during the entire period of 1980-82 when the development expenditure was around 45 per cent of the total health expenditure, about three-fourth of it (development expenditure) was borne by the Government. Thus, the Government supplied in total 89 per cent of the total health sector expenses during that period. The remaining 11 per cent was in the form of project aid (PA) originating from the external sources. During 1982/83 to 1991/92 which roughly includes the period of Structural Adjustment also about 66-74 per cent of the total health expenses was in the form of revenue expenditure which has been the Government responsibility. In addition, the Government supplied about half or little more of the development expenses making the government share again about 89 per cent, the share of external sources being 11 per cent. Since 1992/93 only the external

sources started making greater contribution to health sector expenses. Their share was about 16 per cent in 1992/93, 19 per cent in 1993/94, and about 25 per cent in 1994/95. Thus, for the health sector expenditure the domestic sources played major role throughout the 1980's till 1991/92 and the role of Project Aid was only minimal.

II.2 Nature of Health Expenditure

As noted before, increase in public expenditure is but only one way to ensure better access to public health care by the people. In order to harness better results a careful expenditure strategy also needs to be devised.

The economic-cum-functional classification of the health expenditure reveals that during the 1975/76 to 1984/85 period nearly 60 per cent of the total health expenditure was "current" in nature, i.e. was consumption expenditure involving expenses on wages, salaries, commodities and services (Table 6). The remaining 40 per cent was for acquisition of fixed capital assets. In the second half of 1980s when structural adjustment was underway and development expenditure declined substantially, as high as three-fourth expenditure of the sector fell under the "current" category and one-fourth was in the nature of capital spending. There has been some change in the composition again during the first half of the nineties (corresponding to ESAF, spanning 1990-1994). The capital expenditure rose to one-third of the total public health spending during this period with two-third-being current expenditure.

Thus, historically, the major part of the health expenses has been to meet the operating cost of the sector and only a smaller part could be devoted to create new capacities and/or acquiring capital assets which may bear much implication for quality of health care services.

Table 6

Economic-cum-Functional Classification of the Health Expenditure

Period	Current Expenditure	Capital Expenditure
1975/76 to 1979/80	57.3	42.7
1980/81 to 1984/85	57.0	43.0
1986/87 to 1989/90	74.4	25.6
1990/91 to 1993/94	63.8	36.2

Source: BBS, Statistical Yearbooks (various years).

II.2.1 Distribution of Revenue Expenditure

A component-wise break-up of the health revenue expenditure (Table 7) further clarifies the point just made above. In the revenue expenditure, the expenses on pay and allowances of the health sector personnel and other establishment costs represent the largest item. Not only this, share of this item had increased consistently over the years since 1975. During 1975-80 the relative share of this item viz., the expenditure accountable for "pay and allowances" was about 50 per cent of total revenue expenditure; it rose slightly to 54 per cent in the early eighties; the matched figure jumped to as high as 65 per cent during 1986-90 and remained at that level over the first half of the nineties.

Another area showing continuous expansion in share in the revenue budget is the civil works meant for repair and maintenance. Its increase from 1.2 per cent during 1986-90 to more than 5 per cent during 1990-95 period is remarkable. In sharp contrast, the relative share of the expenditure on medical and surgical requisite (MSR) from which the costs for non-personnel items of health care including drug/medicines are met, and, of 'other expenses' referring to expenses on gas, water, electricity, transport, tax, telephone etc. including diet for in-house patients, have shown a decline. The MSR expenditure during 1980-85 period was about 23 per cent of the total revenue expenditure and was 16 per cent in 1990-95, indicating a decline by a margin of one-third. Similarly, the share of 'other expenses' was 21 per cent during 1980/85 but was reduced to half of that share in early 1990s (10.4 per cent). Thus, the material support and the logistics for health care which often bear critical importance for the quality and efficacy of health care got increasingly marginalized over the years. This is consistent with the field level complaints that one can hear about the deteriorating quality of care in the public sector.³

Table 7

Component-wise Break-up of Health Revenue Expenditure

Components	1975/76 to 1979/80	1980/81 to 1984/85	1986/87 to 1989/90	1990/91 to 1994/95
Pay and Allowances	50.0	53.8	64.9	65.8
Medical & Surgical Requisite (MSR)	20.4	23.0	17.3	16.5
Other Expenses (Including Diet)	27.3	21.0	14.0	10.4
Grants	1.8	1.5	1.6	2.0
Civil Work	-	.8	1.2	5.3

Source: Ministry of Finance: Grants and Appropriation.

These items of some vital importance for the quality of health care indeed, have received least (and declining) attention in all the facilities dispensing health care to the people. This is evident in the revenue expenses of Thana, District, and Medical College Hospitals (Table 8). In all these outlets, the relative expenses on water, gas, vehicle, electricity, etc. including diet for in-house patients have declined substantially between the period of second half of 1980s and the first half of 1990s while that on salary and allowances (particularly those for establishment increased).⁴

On the whole, what can be said safely is that the resources relevant to some important dimensions of the quality of health care experienced a decline over the past

³ In recent years, successive news reports came out in the press that described the deteriorating conditions of curative health care in a large number of district and thana level hospitals (see, for instance, special reports on hospitals in the major Bengali daily *Bhorer Kagoz* in 1997)

⁴ Note that MSR expenses in these facilities are allocated separately from the overall MSR allocation made at the national level. The principle of allocation of this fund is discussed later.

decade in all the major health care facilities in the country. In contrast, the component of salary and allowance of health personnel claimed an ever increasing share of the current spendings.⁵

Table 8

Component-wise Break-up of Revenue Expenditure of Thana and District Level Health Care Facilities and Medical College Hospitals

Components	Thana Health Complex	
	1986/87 to 1989/90	1990/91 to 1994/95
Salary of the Officer	9.6	9.2
Salary of the Staff	40.3	44.2
Allowances	40.0	38.9
Other Expenses	10.1	7.7
All	100.0	100.0
	Medical College Hospital	
Salary of the Officer	13.8	14.6
Salary of the Staff	28.3	31.8
Allowances	32.3	32.7
Other Expenses	25.6	20.9
All	100.0	100.0
	Medical College Hospital	
Salary of the Officer	10.9	9.9
Salary of the Staff	23.4	26.9
Allowances	30.4	36.9
Other Expenses	29.2	26.2
All	100.0	100.0

Source: Ministry of Finance, Grants and Appropriation.

II.2.2 Nature of Development Expenditure

The information provided in this subsection is not based on *actual* expenditure but on allocation made in the Revised Annual development Plan (RADP) of the Ministry of Planning.⁶ The picture based on RADP data, as generated below, may thus understate the severity of the problem.

A component-wise break-down of the health development projects costs of the 1994/95 RADP shows the construction component is the single most important item of expenditure claiming the largest share of the development project budget (Table 9).

⁵ One may argue that some increase in the salary and allowance of the health personnel was necessary to provide incentives. However, we are here talking of a situation whereby the issue of appropriate mix of wage and non-wage components of current spending was ignored altogether. The mix disproportionately changed in favour of paying salaries rather than providing access to medicines and/or lab-tests which cannot but have an adverse impact on the quality of health care. This explains why in many primary health facilities one finds an acute shortage of medical supplies.

⁶ Actual estimates of development expenditures at desired level of disaggregation are notoriously difficult to obtain from the existing sources.

About 33 per cent of the development budget is spent directly on construction and civil work, while another 3 per cent is spent to procure and develop land for construction purpose. Hence, construction related activities represent about 36 per cent of the total development expenditure in the health sector. Another 20 per cent is spent on salary and allowances, training, consultancy, tax/duty, and research and evaluation purposes. An equal amount is spent as 'miscellaneous' expenditure and this fund is used generally, to meet the cost overruns of the projects. Set against these, the amount spent for procuring equipment, vehicle, furniture, ambulance, and the likes accounts for 14 per cent of the development expenditure. The matched figure for drugs/vaccine supply is even less (11 per cent). Thus, of the total development expenditure for health only about a quarter is spent on items upon which much of the quality and efficacy of the services delivered depend.

Table 9

Major Component-wise Break-up of Projects Costs of the Health Sector included in 1994/95 RADP

Component	% of Total Costs
Pay & Allowances	7.00
Construction/Civil Work	33.20
Land/Land Development	2.81
Equipment/Furniture etc.	13.78
Training	4.03
Consultancy	1.84
Drug/Vaccine Supply	11.00
CDVAT	5.18
Research & Evaluation	1.06
Miscellaneous	20.10
Total	100.00

Source: Project Documents of the Planning Commission

There are some qualitative difference in the spending of development projects including under different level of health care services (Table 10). Construction is the single largest item of expenditure of development project under all levels of health care viz. primary, secondary, and tertiary. It accounts for about one-fourth of the total project costs under primary level health care; about 60 per cent under secondary level; and 47 per cent of those in tertiary level. In the primary health care construction item is followed closely by the item earmarked for drugs and vaccine supply (19%). This item accounts for a meager 1-2 per cent in the secondary level and less than 1 per cent in the tertiary level. In contrast, more than a third of the projects costs under tertiary level meant to aid the specialized and/or higher level health care, is spent to acquire equipment, furniture, vehicle, ambulance, and similar items. These items account for 17 per cent of those in the secondary level and 7 per cent in the primary level. The high development spending on drugs and vaccine in the primary health care however, needs careful understanding. This may not be all due to higher emphasis on drugs and medicine for treatment at this level of care. Currently, the

preventive care of the health sector is under the development budget. This being falling under primary health care although the exact amount is not known a large part of the cost for 'drugs and vaccines supply' no doubt would represent vaccine costs and costs for other preventive medicines while this is not the case with the secondary and tertiary level of health care (Table 10).

Table 10
Major Component-wise Break-up of Projects Costs Included Under
Different Health Programmes of 1994/95 RADP

Component	Programmes		
	Primary Health	Secondary Health	Tertiary Health
Pay & Allowances	5.0	1.5	2.8
Construction/Civil Work	23.8	47.1	39.7
Land/Land Development	1.3	13.2	7.6
Equipment etc.	6.7	16.8	33.6
Training	3.4	-	.3
Consultancy	2.7	-	-
Drug/Vaccine	19.1	2.1	.9
CDVAT	2.7	13.1	11.1
Research/Evaluation	1.4	-	-
Miscellaneous		-	
Total			

Source: Project Documents of the Planning Commission

II.3 Resource Distribution into Different Levels of Health Care

Considering the Thana Health Complexes and the Union Dispensaries providing health care services to the (rural) people as primary level of health care, district level hospitals and dispensaries providing curative care and referral services as secondary⁷ one, and specialized hospitals and institutions including medical college hospitals as the tertiary level facilities, one can derive the distribution of revenue and development expenditure into these three different levels of health care. The results are presented in Table 11.

In commensurate with the national objective of health sector to place greatest emphasis on primary health care in order to make health care services affordable and accessible to all, the revenue expenditure focused mostly on primary health care. Encouragingly, it not only has drawn more resources but its share over the years has increased substantially. During 1975-80 about 22 per cent of the revenue expenditure has been spent on primary health care and it rose to 45 per cent in 1986-90. In the years after 1990, the share declined by 5 percentage points but remained yet above 40 per cent of the total. The continual expansion of the primary health care facilities in the rural area is responsible for this increasingly larger share of it in the health

⁷ This classification is, however, not perfect, as all these facilities provide primary health care as well.

revenue budget. The revenue expenditure on secondary health care is about 5-6 per cent of the total revenue expenses while expenses on tertiary health care represent about 15-16 per cent. Thus, the expenditure on secondary level health care facilities which bear the additional responsibility of providing referral services is least of all.

Table 11

Revenue and Development Expenditures by Levels of Health Programmes

Expenditures/Period	Levels of Health Care/Programmes		
	Primary	Secondary	Tertiary
Revenue Expenditure			
1975/76 – 1979/80	22.1	n.a.	n.a.
1980/81 – 1984/85	28.4	n.a.	n.a.
1986/87 – 1989/90	45.3	5.6	16.3
1990/91 – 1994/95	40.6	5.5	15.4
Development Allocation (Revised)			
1980/81 – 1984/85	54.6	12.2	7.0
1985/86 – 1989/90	60.6	17.8	5.7
1990/91 – 1994/95	51.0	11.0	6.8

Source: Estimated from itemwise breakdowns given in Ministry of Finance; Grants and Appropriation (Non-development), and programmes of the health sector given in Revised Annual Development Plan.

The allocation in favor of primary health care is even more pronounced in the development budget. During first half of the eighties, about 55 per cent of the ADP allocation is made for the projects meant for primary health care. The share rose by another 5 percentage point during the second half of the eighties. In the first half of the nineties, it fell down substantially although remained more than 50 per cent.

However, an emerging feature of the health sector expenditure that has become evident in the above distribution of revenue and development budget is that the expenses on direct health care service delivery in general i.e. taking together the primary, secondary, and tertiary level health care, has declined in recent years. Presumably, non-service sectors are getting some attention.

II.4 Distributive Principle for Medical & Surgical Requisite (MSR) and Diet Allocation⁸

As regards the provision of food or the diet of the patients in the hospital, currently Tk. 30 per patient per day is allowed. Given the price level in the country, this allocation for financing three meals a day for each patient is clearly inadequate. Hence, although it is being often alleged that the pilferage, leakage, wastage, and misuse of food are responsible for poor quality and insufficient quantity of diet supplied to the hospital patients, the basic allocation itself has remained indeed, at a level which is deficient and irrelevant to the need to begin with.

⁸ Information of this section is obtained from the office of the Director General, Health.

Again, this allocation for patient's food is done irrespective of the location and the nature of the hospital viz. it is same for a patient in Upazila hospitals, in Dhaka Medical College Hospital located in the capital city, and in the Cardio-Vascular Disease Hospital. Thus, for urban-rural price discrimination as well as for special food requirement for the patients in specialized hospitals, the allocation may prove further insufficient in the urban and tertiary level health care facilities.⁹

It may be worth mentioning that the allocation for medical and surgical requisite (MSR) is done on the basis of the number of beds available in a health care facility and takes no account of the out-patient load. Hence, all the Thana Health Complexes which are mandated to have 31 bed hospitals get the same MSR allocation, even though they may differ in bed utilization rate as well as in the number of out-patient receiving health care. Thus, the current allocation principle may not be the appropriate one to rely upon in deciding what proportion of the MSR is to be allocated to individual health facility operating at a given level.

The MSR fund allocated centrally is distributed in turn to different level of health care facilities as per following principle. All medical colleges and specialized hospitals get at the rate of Tk. 20,000 per bed per year; the district level hospitals get at the rate of Tk. 18,000 per bed per year, while THCs get at the rate of Tk. 10,500 per bed per year. The allocation for other facilities (such as ward level urban dispensaries, school based clinics, etc.) is made on a "per institution" basis. The urban dispensaries get at the rate of Tk. 70,000 each per year, school health clinics too get at the above rate. The Union Health and Family Welfare Centres get at the rate of Tk. 40,000 each per year. The Central medical Store gets a thumb allocation of 20 per cent of the total fund for buying equipment, machinery, and other capital goods.

Based on the allocative principle as described above, a rough estimate of the distribution of MSR allocation can be made and this is done for the fiscal year 1997-98 (Table 12). Note that precise estimates in this regard cannot be done as the bed number in different health care facilities is not known. Neither the exact distribution of the fund into different level of health care facilities is available. Nevertheless, what the estimate in the table shows is that the district level hospitals, medical college hospitals, and the specialized hospitals of the country taken together claim the largest share of the MSR fund. This is not unexpected since majority hospital beds in the country are located under them. Together they consume about two-third of the annual MSR allocation. On the other hand, THCs and UHFWCs which take care of the primary health care in the rural area get only 17 per cent of the MSR fund. The situation with respect to urban dispensaries (operating at municipality ward level) and school health clinics (and, perhaps, in every other) is even worse: the matched share being less than 1 per cent.

An idea about the inadequacy of the MSR fund allocated to different Thana Health Complexes may be obtained from an indirect estimate. At the rate of Tk. 10,500 per patient per year, a THC with 31 bed hospital gets Tk. 3,25,000 annually on this account. If one assumes 100 per cent bed utilization rate in a THC, then per (indoor) patient per day MSR allocation would be around Tk. 29. It rises to Tk. 38 if utilization of bed is in the order of 75 per cent (which is, perhaps, a more realistic bottom line in the current situation) to remind it again, this estimate has not

⁹ This explains why one observes the wide practice of "bringing food from outside" to meet the patient's food need which is done privately in violation of the stipulated hospital practices.

considered outdoor patients who are far more greater in number and make claim on the same MSR fund as the in-patients do.

The emerging message is disturbing and it underlines the fact that the actual per patient allocation is meager by any standard. There is a genuine shortage of supply over and above the problems of pilferage, leakage, and misuse of the medical and surgical requisites at the local as well as higher level. It is being observed that the supply of medicine available in thana level hospitals is actually able to meet only one-third of the demand for it (Rahman and Ali, 1996).

Table 12

Distribution of MSR Funds into Different Type of Facilities

Type of Facilities	% of Total
THC (400)	11.8
UHFWC (1367)	5.0
Central Medical Store	20.0
Urban Dispensaries	.2
School Health Clinics	.2
District Hosp. med. College & Specialized Hospitals	

Source: Estimated from 1996/97 MSR allocation and the number of facilities as existed in 1996 as per Statistical Yearbook of BBS.

II.5 Distribution of Resources to Preventive Care

In order to improve the health status of the people particularly in developing countries where infectious and parasitic diseases dominate the morbidity scenario, the preventive health care possesses an especial importance. Such care provided through appropriate community level interventions can reduce to a large degree the prevalence/incidence of these diseases in a population and this is cost-effective as well in comparison to the management of these maladies through the curative services. The preventive care, thus, constitutes a definite element of the primary health care as envisaged in the Alma-Ata conference.

In Bangladesh prior to the 1980s, the mainstream activities in this regard have been control of epidemic diseases; such as, malaria, small pox, etc. With the control of these diseases the focus of preventive care from 1980s has shifted to the control of childhood diseases through EPI, diarrhoeal diseases prevention, education programmes on nutrition, health, hygiene, etc. with recent area of addition in this regard being the IDS prevention.

Table 13 presents the ADP allocations to preventive care and the revenue expenses made for this over the last two decades. Prior to 1980, the control programmes of the epidemic disease used to claim about 8 per cent of the total revenue expenses of the health sector. But after the effective control of malaria and small pox through vertical health programmes (which were under the revenue budget) was abandoned in the 1980s, and consequently, the revenue expenses on this count dropped sharply. It was less than 3 per cent during first half of 1980's, about 2 per

cent in 1985-90, and was really negligible in 1990-95 with figure being 0.14 per cent. During 1980's and early 1990's, the expenses under this head was made only for quarantine services installed in different entry points of the country such as in the airports, border check posts, etc.

Table 13

Per Cent of Revenue Expenses and ADP Allocations Made in Preventive Care

Period	% of Revenue Expenses	% of ADP Allocations (Revised)
1975/76 – 1979/80	7.9	n.a.
1980/81 – 1984/85	2.7	13.4
1985/86 – 1989/90	2.2	23.3
1990/91 – 1994/95	.14	25.3

Source: Ministry of Finance; Grants and Appropriation (Non-development) and Revised ADP of the Planning Commission.

Since 1980, the preventive health programmes became primarily the affair of development programmes for health and their share in the total development budget increased in recent years. The proportion ADP fund allocated to preventive care was about 13 per cent in 1980-85 and 25 per cent in 1990-95, thus increased nearly by two times over the past decade. While this increasing emphasis on preventive health care is an encouraging trend, yet, the fact remains that taking the total revenue expenses and development allocations together, the health sector as of 1990-95 devoted no more than 8 per cent of the total available resources to preventive care. Considering the fact that still three-fourth of the morbidity burden of the country originate from infectious and parasitic diseases which can be effectively prevented through appropriate interventions, such a distribution of resources between preventive and curative care indicates a relative negligence for prevention of diseases in the country.

II.6 Allocation of Resources to Non-allopathy Medicines

Although at policy-making level non-allopathy branches of medicines such as, Homeopathy, Unani, Ayurvedic, etc. were given importance to improve the access to health care by the people particularly in rural area (see Five Year Plan Documents) they are yet to find adequate place and recognition in the health sector. Over the last two decades these medicines have even remained unable to acquire the status of a line item for resource distribution in the health sector (Table 14). Some resources are made available to them from the head “Grants in Aid” in the budget and during last 2 decades resources thus made available to them never reached even 1 per cent figure. The ADPs of the country too, incorporate no noteworthy programmes for the development of non-allopathy medicines. Hence, for all practical purposes, they have remained a marginal sector and incorporation of them in the mainstream health care delivery has remained an unrealized and unattended goal.

Table 14**Per Cent of Revenue Expenses Made for Non-allopathy Medicines**

Period	% Expenses
1975/76 – 1979/80	0.1
1980/81 – 1984/85	0.6
1985/86 – 1989/90	0.9
1990/91 – 1994/95	0.6*

* It has not included expenses during 1994/95.

II.7 Other Features of Health Expenses

Delivery of effective and adequate health care services in Bangladesh is handicapped not only by severe shortage of resources but by the shortages of trained health personnel and support services. As of 1995 the availability of 15 doctors and 12 nurses for 100,000 population indicates that Bangladesh while suffers in general, from non-availability of trained personnel, it has quite extraordinary dearth of trained nurses.

The revenue expenses made for “medical colleges” and other training schools and institutions which produce trained manpower in the country reveals that the expenses on them (medical colleges, not on medical college hospitals) over the last two decades have declined substantially (Table 15). During 1975-80 about 7 per cent of the revenue expenses was on them and declined to 3.3 per cent during 1985-90 while remained stable thereafter. It is noteworthy that this decline has occurred in spite of the increase in the number of medical colleges in the country. In 1975 there was only 8 medical colleges, 9 in 1985, and the number rose to 13 in 1995. While one of the reasons for this decline in expenses on medical colleges may be the expansion of overall health sector, particularly in the area of primary health care, yet the fact remains that the manpower development during this expansion of the sector has not received needed attention. In other words, this has not kept pace with the expansion made in the health sector.

Table 15**Expenses/Allocation for Medical Colleges and other Training Schools/Institutions**

Period	Revenue Expenses		Development Allocation*
	Medical College	Other Tr. Schools	
1975/76 – 1979/80	6.9	n.a.	n.a.
1980/81 – 1984/85	4.6	n.a.	18.8
1985/86 – 1989/90	3.3	1.2	8.3
1990/91 – 1994/95	3.3	1.2	12.1

* to manpower development

Source: Ministry of Finance; Grants and Appropriation and Revised ADP of the Planning Commission.

The development allocation is also reflective of this situation. The ADP allocations made for the programmes for production and training of different categories of health manpower was about 19 per cent during 1980-85. But, subsequently, in the second half of 1980's it declined to 8 per cent. The situation improved somewhat in the early 1990's but remained still less than the level of early 1980's. The ADP allocation during 1990-95 was 12 per cent for manpower development.

As regards manpower development in the health sector, an important thing to note is that in the health manpower development of the country personnel other than the doctors have received very little attention. During the last decade, only about 1 per cent of the revenue expenses was earmarked for them.

As has already been noted, the share of medical and surgical requisites (MSR), a critical factor determining the quality of health care in revenue expenses has been very inadequate. The ADP allocation for the purpose too is not encouraging. The investments or the programmes relating to production, procurement, supply of drugs, biologicals, and other necessary supplies constituting support services represented only 5.5 per cent of the total ADP allocation to health during 1980-85 period. It increased slightly to 7 per cent in the second half of 1980's, and rose to 9.5 per cent during early 1990's (Table 16). Thus, there has been an increasing trend in the ADP allocations for support services over the last two decades. Yet, the fact remains the relative share of it in the ADP has been less than satisfactory. However, one point to take note in this connection is that the increasing allocation for support services in the subsequent ADPs may be the resultant effect of enhanced emphasis on preventive care which almost entirely is the responsibility of the development programmes and the curative services may benefit relatively less from this increased allocation to support services.

Table 16

ADP Allocations for Support Services

Period	% of Allocation
1980/81 – 1984/85	5.5
1985/86 – 1989/90	7.2
1990/91 – 1994/95	9.5

Source: Revised ADP of the Planning Commission.

Chapter 3

DISTRIBUTIONAL IMPLICATIONS OF PUBLIC HEALTH SPENDING

III.1 Who Benefits from Public Health Spending: A Static benefit Incidence Analysis

Whether, and to what extent, social expenditures have been able to reach the poor still remains an unresolved question. The average allocation figures say nothing about the rural trend, not to mention the more important issue as to what happened to the access of the rural poor to such services. The section throws some light on this issue.¹⁰

III.1.1 Measurement Issues

The key objective of the analysis is to evaluate the extent to which public expenditures on health benefit poorer groups in *rural* Bangladesh.¹¹ The assessment is based on a “benefit incidence analysis” of health expenditures in 1994.¹² However, a comprehensive review of the benefit incidence requires that the analysis should consider the simultaneous determination of the entire tax and expenditure system, employing the government aggregate subsidy to health as one of the parameters of the system. Such data are not available to support the analysis. Hence, the focus is made on the redistributive impact of government expenditures in a partial equilibrium framework. The purpose of the analysis is to see how the “gross” benefits from government spending (such as health) are distributed across the various income (expenditure) groups. The analysis will help to address the issue of re-orientation of public spending.¹³

To measure the direct income benefit from public health programmes, two types of data are needed. The most difficult part is to get fiscal information by required level of disaggregation. Gross allocations on health facilities in *rural* areas have been estimated from the macro budgetary data. Only revenue expenditures have been considered for the estimation of health subsidies. These are “higher bound” estimates of subsidy benefits since no allowance is made for cost recovery. Besides, rural/urban breakdown of public health budget does not exist, at least in readily available form. The calculation of public health expenditures in rural areas takes into

¹⁰ The discussion presented in this section draws heavily on Chowdhury and Sen (1997).

¹¹ The exclusion of urban focus is due to the lack of representative survey data capturing the household “use” of public educational and health facilities in urban areas.

¹² Several studies have applied this analysis earlier in other country contexts. See, Van de Walle et al. (1994), Hammer et al. (1992), Seldon and Wasylenko (1992), Dayton and Demery (1994), Hausmann and Rigdon (1993)

¹³ The analysis requires information on utilization of public services by different groups of beneficiaries suitably classified by per capita income (expenditure). Such information are often not available from conventional household surveys, and hence, some special purpose surveys (such as a hospital beneficiaries survey) are usually required. Given the scope, the study will mainly use whatever information available from the existing household surveys on the use of public services.

consideration some budgetary items which are not earmarked for exclusive rural use. Altogether, five items have been considered for public health expenditure analysis as applied to rural areas: hospital and dispensaries, mental hospital, epidemic control, health center, and upazila (thana) hospital. The inclusion of some of the non-rural health facilities such as district hospitals is valid on the ground that many of the rural patients (suffering particularly from major illnesses) also make use of such facility, as indicated by the household surveys.

Information on household “use” of public health services is measured from the unpublished primary survey data such as those collected by the poverty monitoring project of BIDS (using the recent 1994 round of survey of 62 villages). Here the relevant indicator at the household level is the number of annual visits of household members to government health facility. The survey-based figure of average annual visits per rural person has been used to approximate the total visits to government health facility by rural population, as recorded in 1994. Combining this information with macro budgetary data, one can estimate the “gross” subsidy per (rural) visit to government health facility.¹⁴ Once the estimate of subsidy per health visit is known, one can calculate the total amount of benefits accruing to various income decile groups using survey information on the utilization of public health facility by each group.

There are at least two ways of assessing the redistributive effect of public health spending in the short term. The first consists of evaluating the distribution of spending (i.e. how much of the total public expenditure is received by each income decile). The second consists of determining what proportion of each decile’s income is represented by public spending on health. The progressivity or regressivity of government social expenditures can be analyzed from both perspectives. The two criteria may not necessarily yield the same result. For instance, it is possible that the bottom two deciles receive less than 20 per cent of the total spending on health. However, this transfer can represent, in terms of its income, a larger share than the share received by the most affluent decile. We have considered both perspectives in forming opinion about the effectiveness of public health spending in terms of its impact on equity.

III.1.2 Results

The above observations broadly characterize the distribution of benefits from public health expenditures as well. We shall only focus on the additional moments revealed in the incidence analysis as applied to rural public health.

First, as per the current pattern of utilization of public health facility in rural areas, the highest benefit is received by the fifth income decile (having 17.8 per cent of total transfers). Households located at the top income decile receive slightly higher amount of benefits compared with the poorest income decile (13.6 vs. 12.8 per cent). However, the emerging pattern is generally pro-poor (Table 17). The 62-village survey of BIDS conducted in 1994 showed the proportion of rural population living in poverty to be in the order of 52 per cent (Rahman et al. 1996). Accordingly, the share of rural poor in the total stream of benefits from public health spending would be

¹⁴ This is estimated to be taka 211 in 1994.

about 57 per cent which is much higher than the matched figure observed for income distribution (i.e. 22 per cent).

Table 17

**Rural Income Distribution and the Distribution of the Benefits
from Government Expenditures on Rural Health: 1994**

Per Capita Income Decile	Per Cent of Income	Per Cent of Benefits from Public Spending on Rural Health
1	1.94	12.88
2	3.25	8.86
3	4.11	12.22
4	5.04	3.67
5	6.05	17.84
6	6.91	8.13
7	9.50	8.02
8	12.63	6.87
9	17.38	7.27
10	32.59	13.64
Total	100	100

Note: Public spending on health considered here includes only current expenditures.

Second, the importance of public health access is particularly revealing for the poorest income decile. The latter account for only 2 per cent of rural (private) income, but has 13 per cent of total health benefits. *Third*, a comparison of the relative proportion of public and private health expenditures indicates that benefits through public health still cover only a small part of the health care demand (Table 18). This is true even for those who are virtually cut off from the qualified private health care facility such as those provided by the trained doctors and private health clinics.¹⁵ The public component varies from 8 to 36 per cent of private health expenses for different groups of the rural poor (deciles 1-5). This also shows the potential benefits associated with effective expansion of public health programmes in rural areas. The extreme poor households currently allocate 7-10 per cent of their income to cover private health expenses which is a sizable burden by any reckoning.¹⁶ If this burden can be relieved through greater targeting and provision of public health care, this would have substantial poverty alleviating effect.

Fourth certain progressivity is discernible in the distribution of rural public health care. Benefit from the latter source, as proportion of per capita income, is

¹⁵ The choice for the most of the rural poor is between public health care and traditional (including untrained) practitioners, while the option for the rich ranges from inpatient facility in public health centers to having the ability to access the service of qualified private doctors. On the issue of general health access in rural areas, see Begum (1996).

¹⁶ This is just one aspect of the income erosion. The other, more critical, aspect of it lies in the acute vulnerability of the poor households to sudden and unanticipated health related shocks, leading to the loss of income and employment, and increased indebtedness. Health related shock represents important determinant of the downward mobility along the poverty spiral. On this, see Sen (1996).

found highest for the poorest (2.9 per cent) which declines almost secularly to 0.2 per cent in case of the top two deciles.

Table 18

Public and Private Health Expenditure Incidence by Per Capita Income Decile in Rural Bangladesh: 1994

Decile	Per Capita Income	Per Capita Private Health Expenditure	Per Capita Public Health Expenditure	(2) as % of (1)	(3) as % of (1)	(3) as % of (2)
	(1)	(2)	(3)	(4)	(5)	(6)
1	1693.58	173.71	48.71	10.3	2.9	28.0
2	2911.38	202.19	33.51	6.9	1.2	16.6
3	3678.96	208.29	46.20	5.7	1.3	22.2
4	4457.10	170.80	13.87	3.8	0.3	8.1
5	5361.35	187.40	67.46	3.5	1.3	36.0
6	6352.07	205.56	30.75	3.2	0.5	15.0
7	7930.18	194.14	32.59	2.4	0.4	16.8
8	9986.57	251.23	25.97	2.5	0.3	10.3
9	14291.59	297.74	27.50	2.1	0.2	9.2
10	26915.58	626.57	51.66	2.3	0.2	8.2
All	8317.66	251.11	37.82	3.0	0.5	15.1

Source: Calculated from macro Budgetary and Primary APT Data.

Note: Public health spending includes only current expenditures.

The above results derived under the static benefit incidence analysis as applied to health sector are based on the assumption that unit costs for obtaining public health services are the same for the various income levels. This is hardly satisfactory, given the often high transaction costs involved in getting access to public health care, costs which are likely to be higher for the poor than the non-poor. Besides, one should also take into account the quality differential in the service provided by public health bodies to different socio-economic status (SES) groups, including the difference between poor and non-poor groups. The latter may be measured in terms of waiting time, adequate attention of doctors, differential access to inpatient and outpatient facility, access to medical tests, etc. The results relating to certain progressivity in the distribution of benefits from public health spending in rural areas thus needs to be calibrated by taking these transaction costs and quality factors into consideration.

Chapter 4

SUMMARY AND CONCLUDING OBSERVATIONS

The present analysis of the financial allocation and distribution of resources in the health sector including an assessment of incidence of benefit of public health expenditure that accrues to rural people of different strata led to several important observations.

As observed, the proportion of GDP spent on health is relatively low in the country. Taking public and private expenses together this is little over 3 per cent of the GDP while former is not even 1 per cent of it. The per capita spending on health too is very small. It is only about US\$ 2 per annum. However, following the practices of other developing countries such as Nepal, India, and China, Bangladesh inspite of having low income base can devote more resources to health.

Taking revenue and development expenditure together, roughly 3 to 4 per cent of the government expenditure is spent on health. During the period of structural adjustment in the second half of 1980's this share got reduced further, with adverse effect being more pronounced on the development allocation. The ADP allocation to health during those years reached a negligible 1 per cent or a figure lower than that. Hence, alike many other developing countries, the economic adjustment programmes of Bangladesh too have rendered an adverse effect on health particularly on the development expenditure of this sector.

Historically, the major part of the health expenses is spent to meet the operating cost of the sector. Only a smaller part is devoted to create new capacities and/or acquiring capital assets. More importantly, over the last 20 years the operating costs in terms of salaries and allowances of the officers and staff has been increasing pushing the other expenses down. The most affected heads in the process are: (a) medical and surgical requisites (MSR), and (b) expenses on other items most of which fall under the logistic support including diet for the in-house patients. All outlets of health care delivery, such as, Thana Health Complex (THC), District Hospitals and Dispensaries, and Medical College Hospitals have undergone these changes in expenditure pattern. Analysis of the development budget too indicate that they are the minor items of expenditure. Only about one tenth of the ADP budget is allocated for drugs and vaccine procurement while another 14 per cent for purchasing ambulance, vehicle, furniture, equipments etc. The major item of expenditure in ADP is construction and related matters to it.

Indeed, an emerging feature of the recent public health expenditure is that the delivery of health care services in general, including primary, secondary, and tertiary levels of care, have been getting lesser priority. The share of expenses on them in the nineties has declined.

In commensurate with the national objectives, primary health care is getting priority for resource distribution. The secondary health care is relatively neglected for this. But for smooth functioning of the referral system which is the linch-pin of the primary health care approach, secondary health care requires balanced development.

Preventive health care has remained another neglected area in the health sector. Presently, it is taken care of entirely by the development budget and no more

than 8 per cent of the total public health expenses is spent on this. Given the country's disease pattern of mortality and morbidity dominated by infectious and parasitic diseases, prevention of diseases presumably deserves more attention. Yet, a caveat is that a perceptible transition in disease pattern in the country may not take place till poverty is alleviated substantially. Many of the diseases people suffer from originate primarily from impoverished and unhygienic life and living of the poor people viz., they are intricately interrelated with poverty.

Manpower development also has not received appropriate attention it deserves. Revenue expenses on medical colleges and other training institutions/schools including development allocation for projects designed for the development of manpower has declined substantially over the last two decades. Particularly neglected in this regard has been the development of auxiliary manpower referring to lower level health personnel other than MBBS doctors. Only about 1 per cent of the revenue expenses is earmarked for them. Hence, it is not by chance that the country has extraordinary dearth of nurses or the quacks/untrained practitioners dominate the rural private health care. Thus, development of health manpower in the country while should keep pace with the expansion of the sector, it should give adequate attention to the development of all categories of manpower too required for a sound public health delivery system. While doing so it should also address the need of the private sector as well. It is being estimated that even if existing public health facilities function in full capacity, government health care facilities can not satisfy more than one-fourth of the health care needs of the rural people.¹⁷ Thus, meeting health care needs of the rural people will continue to depend much on the private sector and supply of trained manpower is precondition for efficient functioning of this sector.

The non-allopathy medicine for all practical purposes is yet a marginal sector. They are still not a proper line item for claiming resource from the health budget and receive fund from the 'grants in aid'. Since, substantial number of people use them and they also can be employed to meet health care needs of the people it is desirable that they are recognized and brought under the mainstream health care package.

However, as the public health expenditure pattern of the country indicates, the largest chunk of it is spent on the curative health care based on allopathy medicine and most of these expenses are again spent to meet the operating costs only. Acquisition of assets, building new capacities, support services, drugs and medicine supply, manpower development have been experiencing not only relative neglect but getting increasingly marginalized too in drawing resources which possess much importance for the quality of care.

Another issue viz. the current allocative principle of the government for distributing national MSR (medical and surgical requisite) budget for facilitating the supply of medicine and other requisites for surgical activities also requires

¹⁷ It is observed from one month statistics of four Thana Health Complex that the filled-in positions for the doctors are 70% of the sanctioned positions and doctors remain present in the Health Centre on average of 80% of the working days. The situation is however, worse in the Thana health Complexes which are located in less developed or remote areas. In such Health Complexes 67% of the doctors positions are filled in but doctors remain present only in 37% of the working days. The worst situation prevails in the Union health Centres (USC) which are located at the village level. From these statistics it is assumed the Government Primary Health Care Centres operate a level which may be about half their potential. Hence, making them functioning in full capacity will only double their present contribution of 12 % of the total treatment.

reconsideration. At present, it is distributed to different outlets on the basis of number of beds available and pays no attention to the bed utilization, size of the population or the volume of outdoor patients it serves. Hence, current principle ignores a significant part of the reality which determine greatly the ultimate supply of medicine to the patients. However, that the issue of medicine supply requires an urgent attention is evident also in a per capita estimate of MSR budget. it is being observed that even if we allow for 100 per cent honesty, the per person MSR allocation for indoor patients with 1996-97 budget stands at around Tk. 29 only in a 31 bed Thana Hospital (assuming 100 per cent utilization). As noted above, this allocation in Reality is even lower as outdoor patients claim on this budget. The present allocation for medicine therefore, is an allocation for allocation sake only.

The current allocative principle for the diet as well requires reconsideration. At present, per patient per day allocation for food is Tk. 30 only and this is uniformly fixed for all hospitals across the locations and types. It thus, has considered neither the rural-urban price discrimination nor special food requirement for patients in the specialized hospital. However, a proper diet policy for the hospitals while requires an upward revision of the current absolute amount, requires also accommodation of at least, special food requirement of the patients.

Finally, it is to note that the public health expenditure in the country is pro-poor viz. the poor derive more benefits from this expenditure than the richer section does. Hence, an increased expenditure on health in the country is desirable on two counts. While its pro-poor nature will help the alleviation of poverty, it will help the process of economic development also through the health status of people.

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