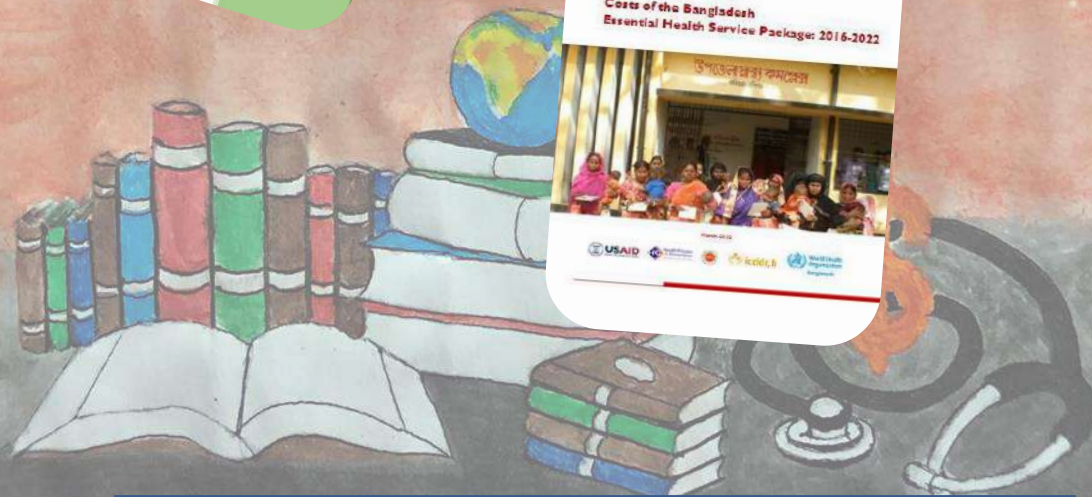
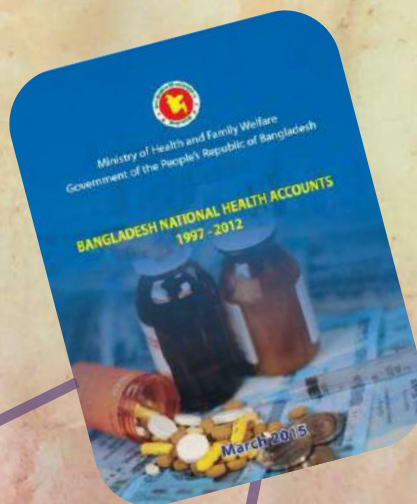
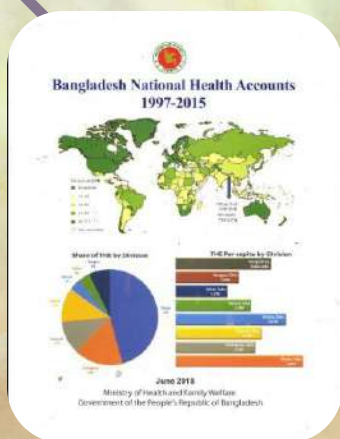


# All Research, Guidelines and Manuals published by Health Economics Unit



**Health Economics Unit  
Health Services Division  
Ministry of Health and Family Welfare**



**All Research, Guidelines and Manuals  
published  
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Health Economics Unit**



**Celebrating 100 years of Mujib**



**Health Economics Unit  
Health Services Division  
Ministry of Health and Family Welfare**

February 2021

This report summarizes all the research, guidelines and manuals published by the HEU from their beginning under the authority of the Health Economics Unit, Health Services Division of the Ministry of Health and Family Welfare. It was prepared and published to celebrate the 100 year of the birth anniversary of nations father Bangabandhu Sheikh Mujibur Rahman.

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মহাপরিচালক (অতিরিক্ত সচিব)  
স্বাস্থ্য অর্থনীতি ইউনিট, স্বাস্থ্য সেবা বিভাগ,  
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়  
গণপ্রজাতন্ত্রীবাংলাদেশ সরকার

## মুখবন্ধ

গণপ্রজাতন্ত্রী বাংলাদেশের সংবিধানের ১৫ (ক) নং অণুচ্ছেদে রাষ্ট্রীয়ভাবে স্বাস্থ্য সেবা প্রাপ্তি জনগণের মৌলিক অধিকার হিসেবে স্বীকৃত হয়েছে। পাশাপাশি ১৫ (খ) নং অণুচ্ছেদে জনগণের সামাজিক নিরাপত্তার অনুসংগ হিসেবে ব্যাধি বা পশ্চুজনিত বা বার্ষিক্যজনিত কিংবা পরিস্থিতিজনিত আয়ত্তাতীত কারণে অভাবগ্রস্ততায় সরকারি সাহায্যলাভের অধিকার নিশ্চিত করা হয়েছে। ফলে, উপযুক্ত ব্যবস্থা গ্রহণের মাধ্যমে সবার জন্য স্বাস্থ্য সেবা নিশ্চিত করা বাংলাদেশ সরকারের সাংবিধানিক দায়িত্ব এবং এ দায়িত্ব যথাযথভাবে পালন করতে বাংলাদেশ সরকার বদ্ধপরিকর। ২০৩০ সালের মধ্যে সবার জন্য আর্থিক ঝুঁকিমুক্ত, মানসম্মত ও প্রয়োজনমাপিক স্বাস্থ্য সেবা নিশ্চিতকরনে বর্তমান সরকার নিরলসভাবে কাজ করে যাচ্ছে। স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের স্বাস্থ্য সেবা বিভাগের অধীন স্বাস্থ্য অর্থনীতি ইউনিটের রূপকল্প হল সর্বজনীন স্বাস্থ্যসেবা এবং অভিলক্ষ্য হচ্ছে স্বাস্থ্য খাতে সম্পদের সর্বোত্তম ব্যবহারের মাধ্যমে সেবা গ্রহীতার সর্বোচ্চ সন্তুষ্টি বিধান। এই অভিলক্ষ্য অর্জনে এই ইউনিট বাংলাদেশের সর্বজনীন স্বাস্থ্য সেবা সংক্রান্ত কর্মকাণ্ডের কৌশলগত নীতিপ্রণয়ন ও বাস্তবায়নে পরামর্শকের দায়িত্ব পালন করে যাচ্ছে। স্বাস্থ্যখাতে পর্যাপ্ত অর্থায়ন নিশ্চিত করতে স্বাস্থ্য অর্থায়ন সংক্রান্ত কর্মপরিকল্পনা নির্ধারণে ২০১১ সালে স্বাস্থ্য অর্থনীতি ইউনিট কর্তৃক স্বাস্থ্য সেবা অর্থায়ন কর্মকৌশল (২০১২-২০৩২) বা Healthcare Financing Strategy প্রণীত হয়েছে। স্বাস্থ্যখাতে খাতওয়ারী বরাদ্দ কত এবং কতটুকু দক্ষতারসাথে এই বরাদ্দব্যয় করা হচ্ছে তা সংশ্লিষ্ট সকলকে জানাতে এই ইউনিট থেকে নিয়মিতভাবে Bangladesh National Health Accounts (BNHA) ও স্বাস্থ্য খাতের Public Expenditure Review (PER) প্রতিবেদন প্রকাশ করা হয়। স্বাস্থ্য অর্থনীতি ইউনিটের পক্ষ থেকে এই পর্যন্ত ৫ টি BNHA এবং ১১ টি PER প্রকাশ করা হয়েছে।

স্বাস্থ্যখাতে সক্ষমতা বাড়ানোর জন্য নিয়মিতভাবে প্রশিক্ষণ, কর্মশালা, সেমিনার আয়োজন এবং গবেষণা সম্পাদন ও সংশ্লিষ্ট Stakeholder গণকে ফলাফল অবহিতকরণ স্বাস্থ্য অর্থনীতি ইউনিটের অন্যতম গুরুত্বপূর্ণ কাজগুলোর অন্যতম। স্বাস্থ্য খাতে বিকল্প অর্থায়নের সুযোগ সৃষ্টি ও আর্থিক প্রতিবন্ধকতা এড়িয়ে সমাজের দরিদ্র জনগোষ্ঠীর জন্য উন্নত স্বাস্থ্যসেবা নিশ্চিত করতে টাঙ্গাইল জেলার কালিহাতি, ঘাটাইল, ও মধুপুর এই তিনটি উপজেলার দরিদ্র জনগোষ্ঠীকে স্বাস্থ্যসেবা পদানের লক্ষ্যে স্বাস্থ্য সুরক্ষা কর্মসূচী (SSK) নামক একটি

## Preface

## Preface

পরীক্ষামূলক প্রকল্পের মূল্যায়নপূর্বক প্রাপ্ত ফলাফলের ভিত্তিতে এই প্রকল্পটি দেশব্যাপি সম্প্রসারণকারার পরিকল্পনা রয়েছে। এই প্রকল্পের আওতায় ১৫ জানুয়ারী ২০২০ খ্রিঃ পর্যন্ত ৩টি উপজেলায় মোট ৮১,৬১৯টি দারিদ্র্য পরিবারকে স্বাস্থ্য কার্ড দেয়া হয়েছে, ইতোমধ্যে ৭৬,১৫১ জন রোগী হাসপাতালে অবস্থিত এসএসকে বুথ ভিজিট করেছেন এবং এই কার্ড ব্যবহার করে মোট ১৩,০৩৪ জন রোগী অন্তঃবিভাগ থেকে বিনা মূল্যে চিকিৎসা সেবা গ্রহণ করেছেন। SSK সেবার আওতায় সেবা গ্রহণকারীর সংখ্যা পূর্ববর্তী বছরের তুলনায় ৫৭ শতাংশের বেশী বৃদ্ধি পেয়েছে। কোয়ালিটি ইম্প্রুভমেন্ট সেক্রেটারিয়েট বা QIS স্বাস্থ্য সেবা প্রদানের গুণগত মানের উন্নতির লক্ষ্যে এ পর্যন্ত ২০ টির অধিক ম্যানুয়াল এবং গাইডলাইন প্রস্তুত করেছে। স্বাস্থ্য অর্থনীতি ইউনিটের আওতাধীন হাসপাতালের সেবা প্রদানের পরিবেশের মানোন্নয়নে QIS কর্তৃক ৫৯ কর্মসূচীর উপর প্রশিক্ষণ প্রদান অব্যাহত রয়েছে। স্বাস্থ্য, জনসংখ্যা ও পুষ্টি খাতে Gender Equity Action Plan (GEAP) বাস্তবায়ন, জেন্ডার বিশ্লেষণ ও জেন্ডার সংবেদনশীল সূচকের (Indicator) সাহায্যে জেন্ডার রিপোর্টিং নিশ্চিতকরণ এবং জেন্ডার ভিত্তিক সহিংসতায় সারভাইভারদের (survivor) মানসম্মত স্বাস্থ্য সেবা প্রদানে স্বাস্থ্য অর্থনীতি ইউনিটের GNSP ইউনিট কাজ করে যাচ্ছে। স্বাস্থ্য খাতে এনজিও ডাটাবেজের বহুমুখী ব্যবহার নিশ্চিতকরণে বাস্তব ভিত্তিক পদক্ষেপ গ্রহণ এবং মনিটরিং ও পলিসি প্রণয়নে সহায়তা প্রদান GNSP এর অন্যতম কাজ। সর্বজনীন স্বাস্থ্য সেবার গুণগত মানোন্নয়নের লক্ষ্যে কোয়ালিটি ফ্রেমওয়ার্ক বাস্তবায়ন এবং মনিটরিং ও ইভালুয়েশন ফ্রেমওয়ার্ক প্রণয়ন, মানসম্মত স্বাস্থ্য সেবা নিশ্চিত করার জন্য বিভিন্ন রোগের প্রটোকল SOP প্রস্তুতকরণ, স্বাস্থ্য সেবা প্রদানকারীদের OTC প্রদান পাশাপাশি সেবা সম্পর্কিত কার্যক্রম পরিবীক্ষণ ও মূল্যায়ন সংক্রান্ত গাইডলাইন প্রণয়ন ইত্যাদির গুরুত্বপূর্ণ কার্যাবলী অত্র ইউনিট নিয়মিতভাবে সম্পাদন করে যাচ্ছে। জাতির পিতা বঙ্গবন্ধু শেখ মুজিবুর রহমানের জন্মশতবার্ষিকী উদযাপনে বাংলাদেশ সরকার বিভিন্ন কর্মকাণ্ডের উদ্যোগ গ্রহণ করেছে। এরই ধারাবাহিকতায় মুজিব বর্ষ উপলক্ষে স্বাস্থ্য অর্থনীতি ইউনিট তার পূর্বে সম্পাদিত গবেষণা এবং চলমান গবেষণাগুলোর উপর একটি গবেষণা সংকলন প্রকাশ করতে যাচ্ছে। এই প্রকাশনার উদ্দেশ্য হচ্ছে, স্বাস্থ্য খাতের উন্নয়নে স্বাস্থ্য অর্থনীতি ইউনিট যেসকল কার্যক্রম চালিয়েছে সেসব সম্পর্কে সংশ্লিষ্ট সকলকে অবহিতকরণ। আমি এই গবেষণা সংকলন প্রকাশের সাথে যুক্ত সকলকে তাঁদের মূল্যবান অবদানের জন্য আন্তরিক অভিনন্দন ও শুভেচ্ছা জানাচ্ছি।

(ড. মোঃ শাহাদৎ হোসেন

মাহমুদ)

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## Research Activities

## **Bangladesh National Health Accounts – I (1996-97)**

*Published on – November, 1998*

### **Summary findings -**

Bangladesh spent a total of Tk. 54,700 million (Tk 5,470 crore) on health in 1996/97, equivalent to 3.9% of GDP and US\$ 10.6 per capita. This was financed 34% by public sources (including foreign assistance), 64% by households and the private sector, and 1% by NGOs. Government health expenditures (including donor funding) only accounted for 34% of the total. Although the level of national health expenditures was greater than the amount estimated as required for provision of the essential services package (US\$ 3.25 per capita per year), these expenditures were mostly not used for that purpose. Public spending was a little under US\$ 4 per capita, but was clearly not financing universal access to the essential services package. Households accounted for the bulk of financing. There were three distinctive features in household spending: (i) 73% was used to purchase pharmaceuticals; (ii) 7% was spent on consultations at non-qualified or traditional medical providers, with only 10% being spent at qualified medical providers; (iii) a significant proportion was associated with visits to nominally free government facilities. In terms of the use of expenditures, Bangladesh devoted a relatively small share of its total national (<10%) and total public sector expenditures (<17%) to the financing of inpatient care. Total NGO expenditure account for less than 3% of NHE, they accounted for 8.5% of total public sector funds and delivered a sizeable proportion of health services in certain areas favored by donors, such as family planning.

### **Policy relevance –**

Bangladesh had spent a marginally higher proportion of its national resources on health care than two other low-income developing countries with better health outcomes, China and Sri Lanka, during that period, and did previously when they were at Bangladesh's level of economic development. This suggested that the major issues for Bangladesh's financing policy framework should be improving the efficiency and effectiveness in the use of both national and public sector health care resources, as well as understanding the implications of the high reliance on private financing and the low share of public spending. There was a need to substantially improve the quality and availability of information on donor financing and expenditures through the Development Budget, as the situation of that time did not readily permit analysis of the role and effectiveness of GOB funds. For the Out Of Pocket Payments, how much of this was due the unavailability of services and supplies in the facilities, and how much was due to the payment of unofficial fees to government providers was unclear, which was an area of concern.

**Conducted by – BNHA Cell**

Health Economics Unit, Data International Limited, Maxwell Stamp PLC UK



**HEU Publication  
Research  
BNHA**



## Bangladesh National Health Accounts – II (1999-2001)

Published on – December, 2003



### Summary findings -

In the NHA-2 estimate, in 2001-02, THE amounted to over Taka 88.3 billion (1.54 billion); comparable NHE and SHA. THE figures for 2001-2002 are Taka 82.8 billion (\$1.45 billion) and Taka 85.3 billion (\$1.49 billion) respectively. THE witnessed a real annual growth (adjusted for inflation) of around 6% during the 1996-97 to 2001-02 period while NHE increased at closer to 6.5% during the comparable period. Total Health Expenditure (THE) showed a steady increase in both per capita and total volume of expenditures. Compared to around 33% in 1996-97, as measured by NHA-1, the share of public sources in THE declined to 26% in 2001-2002. The share of NGO expenditures increased from 3% to 9% while household OOP health expenditure share has remained around 64% of THE during the five year period studied. Overall development partners funding increased from 10.5% of THE in 1996-1997 to 13.3% in 2001-2002. ESP expenditures were estimated to account for around 54% of MoHFW current expenditure excluding proportionate allocation of expenditure on health administration (alternatively termed as "super overhead expenditure"). High Out of Pocket (OOP) expenditure (around 70%) on purchase of pharmaceuticals continued to be the most distinctive feature of household healthcare expenditures .

### Policy relevance –

NHA-2 captured changes occurred in the financing pattern of Bangladesh's national health expenditure. Share of the public sector in the overall financing of the national expenditure, which was dominated by MoHFW expenditures, was declining over the time. On the other hand, shares of NGO and household OOP health expenditure had been on the rise. The pattern of development partners funding appeared to be shifting. MoHFW was collaborated relatively more with multilateral development partners than with bilateral development partners. The reverse was the scenario in the case of NGOs. The MoHFW expenditure pattern exhibited structural shifts. It was in conformity with the major reforms in public health policy and the impetus of Health and Population Sector Program (HPSP). The emergence of Essential Service Package (ESP) as the dominant service mode of the MoHFW providers had resulted in a major shift of focus of MoHFW expenditure from the tertiary and secondary level providers to the primary providers represented by the Upazila– the third administrative tier of the government – and below level Close to Client (CTC) facilities. NHA institutionalization within the MoHFW was remained as a challenge. The role of researchers was limited to collating and collection of data and in preparing NHA-related statistical tables.

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**Conducted by – BNHA Cell**

Health Economics Unit, Data International Limited, DFID (UK)

## Bangladesh National Health Accounts – III (1997-2007)

*Published on – December, 2010*



### Summary findings -

For Bangladesh, THE was estimated at Taka 160.9 billion (\$2,331 million) in 2007, Taka 74.2 billion (\$1,375 million) in 2001, and Taka 48.7 billion (\$1,140 million) in 1997. Over the 1998–2007 period the average annual THE growth rate was 12.7% in nominal terms and 8.1% in real terms. THE as a percent of GDP was 3.4% in 2007. In 2007, per capita spending on health was Taka 1,118 (\$16.2) compared to Taka 988 (\$14.7) the preceding year. Households remained as the main source of financing for healthcare in Bangladesh, comprising 64% of THE in 2007. In 1997, households accounted for 57%, increasing steadily over time. The government was the second largest financing agent making up for 26% of THE in 2007. In 2007, drug outlets accounted for Taka 69.1 billion (\$1,002 million), hospital expenditure was Taka 43.0 billion (\$623 million) and ambulatory care was Taka 35.0 billion (\$507 million). Hospitals' share as a provider had increased steadily through the years – from 17.3% in 1997 to 19.8% in 2001 and 26.7% in 2007. The largest shares of THE were accounted for by spending for drug retail services and services of curative care representing 50.7% (Taka 74.2 billion) and 21.6% (Taka 46.0 billion) in 2007. These two categories were followed by prevention and public health services at Taka 18.1 billion (12.3%). The BNHA3 was estimated for the first time systematically assess spending by geographical division.

### Policy relevance –

In nominal terms, there had been a positive annual growth in health expenditure, ranging from 8% during 2002–03 to 19% in 2005–06, with the annual increase being relatively stronger in those years. However, when measured in real terms, the average rate of increase had slowed, from 8.5% during 1998–2002 to 7.6% during 2003–2007. Health expenditures as a ratio to GDP showed a slow but steady increase over time – averaging 2.8% during 1998–2002 period compared to an average of 3.2% during 2003–2007. The relatively lower number and capacity of public health facilities in Barisal contributed to lower MoHFW spending in that division.

**HEU Publication  
Research  
BNHA**

### Conducted by – BNHA Cell

Health Economics Unit, (GTZ) GmbH, Germany, Data International Ltd. and Institute of Health Policy, Sri Lanka.



## HEU Publication Research BNHA

### **Bangladesh National Health Accounts – IV (1997-2012)**

*Published on – March, 2015*

#### **Summary findings -**

Total health expenditure (THE) in Bangladesh is estimated at Taka 325.1 billion (\$4.1 billion) in 2012, Taka 153.9 billion (\$2.2 billion) in 2007, Taka 81.5 billion (\$1.4 billion) in 2002, and Taka 46.4 billion (\$1.1 billion) in 1997. In 2012, per capita spending on health was Taka 2,144 (\$27) compared to Taka 1,576 (\$16) in 2007 and Taka 825 (\$9) in 1997 at 2012 constant price. In 1997 the share of households in THE was 56% (Taka 26 billion), which has risen to Taka 108 billion (\$1.6 billion) in 2007 to 63% (Taka 206 billion) in 2012. Government financing in THE (primarily offered through the Ministry of Health and Family Welfare) has increased significantly in absolute terms from Taka 17 billion in 1997 to Taka 42 billion in 2007 to Taka 75 billion in 2012. As a financing scheme, Voluntary Health Insurance Payment (NIPSH, Employers and Others) is 5.25% of THE in 2012. Non-profit Institutions Serving Households (NPISH) own contribution in health care services accounts for Taka 6 billion (approximately 2% of THE). Taka 27 billion direct assistance is given in 2012 to NGOs by the development partners, which is reflected in the Rest of World Financing Schemes (8.3% of THE) category. The relative share of laboratory services has been declined from 60.1% in 1997 to 59.9% in 2007 and 57.1% in 2012. In 2012 Taka 43.6 billion was spent on preventive care. The share of expenditures accounted for drugs and medical goods retailers remained steady between 38% and 42% during the period 1997-2012.

#### **Policy relevance –**

THE grew around 14% in nominal terms annually but in real terms, the growth level has been approximately 8% annually. THE as a percent share of Gross Domestic Product (GDP) has remained stable in recent years at around 3%. Households serve as the biggest financing scheme for Bangladesh healthcare system. As a percentage share of THE, public spending has declined gradually. Disaggregation of expenditures by functional category shows that retail drugs and medical goods and services of curative care account for major share of THE. The share of health education, training and research has varied between 1% to 4% during the 1997-2012 period. General day curative care offered primarily by public sector community clinics in rural areas has shown an increase in recent years, while such service was almost non-existent from 2002 through 2009. Expenditure relating to maternal and child health and family planning and counselling activities collectively constitute approximately 83% of preventive care. The percentage distribution of healthcare spending by geographical region has not changed much between 1997 and 2012, except for Dhaka and Chittagong divisions. The main reason for this shift is due to faster increase in private sector health spending as well as investment in Dhaka division. The relative shares are much lower in Sylhet and Barisal, and have changed little.

**Conducted by – BNHA Cell**

Health Economics Unit, Data International Limited



## HEU Publication Research BNHA

### **Bangladesh National Health Accounts – V (1997-2015)**

*Published on – June, 2018*

#### **Summary findings -**

Total Health Expenditure (THE) for Bangladesh in 2015 is estimated at Taka 452 billion. This is equivalent to Taka 2,882 per person, or US\$37 per capita. The share of THE in Gross Domestic Product (GDP) continues to grow at a high pace. THE accounted for around 2% of GDP in 1997; in 2015, it is estimated at 3% of GDP. In 2015, THE in Bangladesh is dominated by private sector financing accounted for 77% of THE, and public sector's share was 23%. The Ministry of Health and Family Welfare (MoHFW) financing share of total public spending has remained stable over the years - 96% in 1997 to 94% in 2015. The share of local government in financing has remained below 1%. Over the years, major financing of health expenditure is dominated by household Out of Pocket (OOP) spending. OOP spending was 55%, 60%, 63% in 1997, 2005 and 2012 respectively, which was increased to 67% in 2015. Health insurance primarily dominated by Employer-sponsored insurance's contributions has been varying between 0.6% to 1% of total private sector financing. Expenditure for inpatient care has increased over time from 41% in 1997 to 51% to 2015. During the 1997 – 2015 period, the share of expenditure on outpatient care has fallen from 55% to 46%. In 2015, pharmaceuticals account for the largest amount of spending (43%), followed by providers of curative care (25%) and preventive care (11%). Divisional breakdown of total health expenditure shows that Dhaka accounts for highest (46%) while Sylhet and Barisal are jointly lowest (4%) in 2015. Dhaka enjoys the highest amount of contribution from both public (36%) and private (49%). For 2015, per capita, health spending on healthcare for Bangladesh is Taka 2,882 (\$37). Per capita spending by government is around Taka 652 (\$9) in 2015. The highest level of per capita government spending is in the Rajshahi division at Taka 679 per capita.

#### **Policy relevance –**

Although the government has continued increase in public sector financing, their relative share has declined from 36% of THE in 1997 to 23% in 2015. There has been a marginal increase in expenditure by other ministries in health sectors. The trends over time show that pharmaceuticals share of spending has increased, while spending on governance, health system, and financing administration has decreased. The highest level of per capita government spending is in the Rajshahi division at Taka 679 per capita. But as Sylhet and Barisal are lowest performing divisions, they were needed to be taken care of by providing necessary supports.

**Conducted by – BNHA Cell**

Health Economics Unit, Data International Limited



## HEU Publication Research BNHA

### **Public Expenditure Review – I (1990/91 - 1994/95)**

*Published on – September, 1995*

#### **Summary findings -**

From the mid-1980s, the GOB, along with its foreign development partners, significantly expanded the funding to the health sector both in the ADP and the Revenue Budget. Between 1986/87 and 1994/95, the resources devoted to the health sector, in constant US dollars, expanded by an annual average of 6%, with even stronger growth in the ADP (13% p.a.). This was achieved by increasing the proportion of funds allocated to the health sector from the GOB's own domestic resource base. Furthermore, in keeping with its objectives, GOB targeted this expansion of funding towards Primary Health Care activities, especially in the ADP. By 1994/95, GOB funding of PHC activities was over 50% of revised Budget allocations to the health sector. The combined efforts of GOB and its foreign development partners resulted in excellent progress toward goals for contraceptive prevalence and fertility. In particular, the fall in the population growth rate to below 2% was a substantial achievement. Between 1990/91 and 1994/95 donors contributed over 60% of funding to the population sector.

#### **Policy relevance –**

The study highlighted current strengths and weaknesses in the process of allocating and using resources in public investment in health and population. A number of direct policy recommendations were forthcoming concerning improved planning systems, financial sustainability and cost-effectiveness of resource use. It was noted that planners need not only to be able to justify improved sectoral funding and targeting of priorities but also to identify cost-effective use of resources and the feasibility of future plans. To further this, it was seen to be crucial that GOB continue to improve its financial databases. Second, the study noted the importance of assessing the financial sustainability of the population sector. GOB was advised to expand its funding of revenue items in the population sector to meet operating costs where external funds were being used to meet domestic liabilities. This might require an assessment of different health care financing options. Third, the paper suggested focusing on the development of a cost effective and viable strategy for tackling maternal health, a key priority for HAPP 5.

**Conducted by – BNHA Cell**  
Health Economics Unit.



## HEU Publication Research BNHA

### **Public Expenditure Review – II (1993/94 - 1997/98)**

*Published on – February, 1998*

#### **Summary findings -**

The share of GOB's ADP funding towards primary health care (PHC) activity dropped from around 53 percent in 1993/94 to 41 percent in 1996/97. Similarly, the share of PHC in the Revenue Budget declined from around 50 percent in 1993/94 to 47 percent in 1996/97. PHC funding dropped partly due to increased funding of other activities like administrative and planning operations of the Ministry. GOB attained targets for CBR, CDR, MMR, and life expectancy, but failed quite clearly to achieve targets relating to PHC coverage, immunization, assisted delivery, antenatal care and nutritional status. The share of development partner contribution to PHC has actually increased from 64 percent in 1993/94 to around 70 percent in 1997/98. In addition, capital expenditures in the ADP had increased to around 91 percent of the total health ADP in 1997/98, while recurrent expenditures had declined to a modest 8 percent from a staggering 18 percent in 1993/94. The population sub-sector had clearly benefitted from increased funding by the GOB and its development partners. Funding had increased in both the ADP and Revenue Budget, although increases in the Revenue Budget were marginal. The GOB had effectively increased its share in the ADP funding of the population activities (from 32 percent in 1993/94 to around 40 percent in 1996/97). The amount of project aid as loans was increasing at a faster rate during the past five year (1993/94-1997/98) than in the previous five years. Interestingly, the grant component of project aid is shrinking, keeping the total amount of project aid more or less unchanged.

#### **Policy relevance –**

A National Health Policy advised to be formulated to provide clear guidelines to planners and programme managers. It was advised that, GOB should attempt to compile health-related databases that allow researchers and policymakers to monitor the policy relevant features of programme performance. Such initiative was advised to make effective as early as possible and used both prospectively and retrospectively. A mechanism proposed to evaluate impact and sustainability of the programmes such as An Annual Sustainability Assessment and Policy Review (ASAPR). Resource gaps during HAPP-5 would require new resource mobilization schemes. It was advised that, GOB should expand its fund allocation from the Revenue Budget to population activities in order to cover recurrent expenditures. It was advised that, Gender equity should be ensured in terms of access to and use of public health and population facilities. A Resource Allocation Model (RAM) was advised to be developed on the basis of health care needs and expenditure in order to tackle the complex issues of equity related to geographic and income variations.

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Health Economics Unit.



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## **Public Expenditure Review – III (1998 - 1999)**

*Published on – January, 2000*

### **Summary findings -**

Over the course of the 1997-2002 five year plan the health and population sector has been allocated 10.6 per cent of the planned budget. Between 1990 and 1998, in nominal terms spending increased more than three and a half times. In real terms (constant prices) spending has doubled. Spending has increased at a rate faster than GDP throughout the 1990s. This reflects increasing priority given to health and other social sectors together with an improving macro-economy and government revenue generation. Spending during 1998/9 was significantly lower than planned largely as a result of delays preparation and approval of Operational Plans and delays in development budget disbursements. A provisional analysis suggests that allocations by geographic region (division) bear little relation to measures of health status or service need. Lower than expected disbursement of the development budget largely accounts for an increase in the overall proportion of expenditure on salary items. More than 70 per cent of expenditure through the ESP health and reproductive health operational plans (which account for the majority of ESP spending) was on reproductive health services. Based on expenditure patterns greater emphasis is given to family planning than maternal health both in terms of overall allocation and in terms of spending as a proportion of allocation. 11% of total ESP (Health and Reproductive Health) operational plan expenditures is on maternal health, compared to 63% for family planning. During 1998-1999 actual disbursement of development spending has fallen short of the planned budget by around TK 292 Crore (23 per cent). The fall is accounted for largely by lower expenditure via development partners. It is worth observing that for the government sector as a whole expenditure slightly exceeded the initial agreed allocation.

### **Policy relevance –**

A small number of output based financial and economic indicators were advised. The structural economic and financial indicators used in the early stages of HPSP give little indication of the outputs or outcomes. Benefit incidence expenditure analysis advised to be conducted for each ESP component. The importance of reducing gender health inequalities through out the progress of HPSP was mentioned. HPSP would impact on gender equity through support of the ESP package (particularly services that directly affect maternal health) as well as through wider reforms in health systems reorganization and development. It was advised to track expenditures on specific maternal health activities, particularly on Emergency Obstetric Care (EOC) (given the priority accorded to it by HPSP). Expenditures on specific ESP services should be broken down by capital, training, salaries and non-salary components. This was advised to attempt through the RIBEC pilot with the Line Director (ESP), DGHS.

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Health Economics Unit.



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## **Public Expenditure Review – IV (1999 - 2000)**

*Published on – February, 2001*

### **Summary findings -**

Total spending for 1999/2000 on HPSP was 1,984 Crore Taka. This is 85% of the original budget. During HPSP spending on health has significantly fallen short of the approved budgets. Spending on the Essential Service Package, using the facility level definition, was between 60 and 70 percent of total spending. Spending by main ESP component is estimated as Family Planning (28%), Child Health (35.5%), Limited Curative Care (12.5%), Communicable Disease Control (3.4%) and Maternal Health (13.2%). For the 1999/2000 financial year, the Ministry of Health was originally allocated 2,441 Crore Taka as the revenue and development allocation for HPSP (Health and Population Sector Programme). This represented 6.6 percent of the total government budget. Total spending on HPSP was 1,984 Crore Taka based on the SOEs of line director and reports from CGA and PFC. While this represents a real term increase of 3.7 percent on last year's spending, it is 85 percent of the original approved budget. In per capita terms spending rose between 98/99, and in 99/2000 it has risen slightly from 135 taka to 143 taka per person. This was a small real term increase but still means public (HPSP) health care spending per capita remains below 1996 levels. Public spending accounted for 1.1% of GDP, the lowest share since 1992.

### **Policy relevance –**

Two key additional sources of funding were suggested that could improve the effectiveness of the health care system which were formalized user charges and health insurance. It would be emphasized that both of these had objectives that are wider than revenue generation. User charges, if retained by health facilities, have the potential to generate significant quality improvements in basic services. Insurance might extend social protection through risk pooling to protect against the costs of catastrophic illness and act as a catalyst to improvements in provider efficiency. The existing efficiency of tax collection was assumed to improve slightly over the course of five years with the proportion of GDP (market prices) collected by government rising from a current level of 8.9 percent to 11 percent by 2005. It was advised that insurance should be developed in two ways. For the formal industrial sector, representing around 6 percent of the population, should be in the form of payroll based social health insurance. Second, voluntary community insurance should develop through multiple schemes for the 35 percent of the population employed in the informal sector.

**Conducted by – BNHA Cell**  
Health Economics Unit.





**HEU Publication  
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## **Public Expenditure Review – V (2001 - 2002)**

*Published on – May, 2002*

### **Summary findings -**

Total spending on HPSP for 2000/01 was 2,046.5 Crore Taka. Expenditure amounted to 78% of the original budget; slightly lower than the previous year's figure of 85%. Under spending is especially extreme for RPA (other) with under spending running at more than 60% of the budget. There is a slight decrease in real per capita expenditure that year. Expenditure remains significantly below pre-HPSP levels. The failure to increase per capita expenditures in real terms seemed to be one of absorption capacity rather than a failure to allocate sufficient funds. Spending on the Essential Service Package (not including overheads) remained above 60%, and at 66% is up from last year's figure. Spending by main ESP component was estimated as Family Planning (15%), Child Health (40%), Maternal Health (21%), Limited Curative Care (14%), Communicable Disease Control (4%), Reproductive Health (Other) (5%) and BCC(1%). The revised budget represented 6.7 per cent of the total revised government budget and represented a slight rise (of 0.1%) from the previous year's allocation (1999/00). However, that year saw a significant fall in health's share in the government budget, from 7.5% to 6.6%. HPSP comprised only 5.2% of total government expenditures in 2000/01 compared to 6.1% in the previous year. Donor support to the development budget was the major source of funding for maternal health services. In total, reproductive health services account for over three quarters of development spending. Combining development and non-development ESP spending,

### **Policy relevance –**

The methods for allocating resources at the Upazilla level was advised to be align in relation to needs and local circumstances. It was suggested that the Ministry should revise its resource allocation practices to better reflect needs and costs. The operational efficiency of the UHC level was advised to take as a particular concern. Under spending continues to be problematic, however, it appears to be more a problem of absorptive capacity rather than under-funding. This per suggested to dig for further causes. It was stated that, clearly there was some way yet to go to make ESP available to all target groups. An analysis of likely resource availability and of the marginal costs of extending coverage suggested that is much possible and an extension of coverage to target groups in both rural and urban areas was foreseeable. It was advised that, alongside a broadening of the resource base, one also requires the aforementioned improvements in operational efficiency are in order to free up additional resources to realize this potential.

**Conducted by – BNHA Cell**  
Health Economics Unit.

## Public Expenditure Review – VI (2003 - 2004)

Published on – September, 2005



### Summary findings -

In the financial year 2003-04, MoHFW spent Taka 27,861 million for HNPSP. Overall, MoHFW's expenditure had shown an increasing trend during 1995-96 to 2003-04 both in nominal as well as real terms and had almost doubled during the period in nominal terms with an exponential growth of 8.1 percent per annum. In real terms, the increase was 48 percent with an annual growth of 4.8 percent. In comparison, MoHFW's share of total GoB spending was 7.2 percent in the year 1995-96 representing approximately 3 percent fall per annum. The Development Partners' (DPs) share to MoHFW expenditure shows a steady increase between 1995-06 and 1999-2000, suddenly experiencing a dramatic decline since 2002-03 and 2003-2004. MoHFW expenditure had doubled with an annual growth of 9.1 percent during 2001-2002 to 2003-04. The divisional distribution of MoHFW expenditures suggests that almost one-third is spent in Dhaka division. Moreover, a typical Bangladeshi received Taka 205 from the public resources assigned to the health sector. The Upazila and below level facilities received approximately half of the MoHFW resources most of which served at the grass-root level. Resource allocation according to the poverty status reflected that on an average a very poor district received Taka 102 per capita only where its actual need was Taka 159 per capita. On the other hand, a non-poor district, on an average, received more resources (Taka 103 per Capita) as compared to its actual need estimated at Taka 70 per capita.

### Policy relevance –

It was advised that current practice of capacity-based resource allocation should be revised to adopt pro-poor allocation so that poor receive more resources to maximize equity. MoHFW should develop a guideline that would be strictly used for resource allocation of HNP sector. Moreover, GoB should try to enhance the HNP sector resources to improve its overall performance. The primary focus of the concerned authority should be to ensure adequate resource for the program. It was suggested to introduce an efficient targeting mechanism so that poor can get more benefits from the limited public resources owed to the health sector. In order to make the efficient and transparent use of budget allocation, the MoHFW should prepare the budget estimates in accordance with the priority and strategy to fulfill the objectives and targets keeping in view of the scarcity of resources. Necessary steps need to be taken from the first of July to start execution of budget grants to achieve the target. In order to increase the transparency, efficiency and information availability of MoHFW, it is to improve and update the entire database system. Moreover, it was recommended to ensure greater accessibility to the database for researchers and policy makers for better policy prescriptions. There should be a central policy for inter-ministerial cooperation to access the requisite data. To this end, a National Databank should be developed.

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## **Public Expenditure Review – VII (2003/4 – 2005/6)**

*Published on – October, 2007*

### **Summary findings -**

Actual total spending in 2005/06 was 37,039 million representing 4.7% of total government spending, with revenue spending similar to the year before but a marked increase in development spending. Spending per capita at constant prices rose with some annual fluctuations. Revenue spending per capita exhibited a consistent upward trend throughout the period from 1995/96 to 2005/06 while both GOB and development partner (DP) funding has fluctuated substantially. The proportion of development spending financed by DPs had fallen from around 66% during the five years of HPSP to just over 50% during the first three years of HNPSP. At both current and constant prices, spending on pay falls lightly between 1003/04 and 2004/05 but rose again in 2005/06 (by 12% in real terms). Spending on medical and surgical requisites (MSR) also fell in 2005/06. By the end of 2005/06 HNPSP has spent Taka 23.8 billion representing 48% of the RPIP and 65% of the approved ADP for the three years. Due to delay in fund release by the end of 2005/06 just under 48% had been financed by GOB. Per capita allocation to the poorest districts had risen by around 31% compared to an average of 25% for all districts. Spending in poorest areas grew by 52% compared with only 24% in the richest when compared with HPSP. The under-spends on the revised budgets in 2004/05 and 2005/06 is possibly the result of uncertainties about the precise cost of transfer of staff from the development to revenue budget. In contrast there is a considerable gap between the original allocation for the development budget and final spending – a gap of between 12 and 45% was reported during the period.

### **Policy relevance –**

It was suggested that budgets should originally (original budget) set prior to the beginning of the financial year. A revision of both physical (operational plans) and financial activity (revised budget) should undertaken half way through the year at the same time as plans are developed for the next financial year. Out-turns (spending) for the entire year should be available within a few months of the end year. The main issue was to observe any trends in the proportion and attempt to explain substantial shifts through further investigation. The hospitals should be upgraded or constructed with a concomitant allocation in MSR and staffing for ensuring service delivery. It reminded to note that the MTBF 2007-08 stated building hospitals as one of the priorities in the health sector in the medium term. This means spending on capital is likely to increase in coming years. Although inequalities clearly persist across the country, further work for investigating to what extent the patterns of inequality are inequitable was suggested. This PER also advised that it is worth investigating which types of facilities – primary or secondary or tertiary facilities are being used by women because HIES 2005 did not provide utilization by type of facilities.

**Conducted by – BNHA Cell**

Health Economics Unit.



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## **Public Expenditure Review – VIII (2006 – 2007)**

*Published on – January, 2010*

### **Summary findings -**

For the 2006/07 financial year, both original and revised budgetary allocation for the Ministry of Health and Family Welfare (MoHFW) increased in real terms by 5 percent and 7 percent respectively compared to 2005/06. Although the actual MoHFW spending about 3 percent of the total government spending - increased by 6 percent in 2006/07, this represents a small real terms decline. Revenue spending increased by 8 percent while development spending decreased by 10 percent. One fourth of the revised development budget remained unspent in 2006/07. The GOB contribution to per capita MoHFW development spending declined by 34 percent in 2006/2007, this was exceeded by Development Partners' (DP) contribution which increased by 14 percent. The proportion of development spending financed by DP increased to 61 percent in 2006/07, one percentage point lower than the proportion envisaged in the Spending at UHC and union sub-centers ('upazila and below') in 2006/07 increased by 23% from the previous year to stand at 52 percent of the total expenditure, while spending at district and above facilities (including tertiary facilities) fluctuated and spending in 2006/07 was 18 percent lower than the preceding year. Interestingly, the districts that most benefited from the growth in per capita allocation during the period from 2003/04 to 2006/07 are those in the richest and the poorest quartile. However, there was some slight improvement in 2006/07 as per capita expenditures dropped only for the non-poor districts while the change in allocations benefited the less poor and the poor. In absence of any clear guidelines, the Line Directors were allocating resources to the districts based on population share. MSR expenditure in 2006/07 in real terms slightly dropped compared to MSR spending in the preceding year.

### **Policy relevance –**

The main suggestion was related to the improvement of the quality of the data collection for PER. Preparation of the Public Expenditure Review (PER) posed a number of challenges to the PER team that were worth documenting. Some of these were related to data availability and reliability while others related to information provision by institutions/ departments. Due to lack of the latest HDS data, this PER could not carry out Benefit Incidence Analysis (BIA) to estimate who benefited from public spending. It was suggested to update HDS data properly and regularly.

**Conducted by – BNHA Cell**

Health Economics Unit.



## HEU Publication Research BNHA

### **Public Expenditure Review – IX (2007/8 – 2008/9)**

*Published on – October, 2011*

#### **Summary findings -**

For the financial years 2007/08 and 2008/09, both the original (Taka 5224 crore in 2007/08 and Tk. 5847 crore in 2008/09) as well as revised budget (Taka 5016 crore in 2007/08 and tk. 5945 crore in 2008/09) for the Ministry of Health and Family Welfare (MoHFW) increased in nominal terms compared to 2006/07. However, for the 2007/08 financial year both original and revised budgetary allocation for MoHFW decreased in real terms by one percent and three percent respectively. In contrast, both original and revised budget for 2008/09 increased in real terms by 5 percent and 11 percent respectively. The share of revised health sector budget as a proportion of revised total government budget in 2007/08 and 2008/09 remained around 7 percent, much lower than the HNPSR Results Framework set target of 10 percent by 2010. Per capita MoHFW spending in real terms decreased in 2007/08 and increased in 2008/09 by around 3 percent. MoHFW's revenue contribution has been on the rise throughout the 2003/04-2008/09 period (with an exception in 2007/08). MoHFW contribution to per capita development spending has been decreasing since 2005/06. DP contribution to per capita development spending increased in 2007/08 and then decreased in 2008/09. The proportion of revised MoHFW revenue budget that remained unspent was about 3 percent in 2003/04 and the proportion rose to around 14 percent in 2008/09. Spending on MSR increased in real terms in both financial years. Contribution of revenue budget in financing MSR also increased. It is worrying that the proportion of MoHFW spending at Upazila and below level facilities dropped from 52 percent in 2006/07 to 48 percent in 2007/08 and further to 47 percent in 2008/09. However, spending at facilities at district level and above increased. Spending per capita ratio between the richest to the poorest districts was 2.3:1 in 2005/06 which came down to 1.3:1 in 2008/09. The Health Economics Unit (HEU) for the first time attempted to conduct a gender analysis of MoHFW expenditure in this PER. The analysis revealed that half of the MoHFW spending benefit women.

#### **Policy relevance –**

Gender analysis of Health PER tracks public expenditure against gender and health sector related policy commitments. Hence, it needs to be incorporated in each PER. For consistency and uniformity gender analysis: (i) needs to analyse public health expenditure following the MOF methodology for gender budget analysis and also (ii) needs to analyse health budget and expenditure following the methodology that GNSP Unit developed during this PER and will be further refined in future. This requires MOF approval for using their methodology as well as enhanced analytical capacity within the GNSP Unit. PER preparation, needs to start right after the budget announcement in order to facilitate data collection and clarification. PER should be ready before October each year in order to inform budget preparation and budget revision.

#### **Conducted by – BNHA Cell**

Health Economics Unit.



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## **Public Expenditure Review – X (1997 - 2014)**

*Published on – July, 2016*

### **Summary findings -**

Public expenditure on health in Bangladesh as a share of GDP in 2012 was 0.8%, lower than what low-income countries (2.6%) and South Asian countries (1.2%) spent. Moreover, the share was falling and remained below one percent of GDP throughout 1997-2012. Revised budget increased more than six-fold in nominal terms and more than doubled in real terms between 1997 and 2015. However, real annual growth slowed during 2010-2015 to 4% from 6% during 1998-2009. The share of MoHFW budget in total national budget dropped to 4.4% in 2015 from 6.8% in 2000. Project Aid had increased more than threefold between 1997 and 2014 in nominal terms. Since 2004 Reimbursable Project Aid (RPA) had been the dominant mode of external assistance. Per capita MoHFW expenditure in real terms had increased by 64% since 1997. MoHFW only spent 12% of its spending on this line item. Per capita spending on MSR by MoHFW was only 6% of per capita out-of-pocket (OOP) payment on medicines (Taka 582) in real terms in 2012. The spending on repair and maintenance was only 3% of MoHFW expenditure. The unallocated block spending was Tk. 551 crore in 2014, representing 8% of the MoHFW recurrent expenditure. 49% of the MoHFW expenditure in 2012 went to upazila and below although the target was set at 60% by 2016. The revised Development budget execution rate was recorded at 89% during HPNSDP while it was 76% during HPSP. Non-MoHFW ministries contributed 28% of spending on medicines, vaccines and medical supplies. 11% of the poorest quintile as opposed to 15% of the richest quintile accessed the government health care services in 2010. Women in using public health facilities for delivery had decreased to 1:2 in 2014 from 1:7 in 2007.

### **Policy relevance –**

The Government of Bangladesh needs to reprioritize health sector within its national budget to increase fiscal space for health towards achieving Universal Health Coverage (UHC). MoHFW should immediately implement needs based resource allocation formula reflecting the needs of the population. Operational Plans (OPs) in the next sector program should clearly indicate how much budget each OP will allocate to different tiers of facilities, especially to Upazila level and below. MSR allocation should be based on the needs of the facilities. Both Revenue and Development budget should be developed jointly and if possible, simultaneously in order to improve efficiency in budgeting and planning. Recurrent line items such as MSR and Diet need to be financed from one budget preferably from the Revenue budget in order to avoid duplication and ensure better transparency as well as predictability. In order to improve transparency unallocated block allocation must be reduced to a minimum level.

**Conducted by – BNHA Cell**

Health Economics Unit.

## Bangladesh Facility Efficiency Survey I - 1998

*Published on: November, 1999*



### Summary findings -

All MoHFW facilities were characterized by high levels of utilisations generally. Occupancy rates are high, close to what might be considered an optimal level of 80-85%, or even higher. Lengths of stay were generally short, ranging from 3-4 days at lower level facilities to 10-12 days at Medical College Hospitals. Facility budgets were generally fixed according to norms, so high utilisation rates translate in to low unit costs of services. DH/GH had the lowest unit costs of all facilities, lower even than THC. In fact, THCs were found to have unit costs similar to MCHs. The high costs at THCs arise from higher staffing intensities than at higher level facilities, coupled with lower utilisation rates. THCs had higher costs largely due to higher staffing ratios. In comparison to most countries, where doctor-bed ratios are lower in basic level facilities, Bangladesh is unusual in having higher doctor-bed ratios at the lowest primary level facilities and overall findings for aggregate unit costs strongly indicated that the current pattern of staffing and infrastructure at lower level facilities is suboptimal. DG/GHs with 100-150 beds appeared closer to an optimal size for basic facilities than THCs. High occupancy rates and turnover rates suggested the problem was more under-capacity than over-supply, which reinforced the case for expansion of smaller facilities.

### Policy relevance –

1. Thana Health Centres had higher staff ratios than district and tertiary hospitals;
2. A consequence was that Thana Health Centres had significantly higher costs per inpatient treated;
3. Costs of outdoor patients were also higher at THCs compared to district hospitals but the difference is less pronounced.
4. Larger THCs with lower staff ratios would be more efficient and could provide more effective clinical services;
5. Further work is required to plan how roles and functions of Thana and District facilities could be changed to improve efficiency without adversely affecting access to essential services;
6. To demonstrate the feasibility of survey methods to collect the necessary information to assess facility unit costs and efficiency.

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**Conducted by – HEU**

Health Economics Unit and Institute of Policy Studies, Sri Lanka

# Reproductive, Maternal, Newborn and Child Health (RMNCH) Expenditure in Bangladesh in 2012

Published on – January, 2016



## Summary findings -

Current Health Expenditure (CHE) for 2012 on Reproductive (R) health is estimated at Taka 21.1 billion. In terms of percentage, this is around 7.1% of CHE. Taka 22 billion was spent on Maternal and Newborn (MN) care in Bangladesh. It constitutes around 7.5% of total CHE. Expenditure on Child Healthcare (CH) for 2012 is estimated at around Taka 13.7 billion which translate to 5.4% of total CHE. Reproductive healthcare services are primarily provided by ambulatory service providers (outpatient centers), 58% followed by general hospitals (36%). A Functional breakdown of the Reproductive healthcare services shows that 92% of the expenditures are made on preventive care. A further breakdown of MN-CHE by Financing Schemes shows that the government financing around 49% of total MN expenditure followed by Household and development partners financing at 20% each. As a provider of MN services, general hospitals are the largest provider accounting for almost 69% of total MN expenditure. MN services include inpatient and outpatient curative care, pharmaceuticals and other medical non-durable goods and preventive care. A Functional breakdown of the MN healthcare services shows that a major portion of the expenditure (68.4%) are made on preventive care followed by inpatient curative care (28%).

## Policy relevance –

The Government of Bangladesh is the largest financier of Reproductive healthcare (62%) followed by the development partner and implemented through NGOs who account for 24% of total R-CHE. Compared to the Financing Schemes of R and MN healthcare expenditure, household out-of-pocket (OOP) expenditure on CH is significantly higher. In 2012, household financing schemes financed almost 73% of CH-CHE. The main reason for shifting of financing responsibility from government to household on CH care is due to the high level of outlay on pharmaceutical drugs. A Functional breakdown of the CH healthcare services shows that almost 66% of CH care expenditures are made for pharmaceuticals.

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Conducted by – BNHA Cell

Health Economics Unit, HFG project of USAID.



## Bangladesh Urban HealthCare Expenditure under SHA 2011 framework in 2012

*Published on – February, 2016*



### **Summary findings -**

Per-capita health expenditure for Bangladesh is estimated at Taka 2,167, urban per capita expenditure at Taka 3,083 and Taka 1,894 for rural individuals. Urban and rural healthcare expenditure is estimated that in 2012 was Taka 106.3 billion (for 34.5 million population) and Taka 218.7 billion (for 115.5 million population) respectively. A divisional comparison suggests per capita urban health expenditure is the highest in Dhaka division (Taka 3,964). The lowest per capita expenditure of Taka 1,529 per year is that of Sylhet division. The biggest health-related expenditure at the urban level was incurred at pharmacies/retail drug outlets as a provider - Taka 48 billion in 2012. A comparison of expenditure on medicine between urban and rural population shows that urban population spends 45% of their THE (48 billion) on medicine while it is 39% for the rural population. The second largest outlay in an urban area is general hospitals, including teaching hospitals, and it accounts for about Taka 29 billion in 2012. The use of hospitals as a service provider is found low in urban areas (28%) compared to 31% in rural areas. In 2012, the urban population spent Taka 13 billion on ambulatory services while the rural population incurred Taka 35 billion for such services. Curative care accounts for 25% of urban THE (Taka 27 billion) in 2012. The share of curative care in rural THE is also similar to urban (26%) outlay. Expenditure on ancillary services like pathological tests or imaging services is found to be between 5% (urban) and 6% (rural) of their respective THE. In 2012, the urban population spent Taka 2.9 billion on use of alternative and traditional medicine. In 2012, Taka 2.2 billion was spent on urban public health programs, and Taka 7.4 billion in rural areas. Around 10% of urban THE (Taka 10 billion) is spent on preventive care, with family planning and awareness creation as major components. The share of preventive care in rural THE is around 15%.

### **Policy relevance –**

In 2012, the share of urban households' out-of-pocket expenses excluding cost sharing comprise 68% of urban THE while by the rural household it was 61% of rural THE. The relative share of urban to rural population suggests 35.3% of OOP is incurred by urban households. Households belonging to the poorest quintile (quintile 1) spend less in the urban area than in the rural area, which is approximately 6% and 7% of respective total OOP for the year 2012. The share of government healthcare spending in the rural area is relatively higher (26%) compared to 17% for urban of their respective THE. In 2012, most of the expenditure was spent on health in Dhaka division, which constitutes 60% of total urban health outlay. The lowest level of urban expenditure is in Sylhet (Taka 2.3 billion) and Barisal (Taka 3 billion).

**Conducted by – BNHA Cell**

Health Economics Unit, HFG project of USAID.

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## TUBERCULOSIS, MALARIA AND HIV/AIDS EXPENDITURE IN BANGLADESH 2015

*Published on – January, 2019*

### **Summary findings -**

In 2015, total government spending on TB was around Taka 1.65 billion of which Taka 1.07 billion was incurred through hospitals providing inpatient and outpatient care. Government spending on prevention of TB for the same year was Taka 0.59 billion. On the other hand, NGOs with direct assistance from the Global Fund and other development partners spent Taka 1.02 billion on TB in 2015. NGO spending on preventive care for that year was Taka 0.31 billion. The only household out of pocket spending on TB was captured was on purchase of medicine amounting Taka 67 million.

Total expenditure on HIV/AIDS is estimated around Taka 2.58 billion for the year 2015. NGOs accounts for more than 90% of the healthcare expenditure on HIV/AIDS. In 2015, combined NGO/ROW spending on HIV/AIDS was Taka 2.35 billion. NGOs offer both preventive and treatment care for HIV/AIDS and approximately 59% (Taka 1.4 billion) of NGO/Rest of the World spending were made on treatment purpose. NGO offered public health programs for creating awareness and educating general people on HIV/AIDS accounts for Taka 1.14 billion. In 2015, NGOs spent around Taka 32 million on medicine for HIV/AIDS patients.

Total healthcare expenditure on malaria in 2015 is estimated Taka 1.4 billion. Around 46% of the healthcare expenditure on malaria is spent on curative care providing inpatient and outpatient services. For curative care, almost 100% of malaria patients rely on MoHFW operated healthcare facilities; 93% of the patients are concentrated in three hill districts. Preventive care expenditure for malaria in 2015 is estimated Taka 729 million. This amount is jointly spent by the Local Government (LG) and NGO/Rest of the World. In 2015, LG spending on prevention of malaria is estimated Taka 465 million.

### **Policy relevance –**

It is opportunistic that the methodology and technique applied in the estimation procedure in this study will enable tracking of outlays of priority diseases in the future. Accordingly, production of different types of disease expenditure estimates can become an integral part of NHA production activity.

While there are differences in the demographics between the three diseases, there is commonality in strategy for containing or eradicating them. Treatment as well as prevention efforts by the government with support and collaboration of international partners (e.g. The Global Fund, WHO) and local NGOs is essential to meet the objectives. The similarities and differences warrant the government and other stakeholders to make informed decision in terms of designing programs, allocating resources, and implementing activities. Knowledge and data on disease pattern, institutional capacity, and private and public costs of both treatment and awareness creation are therefore most pertinent.

**Conducted by – BNHA Cell**

Health Economics Unit and World Bank.



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## **Bangladesh Disease Specific Accounts, 2015**

*Published on – November, 2020*

### **Summary findings -**

The total recurrent expenditure on diseases and conditions for 2015 is estimated at Taka 39 thousand crore. DSA analysis is presented using 21 broad disease classification of ICD-10. The biggest outlay is for Diseases of the musculoskeletal system and connective tissue (Taka 5,508 crore). Further disaggregation of the recurrent expenditure allocated to disease and conditions by gender reveals that Bangladesh spend more money on female (Taka 20,981 ) than male (Taka 18,027) on healthcare. Out of the 23 broad ICD-10 categories, six diseases accounts for around 59% of the healthcare expenditure for both male and female. A comparison between male and female for these six dominant diseases reveals that female are more prone to Diseases of the musculoskeletal system and connective tissue and Diseases of the genitourinary system. Compared to the female, male spend more money on Diseases of the respiratory system and Injury, poisoning and certain other consequences of external causes. A breakdown of expenditure by age group and gender on three types of healthcare functions: inpatient care, outpatient care and medicine also show, both men and women of the 15-49 age group spends considerably higher on all three categories compared to their younger or older cohorts. One third of the recurrent healthcare expenditure for the age group of 50-69 is spend on Diseases of the musculoskeletal system and connective tissue(Taka 1,996 crore) and on Disease of the circulatory system (Taka 1,334 crore).

### **Policy relevance –**

The study reveals that 59% of the healthcare expenditure for both male and female are accounted for six diseases. Preventive interventions, including awareness creation are a key to reducing all the identified diseases. The onus of this effort lies not only with the Ministry of Health and Family Welfare (MoHFW) but also with other ministries. Pharmaceutical drugs expenditure is a key component of the burden of diseases. There is considerable debate and discussion about the over-use of antibiotics in Bangladesh. Policy interventions such as penalizing pharmacies for selling antibiotics as well as disease-specific expensive drugs without prescription should have an effective monitoring and implementing plan. DSA serves as the benchmark for burden of disease analysis for Bangladesh over time. Policy directives in terms of resource allocation for both preventative and curative interventions relating to diseases can be objectively formulated from DSA.

**Conducted by – BNHA Cell**

Health Economics Unit and Data International Limited.

## Bangladesh Public Facility Efficiency Study - 2018

Published on – November, 2020

### Summary findings -

On an average government's recurrent expenditure on MCH is around Taka 1,038 million per year. The Specialized Hospitals (SH) are the second largest public healthcare facilities offering specialized curative care. Beds capacity in public hospitals since 2011 has increased but not significantly except for Medical College Hospitals (MCH). The average annual recurrent spending for SH in 2018 was around Tk 473 million per facility. General Hospitals (GH) and District Hospitals (DH) are secondary level public facilities providing inpatient and outpatient curative care. In 2018, average bed size for GH is 200 beds while it is 131 for DH. The regular hours of operation for routine outpatient services is 6.5 hours per day and offers services 6 days a week. In 2018, average spending on inpatient by MCH was Taka 1.04 billion while it was Taka 474 million for SH. Facilities that provides inpatient service are expected to have larger share of their cost on inpatient care than outpatient. MCWC and 10-20 bed hospitals are distinct type of facilities where 60% and 55% cost of the respective facilities are accounted for outpatient service. that large providers like MCH, GH and DH incur almost 50% of their cost on personnel while it is around 39% for SH. Share of personnel cost is much higher (65% to 70%) for the primary care providers like UHC, MCWC and 10-20 Beds hospitals. Overhead expenses covering salary of the administrative staff and paying utility bills of hospitals accounts for another 20%-44%.

### Policy relevance –

To reduce household OOP expenditure burden on drugs, the government needs to increase its spending on medicine and medical supplies. A cost sharing model can be adopted where both parties share the cost equally. During FES 2018, it is observed that many of those responsible for keeping this data at the facility level are not adequately trained. Also, it becomes evident that, the records and data are not maintained in an orderly manner. Data collation is incomplete or there is a delinquency in collecting information from different departments of the hospital on a timely manner. The turnover or vacancy of the Statistician position further exacerbates the situation. Noncompliance of referral system in admitting patient at the Medical College Hospitals (MCH), General Hospitals (GH) and District Hospitals (DS) is an issue causing extra burden on hospital's medical and nonmedical staff as well as on resources. To reduce the high BTR, flow of inpatient at higher level facilities needs to be decelerated. Improvements in attendance rate and reduction in vacancies of doctors can also contribute to an increase in usage of UHC and inversely reduce crowding in nearby urban secondary and tertiary hospitals. In addition, MoHFW also needs to address the issue of not having sufficient primary level healthcare facilities in urban areas, especially in the metropolitan cities.

### Conducted by – BNHA Cell

Health Economics Unit and Data International Limited.



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## **PATHWAYS TO REDUCE HOUSEHOLD OUT-OF-POCKET EXPENDITURE**

*Published on – November, 2020*

### **Summary findings -**

Bangladesh has made significant progress in one important aspect of UHC, that of coverage of health services, but not in terms of financial protection, reducing its potential for population wellness and economic growth. The largest source of health financing in Bangladesh is household OOP spending, which is, by definition, not pre-paid or pooled. About two-thirds of expenditure on health in Bangladesh is financed by households OOP. This large share of health expenditures financed through OOP payments increases households' risk of financial hardship and even impoverishment in case of illness. According to the WHO and World Bank 2019 Financial Protection Monitoring Report, Bangladesh is one of the countries in the world with the highest share of the population that has incurred catastrophic health expenditure. High household OOP spending not only increases the risk of financial hardship in case of illness but also prevents households from seeking care when in need. In this context, this report aims at providing an overview of different pathways for the country to reduce its high level of household OOPs to improve financial protection and further progress towards UHC. This report discuss three pathways to reduce household OOP expenditure in Bangladesh.

1. Increasing compulsory pre-paid and pooled funds;
2. Improving the use of public funds for health to effectively reduce OOP payments; and
3. Improving public financial management, policies, and governance.

This publication also highlighted some example of many countries how their strategies worked or failed. In a nutshell, improving the readiness of the public health care network to provide quality care, particularly at primary health care level.

### **Policy relevance –**

Reducing household OOP payments will require first and foremost an increase in public funds. It will require an increase in mandatory pre-paid and pool funds like those included in the Government's health budget or those collected through mandatory social health insurance schemes. Reallocation of money is politically challenging and there are many other spending priorities (e.g., infrastructure, debt payments, other social spending, etc.), but could offer the biggest potential source of fiscal space for the country. Given the large needs and the little resources available, an important pathway to reduce OOP payments while decreasing inequalities would be better targeting public subsidies to the poor and vulnerable. Finally, the reduction of OOP payments will require not only additional public resources, but a strengthened management of those resources.

**Conducted by – BNHA Cell**

Health Economics Unit and World Bank.

## Framework for Health Financing and the Legal Base of Analysis of the Legal the proposed SSK Pilot.

*Published on: 2012*

### Summary findings -

The General Objective of this study was to provide an overview of existing and required legislation and regulations to enable and support SSK pilot activities. In order to explore the legal status of SSK and health insurance in Bangladesh and resolve the issues arise in implementing existing relevant laws have been reviewed.

The study specifically addressed the issues such as; what would be the legal basis of SSK? what would be the legal basis of health insurance? what institutional and financial independence should be provided to SSK? whether existing laws would be sufficient or any amendment of existing law is needed or any new law is to be enacted for introducing SSK? whether any legal provision conflicts with the SSK concept? whether GFR and Treasury Rules including any other financial rules and policy would be in conflict with the receiving money from the insurer and using that money by the service providers?

On detailed analysis following recommendations are made:

**Short Term Plan:** MoHFW may establish NHSO/ SSK by an executive order providing necessary management and financial autonomy. The MoHFW may immediately establish one or more health insurance company to provide health insurance for the below poverty level people in the pilot Upazilas. Necessary fund may be created under the Upazila Health Officer which should be operated as per the directives given by the NHSO/ SSK. Necessary Rules may be framed under the Public Health (Emergency) Provisions Ordinance, 1944, Insurance Act, 2010 and Insurance Development and Control Authority Act, 2010.

**Mid Term Plan:** Some amendments can be brought to the Public Health (Emergency) Provisions Ordinance, 1944, Insurance Act, 2010 and Insurance Development and Control Authority Act, 2010 and thereafter Rules framed under such laws should also be amended in the light of the amendments brought to the parent laws. At this stage health insurance should be introduced at more Upazilas.

**Long Term Plan:** A separate law can be enacted to ensure sufficient autonomy and independence of the NHSO and proper enforcement of the health insurance in entire country which should be applied universally.

**Conducted by – SSK Cell**

Health Economics Unit, GFA Consulting Group (GmbH), Germany.



HEU Publication  
Research  
SSK

## Assessment of Local Health Management Committees

*Published on: 2012*



### Summary findings -

The study was carried out to assess the capacity of the Health Management Committees and propose specific interventions for strengthening them for successful implementation of SSK pilot. The study was carried out to assess the capacity of the Health Management Committees and propose specific interventions for strengthening them for successful implementation of SSK pilots.

The study team visited three proposed pilot upazilas, Tungipara of Gopalganj district, Rangunia of Chittagong district, and Debahata of Satkhira district and also three other ongoing pilots such as Chowgacha, Narsingdi and Chokoria to conduct in-depth interview, FGD and few key informant interviews.

The study found that although local level committees centering the Community Clinic (CC) were mostly functioning, they were not functional as expected. Only where local Committee leader was strong it made a difference. One of the important strengths of the committee is that all the members are local and they live within the periphery of the CC. One serious weakness of the CC committee is that meetings are not held regularly and routinely and all members do not remain present in all meetings.

There is no evidence to show that top imposed Upazila Hospital Management Committee formed at the Upazila level is effective or functional. The committee is too large to be effective. However, as the committee is constituted by office order of MoHFW, there is ample opportunity to utilize the services of human resources in health, infrastructure, medicine and health equipment locally for the welfare of the local people. There is neither any representation of union and local community level H&FP personnel nor of the local government representative from the UP level. For that reason the problem of grassroots level are not likely be properly addressed.

The following recommendations were made to strengthening the role of local committees for SSK pilots:

- The committee could be involved in the participatory process (PRA) of identifying the poor, the local level problems and for raising awareness in SSK programme.
- Orientation should be provided to all committee members and staff to build their capacity for the successful implementation of the process, objective and modality of SSK.
- The monitoring role of the community members should be strengthened for ensuring the quality of service and better provider accountability.

### Conducted by – SSK Cell

Health Economics Unit, Research, Training and Management (RTM) International

## Study on Socio-economic Assessment to Identify the poor in pilot Areas and Baseline Studies on Willingness to Pay, Health Seeking Behavior, Health Expenses and Patient Satisfaction

*Published on: 2012*



### Summary findings -

The specific objectives of this study were to (i) conduct a socio-economic assessment of households by using beneficiary selection criteria of major social safety-net programmes (SSNP) to identify the poor, (ii) verify the list of poor endorsed by Local Government Institutions (LGIs), (iii) recommend mechanisms for issuance of health cards to identified below poverty line (BPL) families, ensure IT database updates and a feasible mechanism for poor identification at scale up level, (iv) identify the health services used by the poor (including the provider and expenses of such services), and (v) conduct sample survey at the community level on health seeking behavior, willingness to pay, and patient satisfaction. Being designed as quantitative and qualitative cross sectional, the study exploited two methods: (i) Household census to identify below poverty line (BPL) households and verification of list of poor (SSNP beneficiaries) endorsed by LGIs, and (ii) Household survey for assessing health seeking behaviour, health care expenditure, willingness to pay and patient satisfaction.

The study covered randomly selected 9 Unions and 2 Paurashavas of 3 pilot Upazilas using probability sampling approach. The household census covered all 18,505 households in primary enumeration areas, while household survey involved 844 randomly selected households.

**Key finding are,** About 41% households (satisfying at least three criteria) fall below poverty line in the three pilot Upazilas of SSK. Proportion of BPL households varies with definition of poor where increasing or decreasing the number of criteria (satisfied) will change the proportion of BPL households.

People mostly prefer going for self-treatment or pharmacy (23%), formal private practitioner (21%), and Upazila Health Complex (19%). Among those who go for treatment to Upazila Health Complex (UHC), a substantial large majority (92%) go for receiving out-patient medical services and only a few avail in-patient services. The most commonly reported three reasons for not availing services from public sector health facilities in all the three Upazilas are: (i) long distance from home (ii) non-availability of free medicine, and (iii) doctors are not examining properly. The average amount of health care expenditure per household is Tk. 1,521.5 during last three months preceding survey. Absolute amount of health care expenditure is lower among the households in poorest quintile (Tk. 686) as compared to the higher wealth quintile (Tk. 2,795). The expenditure on drugs and diagnostic test constitutes the major share (57% and 20%) of total health care expenditure. About 75% of the households are willing to accept the insurance scheme. Majority of those (44%) who were willing to accept the scheme, preferred to have free consultation, diagnostic facilities, inpatient care, surgical facilities, transportation costs for referral and preventive care to be included in the benefit package

**Conducted by – SSK Cell**

Health Economics Unit, Human Development Research Centre (HDRC)

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## HEU Publication Research SSK

### **Study on Statement of User Requirements MIS for National Health Insurance**

*Published on: 2012*

#### **Summary findings -**

The general objective of this study was to design an effective automated processing system to meet SSK operational requirements. Specific objectives are to recommend a technology platform for the SSK pilot, hardware and software to meet SSK operational requirements at all health service delivery facilities and databases and reporting formats required for SSK operational needs.

The consultants had carried out two field trips, to Rangunia UHC, Chittagong General District Hospital, Chittagong Medical College Hospital, Tungipara UHC, Gopalganj District General Hospital, interviewing 50 staff and analyzing about 35 different paper forms.

In addition, learning from several meetings held at the occasion of a WHO/BRAC HMIS workshop were incorporated, including with representatives from the University of Oslo and HISP India, regarding the open MRS Hospital Management System, with DGHS-MIS on the general Bangladesh HMIS approach and with GIZ on possibilities of establishing an IT support structure for SSK.

The analysis of the current situation pointed towards some important challenges regarding data management. Concerning Infrastructure & Organization, there are several unstructured and redundant processes, such as a patient registration that is done at 3 different receptions (OPD, Emergency, IPD). Regarding the technical infrastructure, at many places there are internet and electricity problems, the most drastic at the UHC Tungipara, where there is not even a 2G internet connection and the statistician takes a laptop to his home for data entry into the MoHFW online reporting systems. Data management activities also suffer severely from the lack of qualified staff and the high number of vacant positions in UHCs.

The consultants suggest a two-phase approach for the implementation of a system to support the SSK operations. The system architecture will have three main components, the Health card, the NHSO head office software and the hospital management systems.

In a first step, the UHCs should receive an offline system with 4-5 PCs, focusing on general patient management and in a second step, the UHC hospital will be further automated, including OPD rooms, Labs, etc. The referral hospital (General District Hospital) may also be further automated, possibly also including OPD. In addition, a central synchronization database can be established that allows the synchronization of patient records. The synchronization should only take place only in case of referral and upon patient authorization.

#### **Conducted by – SSK Cell**

Health Economics Unit, Patrick Ernst, GFA-BIS GmbH, Germany

## Costing of the Proposed SSK Benefit Package: A Study in Three Pilot Upazilas of Bangladesh

Published on: 2012



### Summary findings -

The main purpose of the costing study was to estimate the cost of health services under the SSK benefit package so as to calculate the required premium for the insurance scheme to be implemented. Method of estimation of costs and of analysis of data: All inputs were divided into two broad groups: fixed and variable. The fixed inputs are human resources, equipment, furniture and fixtures, infrastructure, and utility services and maintenance costs. The variable inputs are: drugs, logistics and supplies, diagnostic test services for surgery, and bed and food costs for in-patients. The total and average costs were calculated using the data on the quantity of inputs and expenditure for human resources and the number of patients which were collected from the facilities, and the market prices of the other inputs.

At the UHC of Debhata upazila, the average total cost (per patient visit) was BDT 295.84, the average fixed cost and average variable cost being BDT 166.55 and BDT 129, respectively. In Tungipara upazila, the total cost is BDT 24243794, of which fixed cost was 61 percent and variable cost was 39 percent. Of the total cost, the cost for human resources is highest. The average total cost (per patient visit) is BDT 258; and BDT 156.44 and BDT 101 are the average fixed cost and average variable cost, respectively. In Rangunia, the total cost was BDT 23678614, of which fixed cost is 71 percent and variable cost is 29 percent. Of the total cost, the cost for human resources was highest. The average total cost (per patient visit) was BDT 588.57; BDT 415.19 and BDT 173.38 being the average fixed cost and average variable cost, respectively.

The study has revealed that insofar as the supply side of health services is concerned, SSK can be implemented without bringing about any major change in the UHC. The only changes required are: proper utilization of the employed providers, to improve the input mix through increased employment of support staff, and increased supply of drugs. These changes will improve quality of care and at the same time reduce average fixed cost of services. Payment of incentives to the providers will increase utilization of provider's time and increased authority of the providers to procure drugs and logistics, as and when needed, will increase availability of drugs in the facilities. Implementation of the SSK will address these issues by way of improving finance of the facilities, paying incentives to providers, and involving a third party (which will make the providers more accountable).

**Conducted by – SSK Cell**

Health Economics Unit, Institute of Health Economics (IHE), DU.

HEU Publication  
Research  
SSK

## Study on Information, Communication and Education (ICE): Campaign Strategy for SSK

*Published on: 2013*



### Summary findings -

This ICE campaign strategy for SSK is prepared to make all concerned better informed about SSK with ultimate aim of effective implementation of the SSK. Objective of the ICE Campaign Strategy was to inform and motivate relevant people about SSK for proper implementation. Specific objectives of the study were to inform and motivate target population (both direct and indirect) for registration and utilization of services under SSK, to inform and motivate people involved at different level of implementation of SSK (member selection process, registration, providing and renewal of health cards, providing services at facilities, claim processing and payment, grievance handling etc.) and to raise awareness on administrations supportive for SSK implementation (IMSC, WC, HEU (of MoHFW), SSK Board and Executive Team, Scheme Operator, SSK management committee)

In implementing SSK, there are different actors and this ICE campaign strategy for SSK is prepared to make all concerned better informed about SSK with ultimate aim of effective implementation of the SSK. The study suggested ICE strategies, including preparation and production of communication tools (materials) like different types of leaflets, booklets, posters, calendars, folders, diaries, flash cards, flip charts, billboards, video clippings, press releases, new letters etc. Some are required at the beginning, while others will be required the implementation progresses and throughout the pilot.

It advised for close monitoring the ICE strategy implementation process and instruments for continuous review and re-planning. Monitoring of the ICE campaign would be done by two institutions – contracted out agency responsible for ICE campaign implementation and also be the SSK executive team.

The study also recommended for frequent field-visits, interaction with direct and indirect population, people involved at different levels of SSK implementation and stakeholders involved with SSK implementation (keeping in mind of transfer of many key people at IMSC, WC, HEU, SSK Board, UNO, UH&FPO, UFPO and others) to find out level of knowledge, understanding and attitude about SSK and take corrective measures by arranging orientation meetings with new comers due to change of people in key positions and strengthen on-going ICE activities for providing on-the support particularly for SSK member selection, registration and issuance of health card, in-patient service provided by service providers, claim submission and payment.

**Conducted by – SSK Cell**

Health Economics Unit, GFA Consulting Group GmbH, Germany.

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Research  
SSK**

## **Baseline Survey: To Assess the Existing Capacity of Human and other Resources for Health Service Delivery at all levels of the Health Care System**

*Published on: 2013*



### **Summary findings -**

This study was conducted to assess the overall existing competence of health facilities at primary levels to meet the needs of the SBP (SSK Benefit Package). The specific objectives were to assess the existing capacity of the public health care facilities in terms of availability of personnel and their qualifications, availability of physical infrastructure, availability of medicines and logistics; to identify the requirement of additional health service providers, level of staff competence, level of human skills/ training, and the data/ information need to meet the needs of the SBP.

The study adopted quantitative techniques including observation checklist and compilation of service statistics. Further, qualitative techniques including Key Informant Interview (KII) and document review were employed during the study. The study was conducted in 3 pilot upazilas: Rangunia (in Chittagong), Debhata (in Satkhira) and Tungipara (in Gopalganj).

Following are the major conclusions and recommendations by the study;

- The existing capacity if assessed in terms of human resources, equipment and infrastructure is adequate for providing care not only to the current number of patients but also in a situation when the number of patients increases by 20% or 30%. However, for proper and efficient utilisation of these inputs, the supply of drugs and logistics should increase, some equipment should be repaired and some replaced, and input mix should be made more appropriate. On the basis of the above findings, it is recommended that:
- Measures need to be taken to ensure that all the employed staff works in the facility for full time, there needs to be adequate number of personnel available for emergency care for 24 hours. An incentive mechanism needs to be devised for providers. Part of the fees collected at upazila level can be retained at local level and paid to the providers.
- Training of health care providers and support staff is required on issues related to SSK, financial management, Management Information System (MIS), store management, and local level planning.
- Monitoring and supervision at all levels should be strengthened. The same indicators should be used in all the three pilot upazilas to monitor the activities of the insurance scheme. Besides regular monitoring, mid-term project evaluation should be undertaken to assess the impact of the insurance scheme.

**Conducted by – SSK Cell**

Health Economics Unit, Institute of Health Economics (IHE), DU.

**HEU Publication  
Research  
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## Shasthyo Surokhsha Karmasuchi (SSK): Concept Paper (Bengali and English)

Published on: 2014



### Summary findings -

SSK (Shasthyo Surokhsha Karmasuchi) is the social health protection scheme developed by the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MoHFW) with support from German Development Cooperation through KfW (German Development Bank) and GFA Consulting Group. SSK is designed to improve access of the poor population to hospital services, to reduce out of pocket payments (OOP), and to improve efficiency of quality hospital care. Under the supervision of MoHFW, SSK will be managed by SSK Cell and operated by Scheme Operator, which will be selected through competitive bidding.

SSK will charge flat rate contributions per household. For poor households fulfilling the poverty criteria contributions will be paid by the Government of Bangladesh (GoB). During the pilot implementation the contributions will be financed by KfW.

SSK members will receive necessary health care through Upazila Health Complexes (UHC), and on a structured referral basis from District Hospitals (DH). Non-government health facilities will be included into the SSK system in due course based on the need and availability of accredited health care providers. The Scheme Operator will pay hospitals for inpatient services on a per case basis following a simplified DRG (Diagnosis Related Groups) system with about 50 positions. The prices for these payments will be set by SSK cell in the beginning of SSK implementation. However, once all partners (SSK Cell, Scheme Operator and providers) have become acquainted with costing, accounting and pricing payments shall be negotiated between hospitals and Scheme Operator. Inclusion of outpatient services (OPD) in SSK scheme will be considered during SSK pilot implementation and then should be remunerated on a per capita basis.

Hospitals will receive the public budget plus the extra payment from SSK. With the extra funds they will have room to improve and expand services so they can meet the quality criteria and avoid complaints. SSK will be supported by an IT based information and management system in order to generate more efficiency and transparency as well as to avoid fraud and misuse.

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**Conducted by – SSK Cell**

Health Economics Unit, GFA Consulting Group GmbH, Germany.

## **Baseline Survey on the Perception and Knowledge of Community Regarding Women Friendly Health Service**

*Published on: 2007*

### **Summary findings –**

Widespread dissemination of messages on female diseases to the community is critical to enhance knowledge and awareness of beneficiaries. Among other various means, field workers of NGOs working on health are an effective tools to spreading information. An increase in number of community representatives in the management committees of health facilities is needed to promote gender equity in health care programs.

A significant gap has been identified and that is absence of services for women beyond reproductive age (49 years). This is a critical area to work on for the policy makers taking into account the fact that quality of live in Bangladesh has improved than ever before and hence the extended average life span.

### **Policy relevance –**

The concept of WFHI is to improve the quality of care with appropriate responsiveness of health care providers according to the need of women. MoHFW adopted WFHI in 1998 as a national directive towards transforming the existing health care into a more gender balanced modality of service. In due course, 28 hospitals at various level have incorporated the WFHI.

The WFHI is a unique modality of service to deliver enhanced gender balanced health services. Lack of baseline information regarding care seeking behavior and decision making benchmarks of improved utilization of services. Therefore need of baseline data is imminent. It was assumed that the survey would better explain the care seeking behavior of the female clients at public facilities. Also it was intended to reveal factors critical to making informed choices of health care by the female clients. Moreover, the study findings were envisioned to create a string evidence base for policy makers for all future initiatives towards improving gender equity in health care services.

**Conducted by – GNSPU**  
Health Economics Unit.



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## Assessing Violence Against Women (VAW) Victims Health Care Need Assessment and Engendering HIS Data Source

Published on: 2013

### Summary findings –

The study identified short term and long term care needed for the victims of VAW. The short term needs include first aid, while the long term needs include clinical procedure and psychological counselling. The health care needs for the victims often remains unsought due to social stigma. Communication between survivor and care provider has been critical for quality service from both demand and supply side.

The study found little evidence of HIV testing done for survivor of sexual assault and rape. For burning and acid throwing, the treatment cost found to be quite high and unlikely to be affordable by most of survivors. The government and NGOs may intervene to significantly curtail treatment cost.

The health care need of VAW survivors are unique and therefore requires training for the providers. The existing infrastructure, in some cases, are not client friendly in terms of privacy which needs to be reorganized/renovated. Again, the study revealed 54% of the victims are unable to access services at public facilities and sought care from informal sectors (pharmacy, village doctors etc.). In some of the hospitals, with exception to OCCs, do not keep records of general ward. Also the data is not disaggregated by sex.

### Policy relevance –

In the context of Bangladesh, statistics show that oppression of women has increased to sever extent over past years. According to the data from Police Head Quarter, the number of incidents of women repression including those of rape, killing, abduction and sexual harassment reached 12,904 in 2009 and 16,212 in 2010. Irrespective of class, gender, ethnicity, violence against women is highly prevalent in the form of eve teasing, rape, acid throwing, dowry killing, wife battering, trafficking and many other sexual abuse and assault.

The importance of Health Information System (HIS) lies in the very nature of the system itself as it is data recording and generating system. Therefore it may help to reduce clinical errors, use to support health professionals, and to improve the quality of patient care.

**Conducted by – GNSPU**  
Health Economics Unit.



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## Situation analysis on GOB initiative on gender equity in health

*Published on: 2015*

### Summary findings –

The study finding recognized that a number of initiatives had been taken by the Government to address the gender issues in HPN sector. It has acknowledged the progresses made by the country were significant towards achieving improved gender equity, which was one of the Goals of the MDGs.

### Policy relevance –

This study was undertaken is an attempt to document the present status of government initiatives to mainstream gender in health, population and nutrition sector. It contains a review of policies, procedures and services as it also looked into the bottlenecks, further scopes and recommendations for future actions with regard to establishing women and girls' equitable rights in that sector.

Understanding the country's existing health related gender issues, especially the poor and their lesser access to health care facility; and also recognizing the GOB's different national and international commitments to address the issues , the Ministry of Health and Family Welfare adopted GE Strategy in 2014 with a view to enhance gender equity in health sector. That includes some strategic objectives and areas for improvement. Considering the successful implementation of GES, it is a demanding requirement to assess the achievements, progresses; identify the scopes and bottlenecks; and finally recommend for further actions.



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Health Economics Unit.and Breakthrough Institute.





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## **Gender Analysis of IEC materials in HPNSP**

*Published on: 2018*

### **Summary findings –**

This study has reviewed IEC materials that currently being used across the health care system. The findings establishes the relevance of the materials with context. The type and contents are adequately aligned with the purposes of them.

### **Policy relevance –**

A distinctive correlation exists between the ratio of male to female population in Bangladesh and sex selective healthcare. There are significant disparities in the health status of population groups, especially the poor, women and indigenous people

Despite some guidelines to incorporate gender issues in HPN sector and IEC materials development, there are lack of data over the inclusion of gender context and gender analysis in the IEC materials in HPN sector. In Bangladesh there is not enough data on gender issues and analysis of IEC materials in HPN sector. Though communication plays most important role to change gender norms and increasing awareness regarding HPN sector, yet there is few information regarding the gender context of developing IEC materials and also the gender analysis of these materials. The gender analysis of IEC materials in HPN sector could help to improve the IEC materials in gender sensitive way and in future it will be beneficial to establish gender equity-based society by building awareness among mass communication through gender sensitive IEC materials.

**Conducted by – GNSPU**

Health Economics Unit and Dev Resonance

## **Gender Analysis of Operational Plans (OPs) in Health Population & Nutrition Sector Programme (HPNSP)**

*Published on: 2018*

### **Summary findings –**

The finding and outcomes of the study has shown the OPs have adequateness and appropriateness to achieve the embedded objectives of equitable health care. There are however, areas the study has identified which need to be looked into more rigorously for further enhancement.

### **Policy relevance –**

There are significant disparities in the health status of women compared to men. The MoHFW plays a strategic role in the sustainable development of the country by ensuring quality and equal healthcare for all citizens, thereby promoting gender equality. The Government of Bangladesh, through MoHFW pursues creating an enabling conditions whereby its people have the opportunity to reach and maintain the highest quality of health as a fundamental human right.

The core objective of the OPs in the HPN Sector Programme of the MoHFW is to effectively mainstream gender into all its operational Plans. A framework of assessment and analysis of programmes implemented by the OP in HPN sector is vital to create evidence base for the health policy makers to better address gender issue in health care policies. A thorough research and evaluation was considered central to examine how gender related norms and behaviours influence specific health behaviours.



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## **Mapping of Gender Based Violence (GBV) Services**

*Published on: 2018*

### **Summary findings –**

A variety of information on the GBV services in the country has been compiled as a reference directory. It shows majority of districts have GBV services ranging from medical to legal aid services. There are other components of services available sporadically across 64 districts. The report has also presented a geographical map with service icons to quickly identify the type and location of services. However, the GNSPU technical panel is working on the directory for further enrichment making it more user friendly.

### **Policy relevance –**

Gender Based Violence is one of the severe and extensive problems in Bangladesh. Currently, in Bangladesh several agencies, both GO and NGOs are providing services to the GBV survivors. Considering the severity and the extent of incidence and prevalence of the GBVs in Bangladesh, the urgency to know the availability of services for the GBV survivors by types is most essential. Currently such information is neither available with the agencies providing services nor with the GBV victims and the survivors. In the absence such information, many of the victims fail to obtain right kind of services and above all the perpetrators go unpunished for the heinous crimes committed. Out of ignorance, the society most of the times remain silent.

There has been no comprehensive study undertaken across 64 districts of Bangladesh to identify the status, availability and locations providing services; particularly in regard to seeking remedies (legal actions) or services: medical, psychological counseling and rehabilitative services. Hence, it is essential to obtain information about the services, rendered by the GO and NGO agencies for the GBV Survivors. Moreover, effective information on the availability of services by types would also enhance access to services and service facilities for the GBV survivors.

**Conducted by – GNSPU**

Health Economics Unit and Research Evaluation Associates for Development Ltd. (READ)

## Equity in health with a special focus on gender inequities in Bangladesh

Published on: 2019



### Summary findings –

Based on both quantitative and qualitative findings, it is clear that inequity in the health service utilization is pervasive. In addition, various marginalized groups are discriminated in getting services. Even though government is attempting to improve the health service delivery in local level, it turns out that severe confidence crisis still persists.

### Policy relevance –

In Bangladesh, the gross national income per capita in 2015 was 1,190. The country ranked 142nd out of 187 countries on the HDI scale. The Gini coefficient, a measure of income inequality, is estimated at 0.483. Using upper and lower national poverty line estimates, the headcount ratio is estimated between 24.3% and 12.9% respectively.

Data from Bangladesh Demographic and Health Surveys (BDHS) shows that access and equity are improving in maternal health in the last two decades. While there are impressive results in immunization, child health, it is important to identify which are the most vulnerable groups that are not benefiting from health services.

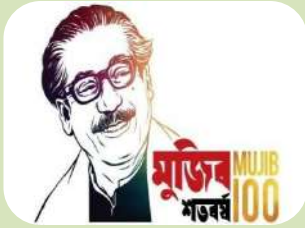
This study should not only focus on national level but should take into account at the administrative divisions and below. Similar questions can also be asked about the morbidity, nutritional status, utilization and accessibility of the healthcare services. Also important to know is the resource allocation and expenditure on health services by the public and private sector equity sensitive

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**Conducted by – GNSPU**  
Health Economics Unit

## **Analysis of existing curricula of medical education from gender perspective**

*Published on: 2019*



### **Summary findings –**

The findings of this study would help to understand the gender perspectives in the medical curriculum. At the end of this study the findings will share with GNSPU unit for taking necessary steps. As a result, a gender-sensitive learning would be expected across the medical education system which would help ensuring quality health services to all men, women and transgender in the society.

### **Policy relevance –**

Prioritizing the gender issue, Bangladesh Ministry of Health and Family Welfare (MoHFW) has developed a gender equity strategy 2014 with a set of core objectives. Furthermore, in order to be able to achieve the targeted objectives, a Gender Equity Action plan (2014-2024) has been developed.

The action plan and strategy obliges GNSPU to emphasize gender issue as to how the health policies are conceived and implemented. Among various other polices in the country, the teaching curriculum for both MBBS and other allied health providers such as Medical Assistant/Paramedic, Nurse, Midwives and public health practitioners forms an integral and vital component of health policies. There are little or no information available on any review of these policy documents has ever been undertaken to determine their adherence with the principles and practices of gender issues defined in the policy and strategy.

In light of the above, the study findings would be crucial to determine the scope of potential changes in the medical education curriculum towards improved alignment with the gender equity action plan and strategy. It refers to undertaking a descriptive and exploratory study, the finding of which will strengthen advocacy by GNSPU to take forward issues around gender.

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**Conducted by – GNSPU**  
Health Economics Unit

## **Situation analysis: Health care and protection services for GBV survivors among the Rohingya community (FDMN) in Cox's bazar**

*Published on: 2019*

### **Summary findings –**

More than half the arrivals are women and girls. A vast majority of women of reproductive age has suffered some degree of gender based violence while fleeing the atrocities. Even after taking shelter in Bangladesh, many women and girls reportedly continue to suffer. Already marginalized and vulnerable, they are bearing the impact of the crisis.

Several GO/NGO/INGO interventions are in place to address GBV issues among the refugee community. The providers are operating at various locations and extent within and outside camp area within the region.

### **Policy relevance –**

Nearly a year and half since August 2017, an estimated figure of more than a million Rohingya have fled the brutal violence in Rakhine state of Myanmar and sought refuge in southern Bangladesh district of Cox's Bazar.

Such unprecedented influx has resulted in a situation of statelessness and acute vulnerability for the affected people. Despite being a limited resource country, Bangladesh government has shown highest degree of humanity to provide immediate shelter to the distressed people. Subsequently in no time, the humanitarian communities from across the world has stepped in to support GOB to help mitigate a critical humanitarian emergency. The response is also designed to support the host Bangladeshi communities most directly affected by the influx and improve their ability to cope with the strains of hosting a refugee population.

The study outcome will be of use to ascertain the current extent of GBV burden, the services available for GBV survivors including health care services and how these interventions are making difference in the lives of the GBV survivors.

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## **An Analysis of Recurrent Costs in GOB Health and Population Facilities**

*Published on: July, 1995*



### **Summary findings -**

The ADP database revealed that for health projects in the ADP, construction was the largest category of expenditure in 1994/95, followed by purchase of equipment. In contrast, for the ADP population projects the largest line items in 1994/95 were recurrent in nature, such as Supplies, Salaries and Allowances. Indeed, recurrent activities amounted to approximately 80% of the expenditure incurred in such projects. While the funding of health activities in GOB's Revenue Budget was quite substantial (over US \$140 million in 1994/95) that of the population sector was small (less than US \$12 million in the same year). It was apparent that donors had taken on many of the costs associated with the operation of population activities. The study also found that a three-year lag between additional investment and an increase in operating costs (no such relationship is evident for the population sector). However, the study noted that this is likely to be an inaccurate method of estimating future recurrent costs given the lumpy and diverse nature of capital investment.

### **Policy relevance –**

Today's investment in the health and population infrastructure can often turn into tomorrow's financial liability, given the associated running costs of new facilities and new equipment. The study noted that in the population sector GOB was protected from such liabilities by donor funding. The report debated whether the GOB could continue relying on external aid to fund much of the recurrent costs of the population sector or whether it needed to institutionalise more population activities in the Revenue Budget, in order to be able to guarantee sustainability.

In order to forecast effectively future running costs in the health and population sectors, the report suggested three steps. First, it was necessary to develop the HEU's initial survey database into a comprehensive and consistent Budget database. Second, all the proposed and actual outputs of the ADP, or its constituent projects, needed to be known to help future and current resource allocation decisions. Finally, more analysis needed to be conducted on existing and optimal unit costs of facilities. Such information would be invaluable in planning for the sustainability of HAPP 5.

**Conducted by – HEU**  
Health Economics Unit.

**HEU Publication  
Research  
UHC**

## Balancing Future Resources and Expenditures in the GOB Health and Population Sectors

*Published on: January, 1996*



### Summary findings -

The report revealed that there were insufficient resources under projected conditions for the GOB to carry out its planned activities in the population sector. In 1997/98, the report forecasted a resource gap of US\$

13.7 million which broadened to US\$ 42.4 million by 2001/02. Key line items which would be underfunded in this simulation were Medical (and contraceptive) supplies, Operation and Maintenance, and Construction. The funding gap for the first two of this line items was particularly worrying given their importance to GOB objectives. Funds were also unlikely to be sufficient for carrying out health activities as set out in the Perspective Plan. Using different scenarios for development activity, HEU projections showed that continued high capital investment was unfeasible without substantial additional resources. Even under a reduced investment scenario, there was still a shortage of resources over the period of the 5th Population and Health Project. The report also highlighted that the alternative strategy, an ESP, may be too expensive in the short term for Bangladesh. Estimated costs could reach US\$ 12 per head, according to the 1993 World Development Report, much higher than the US\$ 3.2 per head spent through GOB Budgets in 1994/95.

### Policy relevance –

The report made many strategic recommendations for dealing with the potential funding gaps associated with the different policy options. In particular the report recommended that GOB should proceed with its pilot study of the impact of user fees within the health sector and assess the viability of a social health insurance scheme to help mobilise resources and bridge any remaining gaps. Furthermore, the report noted necessary areas for cost-savings to be pursued in the public health sector. Additional areas of need identified by the report were the continual refinement of costing as more sophisticated plans were developed and the incorporation of recurrent cost implications in future plans, as a matter of course, to guarantee the financial sustainability of HAPP 5 activities.

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Conducted by – HEU  
Health Economics Unit.



## **Mobilising Resources through hospital fees in Bangladesh: a report on quality and ability to pay**

*Published on: August, 1996*

### **Summary findings -**

User fees are charged as a fixed outpatient or inpatient registration fee, as variable charges on a number of services including surgery, ambulance fees, pathology tests, radiotherapy, ECG, blood blank charges and x-rays, and for 'paying beds' and cabins. Targeted exemptions are available for those who are unable to pay. Civil servants, physicians, nursing staff and hospital employees are fully subsidised for use of 'paying beds' and cabins, although they are required to pay other charges including the registration fee. All user fee revenues are deposited directly into the general revenue accounts of the GOB treasury. Service charges (51% of total) and rents for paying beds and cabins (26% of total) are the two most important sources of revenue. Other revenue sources were outpatient registration fees (18%), services(7%) and inpatient registration (5%).Of the patients surveyed, 23% paid hospital charges from current income and 20% made payments from existing savings. Although "distress sale" was not common, over 21% borrowed to meet some or all of the expenses. All patients reported making significant unofficial payments. The survey found that the share of these unofficial payments to total payments was 85%, and relative to income, they were highest in the lowest income group. As a percentage of expenditure, user fees revenues were 16% of salaries and allowances, 149% of patient food and 118% of medical and surgical requisites and equipment.

### **Policy relevance –**

User fees are used in the hospital setting in Bangladesh as a revenue generation tool. However, this study has observed under collection of fixed fees due to non-payment, exemptions and misuse of the exemption system. This both reduces potential revenue and may lead to worsening inequalities. Further inequalities were highlighted in the rapid survey, which indicated that unofficial fees were charged such that the lower income groups paid out relatively more than the higher income groups. These impacts emphasise examining the financial dynamics of any resource mobilisation effort. In the case of Bangladesh, the study showed the importance of using and improving estimates of price elasticity of demand for health care as well as considering the unofficial charges and exemption mechanisms. The management of the user fee funds should also be explored more closely. In particular the collection of user fees could be linked with improvements in service quality.

**Conducted by – HEU**  
Health Economics Unit.



**HEU Publication  
Research  
UHC**

## **An Assessment of the Flow of Funds in the Health and Population Sector in Bangladesh**

*Published on: January, 1997*

### **Summary findings -**

Government of Bangladesh (GOB) resource allocation in the health and population sector amounted to just under US\$ 230 million in 1994/95. The largest recipient of GOB expenditure was primary health care and maternal and child health/ family planning services. For Donor fund, Food and commodity aid for the health and population sector in 1994/95 was approximately US\$ 40 million. This accounts for less than 5% of the entire sector funding. It is also worth noting that health and population sector services funded by food and commodity aid showed up in the Government's budget as over 1% of the entire public sector budget. The flow of fund from donors to various NGOs in 1992/93 was estimated to be in the region of US\$ 46 million and it could be an under-estimate due to survey methodology. In 1995, the population of Bangladesh was approximately 120 million, with approximately 5.1 people per household, implying that there were around 24 million households. The total spending by individuals on health care in 1994/95 was over US\$ 400 million or almost US\$ 3.4 per capita. Even more alarming is the fact that the poorest quartile spent less than 10% of the total on health and population services, approximately US\$ 1.3 per capita per year.

### **Policy relevance –**

Under-utilisation of existing facilities, particularly for in-patient services at Thana facilities is a key indication that some GOB services do not have the confidence of households. This can be partly remedied by determining the unit costs of running facilities well. Such unit costs can then be used as bellwether for Revenue Budget allocations. Expansion of user fees, albeit important for the funding of an essential package, will be difficult outside the richest 25% of the population, who seem to account for approximately 60% of total household expenditure on health and population services. The study made a first attempt to gather health and population sector funding data from various sources. The inconsistencies and unavailability of data compelled the study to analyse funding flows for just one financial year, 1994/95. The study, however, envisages that the National Health Accounts project will collect time series data to construct a dynamic picture of the sector and improve the financial accounting procedure of the donors and NGO community.

**Conducted by – HEU**

Health Economics Unit, Data International Limited and WHO.



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**Conducted by – HEU**

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## **Health and Technical cost-benefit analysis of reducing lead emissions from vehicles in Bangladesh**

*Published on: February, 1998*

### **Summary findings -**

The study showed that mean blood lead levels in the sample were 50 $\mu$ g/dl – five times the level at which brain development in children maybe affected. This suggests the health benefits of airborne lead reduction would be high. The results of the benefit cost analysis confirm this. Even using the low benefit estimate the switch to unleaded petrol shows a monetary gain of 16.11 cents per litre (US 1997 prices) inclusive of health benefits and an overall net benefit of 30.4million US dollars (1997 prices).

### **Policy relevance –**

As demand for petrol exceeded supply, the Eastern refinery was forced to blend its leaded petrol with imported unleaded petrol. As a consequence, much of the petrol now produced in Bangladesh is unleaded. However, with the due expansion of there finery, unless adequate measures are taken, petrol production may return to its former leaded product. The benefit cost analysis shows policy-makers that the gains to be made from switching to unleaded petrol production are substantial, for both health and vehicles. It is recommended that if and when the refinery expansion takes place, a switch to unleaded petrol is made and facilitated. The study further highlights the points:

1. Any unleaded petrol should use octane enhancers that minimise health hazards
2. Unleaded petrol can and should be introduced without a complex, expensive transitional period.
3. Ethyl alcohols and ethers produced from biomass production should be explored as an alternative source of octane enhancers

**Conducted by – HEU**  
Health Economics Unit.

## Unofficial fees at Health Care Facilities in Bangladesh : Price, Equity and Institutional Issues.

*Published on: March, 1998*

### Summary findings -

At the District and Medical College Hospitals, unofficial fee payments are procured almost exclusively by ayahs, ward boys, sweepers i.e. the medium and the lower support staff and their associates. Fees for commodities appear to be the most common form of payments, in particular for medications, supplies and surgical instruments. Payments are also made for assistance in patient registration and in order to obtain beds. Overall, fee for commodity payments made up 85% of total unofficial fees paid. Fee for services made up the remainder 15%. At the Thana facility, the methods of payment were not established. However, 7% of the patient sample paid unofficial fees to staff for commodities and drugs. These fees were paid at the point of service. Overall unofficial payments on an average is BDT 2951/patient. The middle-income group were found to be paying relatively more in unofficial fees than the other income groups except in the Medical College Hospital did the higher income group pay more. Quality ratings were highest for professional staff at the hospitals and the Thana. Approval ratings for all other staff varied across the facilities but were generally low. Cleanliness of the facility, food quality and quantity were all given low to moderate quality ratings. Further analysis found that duration of stay and number of past visits most strongly affected respondents' views of facility quality.

### Policy relevance –

While unofficial fees may affect middle and upper incomes, most are levied without regard to income and act like a form of flat tax. Thus, they add to the existing inequities of distributive subsidies. Further, the incentives they create sap efforts to remedy market failures and therefore reduce the allocative efficiency of health care provision. In addition, the payment system may be integrated into work patterns. Without knowledge about the existence, validity and extent of unofficial fees, patients may perceive unofficial charges as officially authorised arrangements. The study suggests that unofficial fee collection takes place because a government fails to deliver required levels of services, commodities or accessibility. The collectors of these payments recognise that there is a considerable consumer surplus in low quality, subsidised health care services. They, therefore` initiate a process of 'rent capture' i.e. unofficial fees are charged to capture part of the difference between what the consumer is willing and able to pay and they are required to pay. Thus, the unofficial fee collector relies on low quality and quantity of health services to maximise the consumer surplus. This has implications for health sector reforms as it suggests there maybe resistance by health workers involved in unofficial fee collection to the introduction of quality improvements.

**Conducted by – HEU**  
Health Economics Unit.



**HEU Publication  
Research  
UHC**

## Consumer Costs of Caesarean Sections at Public, Private and NGO Health Care Facilities in Bangladesh – Cost-effectiveness Analysis

*Published on: March, 1998*



### Summary findings -

The mean monthly household income for C-section patients was highest at Monowara. This was significantly higher than at Myemensingh Medical College Hospital(MMCH) and LAMB hospital. The study found that patients expenditures for C-sections were the highest at Monowara, as expected, and lowest at MMCH. The expenditure per patient day at MMCH and LAMB was less than one sixth of that at Monowara. The major patient expense at Monowara was found to be the operation charge (Tk.12,964) while it was the drug cost (Tk.3,729) for the public hospital. When the data were analysed by income group rather than facility, not surprisingly, a positive relationship was observed between expenditure and income. In the low-income group consumer expenditures were on average more than Tk.5,000.00 which is equivalent to more than twice the average monthly income. The middle-income group consumer expenditure was exceeded their average monthly income by 20%.

### Policy relevance –

It is observed from the study that, the consumer expenditure for the procedure, relative to income is very high at all facilities. The majority of Thana patients are those individuals from lower- and middle-income groups and would be little able to afford a c-section operation. So, it is vital that, if HPSP continues the plan to extend EOC at Thana level, these costs to the patient must be minimised. The study suggests that further investigation regarding cost and outcome comparisons between public, private and NGO hospitals can contribute to guidelines for policymakers. Specific cost information when coupled with clinical outcome estimates and procedure-specific consumer cost data will permit a focused cost-effectiveness assessment of care provided in one of the most resource intensive areas of the Bangladesh health system. Such information will be of special value in determining specific methods for balancing the public provision of health services with that made available by the private sector.

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## FINANCIAL ANALYSIS OF MYMENSING MEDICAL COLLEGE HOSPITAL FY, 1994-95

*Published on: June, 1998*



### Summary findings –

The Occupancy rate varied widely across departments, with a low of 28.0 percent in psychiatry and a high of 129.4 percent in pediatrics. New cabin beds were only 55.7 percent occupied. Death rate was 5.4 per 100 admissions while 2252 births occurred at the hospital. Of the Gynae/Obs patients, 28.4 percent were for delivery. Total cost during the study were 118,461,474 Taka or about US\$ 2.5 million. Medical staff, personnel, supplies (including drugs), depreciation, food and electrical expenses were 92.5 percent of the total expenditures of MMCH. Medical staff Expense amounted to 18,882,107 Taka or 15.9 percent of total expenses. 15.1 percent of total study expenditures came from building and expenditure and equipment depreciation (17,841,407 Taka). Pharmaceuticals and medical supplies (MSR), including radiology supplies, were 19.1 percent of total expense, while food was 6.8 percent and electricity was 6.6 percent of total hospital expense. Total costs per patient-day 311 Taka, 48 of which was for medical staff. Highest medical expense areas: psychiatry (360 Taka), CCU (268 Taka). Lowest medical expense areas: Surgery (24 Taka), Gynae/obs (35 taka). Average cost per admission was 2246 Taka (for 43,000 admissions). Interns were greatest part of inpatient medical staff expenses (57.5 percent). Administrative expense accounted for 5.5 percent of total expense. Laboratory and pathology were 3,754,704 Taka while Radiology was 3,301,441 Taka per year.

### Policy relevance –

Personnel was the largest component of MMCH expenditure, but the MMCH study found that personnel expenditures of the hospital were 7.3 percent below the payroll budget. The ratio of assistant registrars was disproportionate to the nursing ratio. Psychiatric, student, staff and new cabin beds were under-utilized when compared to the MMCH overall occupancy rate. The lack expenditure for the repair and maintenance of buildings and equipment is likely to significantly decrease the life of the buildings and equipment. The replacement expense would be greater the cost of maintenance. Fees at MMC were low compared to the private sector, but the fee structure does not account for all of the difference. Revenues for MMCH can be enhanced, by review of exemptions.

**Conducted by – HEU**  
Health Economics Unit

## **Economic Aspects of Human Resource Development: Flow of Funds in Human Resources of Government Health and Family Planning services**

*Published on: September, 1998*



### **Summary findings -**

Total spending on 121,541 staff positions under MoHFW was estimated to be Tk 4.5 billion per year (equivalent to US\$102.4 m). The largest part (36%) is being spent on PHC staff, followed by support staff (25%), and 17% each on medical and nursing services. 20% of the total staff expenditure flows into urban districts, which account for 14% of the population. Nearly one third of total expenditure in urban areas is dedicated to support staff. In THCs the largest part of expenditure is incurred for PHC staff (41%), followed by support staff (20%) medical staff (16%), and nurses (13%). In district hospitals the major part of funding is dedicated to nursing (34%) followed by support staff (30%) and medical and dental services (28%). The overall nurse/doctor ratio at 0.96 is low, but it is higher in district hospitals (2.34) and in medical college hospitals (1.73). Population/staff ratios in PHC (Thana Health Complexes and Union-Sub centres) are 4600 for FWAs, 5,900 for HAs. In PHC each FWW serves a population of 20,000, each nurse of 48,000 respectively and each doctor a population of 38,000. Comparing staffing patterns between DGHS and DGFP shows that a unified service structure at PHC level will not automatically compensate for staffing imbalances between districts.

### **Policy relevance –**

The analysis reveals a number of imbalances in resource allocation related to level of care, geographical areas and staff functions. It is difficult for most people to gain access to medical and nursing services in rural areas. Overall nurse/doctor ratios are relatively low indicating that doctors perform tasks, that are normally done by nurses and other health professions in other countries. Substituting staff functions by more appropriate ones is being discussed as a way to achieve a better match between tasks and skills and to achieve further efficiency gains at service delivery level.

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## **Economic Aspects of Human Resource Development: Dual job-holding practitioners – an exploration**

*Published on: September, 1998*

### **Summary findings -**

71% of the respondents of this study reported additional monthly earnings from private practice of up to Tk.20,000 per month, 9% between Tk.20,000 and Tk.30,000, 10% between Tk.30,000 – Tk.50,000 and less than 10% above Tk.75,000. Consultation fees were Tk.120 on average (range Tk.20 – Tk.300) and, correlated with the qualification of the practice owner: GPs charged Tk.50 on average; doctors with a diploma Tk.125; and specialists Tk.200. All doctors at Thana level reported that they would give up private practice if they were paid a higher salary, but only 54% of the respondents in secondary and tertiary did so. Only a minority of doctors would give up government employment to set up full time in private practice. If given the opportunity a majority of respondents (68%) would like to set up their private practice in government facilities. Other areas identified for improvements in private practice related to regulation and quality improvement. Only a minority of respondents considered in public health or primary health care as fields for career development.

### **Policy relevance –**

Most dual job holding doctors in the study sample are able to double their income by engaging in private practice. The propensity to give up one of the jobs in favour of the other was found to be low. The data suggest that doctors have adopted individual strategies to accommodate the advantages of both government employment and private practice in their career development, thus maximising benefit from the incentives provided to them e.g. status of a government job, and minimising opportunity costs of economic losses e.g. lower salaries. Financial incentives to increase numbers of doctors in rural areas, such as a non-private-practice allowance, are more likely to be appreciated by younger doctors who are at the beginning of their career. The responses showed that improved training and access to career opportunities appear to be of high importance to increase job satisfaction of doctors posted in rural areas.



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## Economic Aspects of Human Resource Development: Costs of Education and Training of Health Workers in Bangladesh

*Published on: September, 1998*



### Summary findings -

On average, each medical college spends Tk.33 million on undergraduate medical education. Of this cost 29% is borne by the attached College Hospital. This is equivalent to Tk. 250,000 per undergraduate medical student. Ninety-three percent of the costs are covered by the revenue budget, 2.2% by the development budget, 4.1% by tuition and hostel fees and 0.3% by other income. The overall cost of basic nursing education is Tk.149,000, including the stipends for student nurses which total Tk.44,000. Basic training for PHC workers is provided at cost of Tk.200-Tk.400 per training day. The annual equivalent cost of education and training (the present value of the educational investment, discounted and apportioned at 5% to the persons working life years) is Tk.19,607 for GPs, Tk.46,035 for doctors with Diploma, Tk.73,758 for medical specialists, Tk.5,310 for basic nursing education and Tk.31,229 for post-basic nursing education. The IRR on private costs of medical education and training is relatively high by international comparison (22.3% for GPs and 30% for specialists), indicating that students bear only a minor part of the total cost. If the full cost of education and training had to be financed by the students themselves the IRR would drop to 12.6% for GPs and 16.1% for specialists, arrange which is deemed adequate in other countries.

### Policy relevance –

Expenditure on medical education is the largest public investment in education and training in the health sector, followed by training for PHC personnel and nurses. Costs per student are relatively low for both medical and nursing students, underlining the fact that education of these professions is largely based on formal instruction of high student numbers, rather than on intensive training in small groups. Since only around 51% of doctors who receive medical training, work in the government health services, the cost to government of training for these roles is inflated by the numbers doing private work or going abroad. The data demonstrate that there is scope for a recovery of public subsidies from the graduates themselves or from institutional providers in the private sector who do not engage in education and training. If full cost recovery were possible in cases where doctors work outside the government or NGO sectors, then the net government subsidy for training would be reduced by around 32%. In the case of nurses, the rate of employment in government services should be increased and incentives changed to encourage qualified nurses to work in services in country. Since government services have not employed newly trained nurses during the last 5 years and large numbers are assumed to work abroad or to be unemployed, the return on investment in training nurse education is currently a near complete waste.

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## Private sector Medical Clinics and Hospital Survey

*Published on: September, 1998*



### Summary findings -

The private health care sectors, like other sectors of the economy, suffers from policy distortions that discourage firms to grow in size. Policy distortions also focus attention on inputs and not the quality of care per se. Moreover, the existing policy not only fails to encounter deficiency in quality of care in the private sector but also encourage rent seeking behavior in the public sector. The staff at private medical clinics consists of owners and directors from among medical college professors with residents acting as junior staff to provide diagnosis and interventions. This poses the question of the ability of the staff in allocating their time both at the public and private facilities and the maintenance to double standard in quality of care at these workplaces. Population density, income levels and accessibility are close linked with private bed supply implying policy implications for national coverage and health care financing to depend on income and geographical linkage issues. Moreover, the fact that private sector is more likely to supply inpatient service to urban than rural populations. Private clinics show lower lengths of stay and higher occupancy rates than public clinics of comparable size showing a greater degree of resource efficiency than comparable public clinics. The possibility of the public sector moving out from services where the private sector has gained enough strength still seems removing due to existence of an effective health care financing system (private and social insurance, etc.) to ensure coverage of the most disadvantaged and lack of regulations and its applications to monitor quality.

### Policy relevance –

The survey of private clinics provides an important first step to helping policy makers understand how the private sector operates in providing in-patient clinic services. Keeping in mind the wide spectrum of private sector facility canters and service that not only include the private clinics but also the NGOs, outpatients' clinics, the laboratories, and the pharmacies, there is the need for defining the 'partnership' that exists between the private and the public sector and also within the private sector. This paper has highlighted a number of issues that need to be considered in the implementation of HPSP. Scope clearly exists for the development of public-private sector partnerships in the delivery of an ESP. Private clinics exhibit a wide range in the quality, type and cost of care provided. There is a clear tendency for clinics to focus on the quality of inputs rather than the quality of health outcomes. While evidence of market failure exists, in the sense of imperfect competition, there is also evidence of Government failure, through weak and distortionary regulation. Existing attempts to regulate and license private clinics are at best inconsistent and at worse encourage inappropriate attention to health care inputs rather than outcomes.

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## Resource Allocation in the Health Sector of Bangladesh: A Case Study of Medical and Surgical Requisites

*Published on: February, 2000*



### Summary findings -

Although an essential element in the delivery of health services at the public health facilities, GOB allocation for MSR does not meet the needs at the health facilities. Only half of the demand placed by directorate is allotted to the facilities. As a result, increased allocation to the health sector in the recent years did not translate into increased allocation of MSR at the health facilities. The existing criterion for MSR allocation may result in inadequate MSR supplies at most of the health facilities and hospitals at different levels. Besides, Allocation at the Health facilities was not based on actual needs at the facility. Allocation for MSR to the health facilities under the existing criterion of allocation seems biased towards the non-primary level facilities i.e., District Hospitals and Medical College Hospitals, based on an estimate made in 1985. More resources for MSR were being funded to urban areas than the ones that are within close distance of the rural poor.

### Policy relevance –

To increase in MSR allocation by the GOB at the health facilities without altering the priorities would have a very little distributive impact. Therefore, the allocation for MSR supply should be made on the basis of demand and needs at the health facilities. This needs-based resource allocation system could be made more equitable by basing distribution on criteria related to need including size of population, demographic composition and local healthy needs. The MSR demand for delivering ESP should be considered. In the backdrop of unification of the health & family welfare services at the Thana and its lower levels, there remains a scope for introducing a new set of principles in the allocation of resources for MSR by taking into consideration the separate requirements in each of the two sectors. Guidelines for retention of resources and its use at the facility level should be developed for financing supply of MSR. Financial decentralization at the facility level for MSR purchase needs to be given due consideration. International experiences in designing such formulae that could be exploited to aid the development of policy.

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## Calculation of Total Unit Cost for Diarrheal Management at District Hospital and Thana Health Complex

*Published on: February, 2001*

### Summary findings -

Capital cost had the largest share in diarrheal disease service provision to patients at District Hospital and Thana Health Complex, followed by the labor and material cost. The estimated provider cost per patient day for the management of IPD cases at DH was Tk 317.87, at THC it was Tk 406.90. Cost per OPD visit at DH was Tk 53.74 and at THC it was Tk 63.32. In District Hospital percentage of costs shared by capital, labor and material was 41.4%, 25.7% and 23.3% where as in THC it was 44.1%, 29.8% and 19% respectively of total unit costs. Average provider cost at both inpatient and outdoor patient departments of District Hospital was lower than that of Thana Health Complex. This was mainly because of nearly full utilization of DH and under utilization of THC and also might be due to DH was more efficient and effective in their services.

### Policy relevance –

Quality improvement of services at rural health facilities may be worth considering in reducing excessive pressure at District Hospital and increasing the utilization of Thana Health Complex. Increased utilization implies reduction of the capital as well as some recurrent costs at Thana Health Complex. User charges may be introduced up to District level to recover at least recurrent costs of material according to financial solvency of the patients. Referral system needs to be introduced in order to treat less severe cases locally while referring more severe cases to District level facilities.



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## Geographic Resource Allocation in Bangladesh/ Resource Allocation Formula

*Published on: March, 2001*



### **Summary findings -**

The level of public finance for healthcare provided to each geographic area in Bangladesh is largely determined by the size of facilities and employment of staff rather than health or socioeconomic need. The system has two fundamental weaknesses. First, it tends to towards the objective of allocating resources towards the most vulnerable and means that national equity objectives may not be carried down to local level. Second, since allocations are not related to the level of activity of facilities but rather to the size of capacity, it does nothing to reward a greater level of system (technical efficiency). Resources are currently allocated to districts and upazilas largely according to the size of inpatient facilities and numbers of staff in post. The system can, therefore, be both inequitable and inefficient. Current system of geographic resource allocation may be an impediment to attaining one of the core objectives of HPSP, namely the improvement of health status of the most vulnerable groups, particularly the poor, women and children. It leads to wide differences in district per capital locations in both the revenue and (Government) development budget. Findings of the study suggests that the allocations have no significant positive relationship to health need and may even be inversely related to general deprivation of the area.

### **Policy relevance –**

Reforming the system of geographic resource allocation could have a profound impact on the effectiveness of resource use. Resources could be utilized more effectively by channeling more resources to needy areas and reducing the incentive to preserve capacity rather than addressing local needs. It would be necessary for the Ministry of Finance to de-link budgetary allocation from the system of line-based norms established for budget allocations.

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## Who Benefits from Public Health Expenditure?

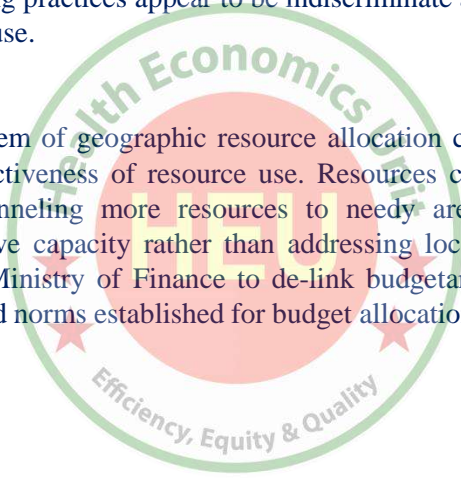
*Published on: March, 2001*

### Summary findings -

The process of accessing care is found both inequitable because the poor appear to wait longer and pay more for service and inefficient because scarce medicines financed by both government and by patients are often distributed indiscriminately and without proper attention paid to their correct use. Benefits to the poorest income quintile (35% of visits) exceed those to the richest (14% of visits) suggesting that attendances at facilities are generally pro-poor. Overall women and girls make use of Upzila and below level facilities accounting for about 54% of visits. Benefits to men and boys (Tk.66/year) exceed those to women and girls (Tk.170/year) by around 10 Taka per capita when reproductive health services are excluded. Fifty-five percent of the total health recurrent budget benefited females. Most user payments for service occur at Upzila level. Medicine prescribing practices appear to be indiscriminate and often not linked to appropriateness of use.

### Policy relevance –

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## Financing the Health and Population Sector – Resource Projections

*Published on: May, 2001*



### Summary findings -

Assuming a worst-case macroeconomic environment, the study finds that the revenue potential from social insurance is slightly higher than with community insurance. In contrast to insurance, the revenue potential of user charges is small, projected to reach 12 crore Taka by 2006/07. In this study, the 'baseline' scenario is a worst case, assuming a continuation of disturbing recent policy trends, and, in particular, continuation of fiscal expansion. In respect of revenue collection, the study assumes that (a) efficiency gains increase the share of tax revenue to GDP to 9.5%; (b) a zero-real growth in the donor budget; (c) donor and government expenditures grows at approximately 6.5% in real terms; and (d) in per capita terms real spending grows by 6 percent per annum. By contrast, the 'adjustment' scenarios based on the assumption that the authorities concerned adopt a comprehensive package of policy reforms. Accordingly,

1. Aggregate economic growth is predicted to accelerate to 7%; and
2. Accompanied by significant growth in trade volume and lower inflation.

The positive scenario is driven primarily by improved tax-collection.

### Policy relevance –

Whilst government and donor funds will continue to dominate the financing of the health sector, alternative sources of funding can, if implemented seriously, comprise 13-20% of total resources. The potential for exploiting high land and property inflation in order to finance the burgeoning needs of urban populations should be considered seriously. This potential area of govt. revenue generation lies with appropriate reform in property tax. Assuming that property is valued at its market value, and the rate of property tax is approximately 1% per annum, the contribution from tax reform may reach approximately 5% of national health expenditure in 2006/07.

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## Funding Health Care in Bangladesh – Assessing the Impact of New and Existing Financing

Published on: May, 2001



### Summary findings -

The financing of health care in Bangladesh is dominated by two main methods : Taxation/Development Partner (DP) funding which is mostly finances the public provider system and *Out of pocket payments* which is predominantly used to purchase pharmaceutical products and diagnostic tests. Social and private insurance and official user charges in public facilities currently comprise a very small proportion of total funding. A key health financing policy consideration is the extent to which alternate sources of funding might be extended in order to channel funding into public services or organized insurance schemes. Medium term projections suggest that, even if new sources of funding are developed, taxation will continue to be the dominant form of funding contributing at least 63 percent of funding, with funding from DPs providing a significant but diminishing share of resources. Of the alternate sources the development of social and, to a lesser extent, community insurance could provide important additional finance. Based on an income related contribution (average premium of 500 Taka per person or around 2,000 – 2,500 taka per household). Social insurance could contribute up to 8 percent additional revenue for the sector. Community insurance, if developed, in key areas such as Thana Functional Improvement Project (TFIPP) upazilas and areas served by NGOs, would extend funding be at least another 4 percent. User charges remain an important way of releasing resources at facility level for consumable items but in total system terms the contribution is likely to be modest.

### Policy relevance –

A pluralist funding system, that relies increasingly on new forms of funding, can be implemented in a way that improves overall equity, provided that attention is paid to exemptions from user charges and subsidized insurance for the poor and most vulnerable. The bulk of funding through insurance and user charges must be used to benefit contributors, mostly the non-poor. There is an important opportunity to use the uncommitted finance to extend risk pooling for catastrophic care to the poor and so lay the ground for a system that can offer something to all parts of society.

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## The Current Costs of Essential Health Services – a Study of Government Facilities

*Published on: June, 2001*

### Summary findings -

There are wide variations in the cost of Essential Services across the country. The study findings suggest that ESP cost per patient is about taka 48 at UHC and slightly higher than taka 43 in UHFWC. With a maximum of taka 112 for the communicable disease control and the lowest (taka 25) for the family planning services at the UHC level. But at the UHFWC, ESP cost per patient is highest for delivering reproductive health care (about taka 70) and cheapest in providing child health care (taka 20). Cost of providing child health care from UHC is the highest (about 40%) among all other components of ESP. Among various sub-components of reproductive health care, maternal health constitutes about 43% of UHC service cost. The average monthly cost of ESP is 18% higher than average in Barisal division and lowest in Rajshahi division. More than 90% of the total ESP cost at UHFWCs is comprised of staff costs and costs of commodities and consumables. Super-overhead cost, a non-ESP cost indirectly and directly related to delivery of ESP, as incurred at the district and central level different agencies, contributes 8% of the total cost for the delivery of ESP issues. Substantial variation exists in productivity between geographic areas.

### Policy relevance –

There appears to be scope for increasing use of services at relatively low additional cost through the use of idle staff time and excess physical capacity. As Government wrestles with the financing of health care, a pragmatic involvement of non-governmental organizations and the private sector in the delivery of services may be beneficial. A greater reliance on the competitive provision of service would likely improve both - the responsiveness of health care systems of their clients and the efficiency with which the facility / provider operates.



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Conducted by – HEU  
Health Economics Unit.

## Projecting the cost of the Essential Service Package

*Published on: June, 2001*



### Summary findings -

The Essential Service Package (ESP) provided mainly through Upzila, union and community health facilities is pivotal to the HPSP strategy. This study tries to project the likely costs of extending the essential service package to the entire rural population based on the previous estimates done by HEU (Research Paper 25). The baseline costs suggest that the average cost of ESP per patient is 74 Taka while the per capita cost (for the rural population) is 68 at Upzila based facilities. For service utilization, the projections also suggest that utilization would need to rise by around 40% overall. The projections indicate that increasing utilization of services to the planned levels would increase the real cost of services by around 45%. This implies a per capita cost of ESP of 171 taka or around 3.3 USD. Per capita national spending of 198 taka (1999/2000 prices) is required to cover the rural population for ESP and 230 taka per capita to finance both urban and rural costs.

### Policy relevance –

It is important to stress that increasing utilization of services is not only a supply side activity. People have to be willing and able to use services. Information and education, as developed through the BCC strategy, is an important dimension of this strategy although there is an inadequate evidence on the success of different approaches. Also important are economic barriers, such as transport cost and lost wages, to users. One way to stimulate demand is to provide some financial subsidy for these costs. Such subsidy, which might be programmed through the Local Level Planning Initiative, has potential to increase access but would add to the cost of the ESP as a whole.

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## HEU Publication Research UHC

### **Tuberculosis and the Poor**

*Published on: June, 2002*

#### **Summary findings -**

As for the utilization of DOTS services by the poor, the study found that a significant majority (70%) of the study patients belong to the poor segments of the population and had income below the area specific poverty lines (of Taka 582 per person per month or Taka 19 per day per person in rural Rangpur and Taka 971 per month or Taka 32 per day per person in urban Chittagong area). In fact, 61% were found to be absolutely poor and had an average income lower than national poverty line of Tk.582 a month. Adding travel expenses, expenses on account of the diets of the patients and expenses of the accompanying persons, the cost of illness increased significantly and was found to be generally of catastrophic dimension. On the average, treatment cost was found to be slightly higher than the patients' monthly income, but almost 50% higher in case of the poor patients. The economic losses suffered by the TB patients were found to be of catastrophic dimensions vary from seven and half times the per capita income in case of the poor patients, and more than twice the per capita income in case of the non-poor patients. The hardship of the patients, particularly the poor patients, were compounded in absence of social safety nets and majority of the patients (72%) were found to adopt coping strategies the impact of which on their livelihood or asset holding was largely negative. In respect to gender inequality with DOTS treatment, accessibility and intra-household expenditure pattern, the study did not find any inequality in DOTS treatment or accessing DOTS treatment regime by the female patients.

#### **Policy relevance –**

A comprehensive awareness building and motivation program is needed to inform the people in general, and potential as well as actual TB patients in particular, about the services being provided under the DOTS TB program. In addition to the motivation and information campaigns, skill development training related to identification and referral of TB cases for the Health Workers may be strengthened so that the workers can identify the potential TB cases at the first instance and make necessary referrals for bringing the patients under the DOTS program. Although the DOTS program envisages providing free services and medicines to the patients, it was found that in some instances the supply of medicines could not be ensured on time. In view of this, it is recommended that the medicine stock at the services canters should be ensured. It is also recommended that the staff be motivated not to exploit the patients. Efforts are to be taken to minimize the number of defaulters/drop-outs. Effective income-generating options should be explored to from social safety nets for the TB infected patients in order to make up their up their household income and asset loss and to arrest the process of pauperization.

**Conducted by – HEU**

Health Economics Unit and Centre for Development Studies



## HEU Publication Research UHC

### Public Health Services Utilization Study

*Published on: November, 2003*

#### Summary findings -

The study found that among the study populations, about a third (33.8%) utilized DHs, almost half (50.8%) visited UHCs, about a tenth (11.9%) visited HFWCs, while only 3.5% went to CCs. Overall utilization was 46% by males and 54% by females. Only at the district hospitals male utilization was found to be higher than that of females (52% vs.48%), while utilization of facilities by females was higher than that of males at Upzila level and below. Male utilization rates are higher than that of females for all age groups except the reproductive age span (15-49 years). Around 65% of the facility users belonged to functionally landless category, of them 7% of the users belonged to households not having even any homestead land. About a third (35%) of the users belonged to the poorest category (with monthly income not exceeding Tk. 2000), while only 9% of the users belonged to the group having monthly income above Tk.7500. Overall, 53% of the patients visited health facilities for LCC services, 18.7% for CH, 7.2% for RH services, 2.5% for CDC, 14% for non-ESP services and 3.1% for “unspecified” diseases (i.e. diseases that were difficult to categories.). Physical accessibility is not a barrier of access to facilities and waiting time is 25 minutes for DHs which goes down to 17 minutes for UHCs, 13 minutes for HFWCs to 7 minutes for CCs. On the average, an outpatient spent Tk.44.78, while in case of inpatients the average amount spent was Tk. 1560.43. The largest proportion of total cost (70%) was spent on drugs for both in-and-out patients. The poorest households had to spend 38% of their monthly income for treatment purposes as against 3% by the richest households.

#### Policy relevance –

Overall, the poor dominate the use of public health facilities, accounting for roughly two-thirds of the total utilization. The findings suggest that public spending on health is pro-poor. The finding clearly showed that out-of-pocket cost have major consequences in the process of seeking care. People from the poorer strata have to undergo a lot of economic pressure to meet the treatment costs. Inadequate supply of medicine and shortage of staff are the main problems. Poverty is one of the significant factors affecting health-seeking behaviour. Insurance scheme to cover the poor/or low-income households who are mostly in the informal or unorganized sector can be devised. Also, even if the government hospitals want to levy user charges, people below a certain income level should be exempt from paying such charges, and this could be achieved through proper targeting. These results along with the earlier BAI findings show that public spending on health is pro-poor and pro-gender, and government health services play a major role in providing critical services, either free or at heavily subsidized prices. The government will have to continue to play a significant role as a service provider, at least in the short to medium term, if basic services for the poor are to be ensured.

**Conducted by – HEU**

Health Economics Unit and Centre for Development Studies

## Cost of Bangladesh Essential Health Service Package: 2016-2022

*Published on: November, 2003*



### Summary findings -

Based on the 2016 data, the estimated total cost of the ESP in the public sector in 2016 was BDT 76,195 million. This higher estimated cost of ESP services in 2016 is due to several factors, including the costing approach used, which involved costing ESP interventions as per current practice, as well as using standard protocols and assumptions for those interventions which were supposed to be available through the ESP but were not found to be fully operational at the time of data collection. The cost of ESP services is expected to increase to BDT 103,194 million in 2022, based on planned increase in service coverage and resources committed for 2017-2022 in Operational Plans, the cost of current and new services, standard protocols and assumptions. The study team calculated an “average cost per beneficiary (or service user)” in 2016 in public facilities as approximately BDT 2349 (29.8 USD)- which would be reduced to BDT 1805 (22.4 USD) in 2022 due to planned increase in coverage and expected efficiency gain through using fixed assets. The study team used the OHT to calculate the unit costs of 132 interventions across 10 delivery channels in the public sector. The public per capita cost for the ESP was BDT 475 (6.1 USD) in the base year 2016, increasing over the target years to BDT 596 (7.4 USD) in 2022. This per capita cost has been estimated for local and international comparison. ESP services at district hospitals and upazila health complexes (UHCs) accounted for the highest proportion of total costs in 2016, a trend that continues from 2016 to 2022.

### Policy relevance –

The results of the study are expected to be used in advocacy for domestic resources required to implement the updated ESP during the target years. These results provide an estimate of the annual investment required for delivering ESP effectively. Policy planners may consider these estimates and use them to advocate for increased funding for health to match the costs. These estimates should be used by policymakers for further development of a feasible and efficient ESP package and for setting target of the coverage through public delivery channels for next sector programme and also to increase fiscal space for health. Future ESP cost estimates should also use standard protocols (normative costs) for all interventions, or WHO guidelines if Bangladesh-specific guidelines are not available, to identify the gap between current practice and protocols, and to provide planners with evidence to advocate for increase funding for the provision of quality ESP services across all relevant delivery channels. As the country moves towards UHC by 2030, future analyses should look at the cost of current and projected coverage of ESP by both public and private sector and cost for service delivery by level of care (primary, secondary and tertiary) . That exercise will help the government to plan and extend ESP coverage by both sector in a coordinated approach.

### Conducted by – HEU

Health Economics Unit , icddr,b and WHO

HEU Publication  
Research  
UHC

## **REVIEW OF NATIONAL AND INTERNATIONAL EXPERIENCES WITH HUMAN RESOURCES INCENTIVE PACKAGEES**

*Published on: February, 2010*

### **Summary findings -**

The study was a literature review. It was part of Study C (Design of Incentives for Health Sector Human Resources) of the project “Review, Analysis and Assessment of Issues Related to Health Care Financing and Health Economics in Bangladesh.



As well as suffering from an absolute shortage of health care providers, almost all the countries in Asia-pacific region, including Bangladesh, are facing the problem of mal-distribution of health workers. After deploying health professionals in remote areas, it is difficult for the government of Bangladesh to retain them there as the health professionals prefer to live in major urban areas. In hard-to-reach areas such as the Chittagong Hill Region and others, it has proven increasingly difficult to attract and retain providers. Comparatively higher wages in the private sector are aggravating the drain of health workforce from public to private sector (MoHFW, 2008). Naomi et al (2007) reported that the newly recruited doctors at Upazila Health Complex (UHC) earn taka 9,000 as compared to taka 25,000 being earned by their classmates who work at Apollo hospital, Dhaka. A doctor in a rural health facility typically has few opportunities to build a private practice- thus they recognize themselves in a doubly disadvantageous position because in Bangladesh, urban areas are more attractive to health care professionals for their comparative social, cultural and professional advantages. In Bangladesh incentives are offered to health care providers who work in the Chittagong Hill Tract (CHT) area. They receive a 33% pay differential and a small transportation allowance

### **Policy relevance –**

Taken together with decades of developed-country studies, some conclusions and recommendations can be made:

1. Attraction and retention are often motivated by incentives separate from those that control performance.
2. Financial incentives for performance are usually quite effective, but often unsustainable in the developing-country context.
3. Non-financial incentives, especially recognition for good performance, has been shown to be both effective and sustainable.
4. Financial incentives for retention have shown mixed results, in terms of effectiveness and (especially) sustainability.
5. The best results for retention and distribution have been obtained through a flexible package of financial and non-financial incentives including housing, education, and transportation allowances.
6. Retention is improved through recruiting locally and limiting hardship postings to a limited time period (e.g., two years).

### **Conducted by – HEU**

Health Economics Unit , gtz, Abt association inc. and RTM international





# Guidelines/ Manuals

## Health Sector Response to Gender Based Violence; Protocol for Health Care Providers

*Published on: 2017*

### Summary findings –

GBV is a severe social and human rights concern affecting virtually all societies. Globally, it is estimated that 35% of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence.

In Bangladesh, almost two thirds (72.6%) of ever married women experienced one or more such forms of violence by their husband at least once in their lifetime, and 54.7% experienced violence during last 12 months. Adolescent boys are also not excluded from experiencing gender based violence. As it is crucial to develop a system to provide emergency services to the survivors of GBV, this protocol for health care providers was first developed in 2006. It has been revised to make further comprehensive, updated and contextually aligned, as per the Gender Equity Strategy 2014 of Ministry of Health and Family Welfare (MoHFW) and the Gender Equity Action Plan 2014 – 2024.

The protocol aimed to provide the healthcare personnel with guideline for achieving comprehensive physical, psychological and social care to survivors enduring gender based violence who resort to a health care center. It also intends to make health care personnel aware of the GBV and its consequences so that they consider it as a serious public health concern.

### Policy relevance –

Gender Based Violence remains a critical barrier towards having a society free from all discrimination regardless of wealth and social status. The government has a strong commitment to stand against all sorts of gender disparity in all aspects.

The GBV protocol has clear directives for providers in health care delivery to prevent violence against women as well as manage GBV survivors. It will enable the providers to maintain strict adherence to this protocol in order to will curb GBV prevalence and improve quality of life for the survivors. I

The GBV services remain a multisectoral response. The protocol has defined a clear directives on synchronization of services across various departments and sectors. This is a crucial guideline for all GBV service providers to know and work in a multisectoral approach.

**Conducted by – GNSPU**

Health Economics Unit.and UNFPA, Bangladesh.



**HEU Publication  
Rese  
GNSPU**

## **Gender Equity Strategy-2014**

*Published on: 2015 (Based on the Gender Equity Strategy 2001)*



### **Summary findings –**

In 2011, the third sector-wide programme, Health, Population and Nutrition Sector Development Programme (HPNSDP) launched for five years (2011-2016). Like the previous sector programmes, the Government has recognized the need to address gender equity issues in HPNSDP and has decided to update the existing Gender Equity Strategy (2001). The MoHFW plays vital role in sustainable development of the country through ensuring quality and equitable health care for all citizens, promoting gender equality.

The strategy was developed create an enabling policy environment nurture an effective health care system that ensures the delivery of equitable and quality health care, preventive, rehabilitative and curative, for all citizens of the country, while promoting gender equality among all sexes

### **Policy relevance –**

GNSPU intends to create an enabling policy environment nurture an effective health care system that ensures the delivery of equitable and quality health care, preventive, rehabilitative and curative, for all citizens of the country, while promoting gender equality among all sexes

With the strategy being in effect, it is expected to improve the health of people of Bangladesh through better utilization of services especially for women, children, adolescent, socially excluded and geographically marginalized population and the poor.

**HEU Publication  
Guidelines/Manuals**

**Conducted by – GNSPU**  
Health Economics Unit



## Gender Equity Action Plan

*Published on: 2018*

### Summary findings –

Realizing the importance of gender in determining to health and nutritional status of the population and the effectiveness of the health care delivery system, the Government of Bangladesh has been trying to integrate the issues within its health, population, and nutrition sector program.

To address the gender related issues in HPN sector and to capture the policy priorities of gender in health, MoHFW has developed Gender Equity Strategy 2014 based on the experience of the implementation of the Gender Equity Strategy 2011. The goal of the GES 2014 is “to improve the health of the people of Bangladesh through better utilization of services especially for women, children, adolescents, and marginalized population and the poor”. This has six strategic objectives and each objective has one or more than one intermediate objectives. To achieve these objectives, Gender Equity Action Plan (2014-2024) has been developed.

### Policy relevance –

In order to attain the objectives set forth in GES 2014, the GEAP has been developed. It is further meant to serve both as guiding document as well as navigating tool.

The activities of Action Plan are phased with timeline: a) Short term (2017-2020); b) Midterm (2020-2022) and c) Long-term (2022-2024).The development of the Action Plan followed a multi-staged process including included: formation of a committee comprising 20 representatives<sup>2</sup> from relevant ministries, different Operational Plans, different departments, NGOs, academics, and development partners.

## HEU Publication Guidelines/Manuals

**Conducted by – GNSPU**  
Health Economics Unit

## Health Care Financing Strategy: 2012-2032

*Published on: September, 2012*



### Summary findings -

The Health Care Financing Strategy 2012-2032 provides a framework for developing and advancing health financing in Bangladesh. The strategy is aligned with the vision of the Health, Population and Nutrition Sector.

The challenges posed by health financing in Bangladesh are many and can be summarized under three broad categories. These are:

- inadequate health financing;
- inequity in health financing and utilization; and
- Inefficient use of existing resources.

The strategy recognizes the importance of other building blocks of the health system; however, discussions on those and their impact on this strategy have been beyond the scope of this document. This strategy document has been developed through a participatory process, led by the Health Financing Resource Task Group with the Senior Secretary of the Ministry of Health & Family Welfare (MoHFW) in the chair. Thematic papers on the financing challenges were drafted by technical working groups with representatives from the academia, research organizations, NGOs and public sector; integrating the thematic papers, a preliminary draft was shared with representatives of stakeholders in regional consultation workshops. A national consultation with the principal stakeholders on the redrafted document was held to arrive at the final draft.

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

The strategy will be implemented in three phases, - short, medium and long. The short term one will be up to the end of HPNSDP; in that phase SSK pilot rolls out, and NHSO and other key elements of the social health protection scheme will be designed. The medium term will be up to 2021 when the activities launched during the preceding phase (SSK, NHSO and social health protection programs) will be appropriately scaled up. In the long term, the next 11 years, Bangladesh will move ahead to achieving universal health coverage building upon the achievements of the short and medium terms of sequenced implementation of the strategic interventions proposed here.

The HCFS is comprehensive in its inclusion of a logical framework and a set of indicators. This analytical framework will make it easy for all stakeholders to assess the on-going and proposed interventions in the light of the defined objectives of this strategy.

This Strategy points the way to the long-term objective of universal coverage. What is important is to begin and take active steps to protect All citizen of Bangladesh from the financial risk of seeking or obtaining care.

**Conducted by – HEU**  
Health Economics Unit

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**UHC**

# Implementation Plan of priority action for the Health Care Financing Strategy, 2012-2032

*Published on: December, 2013*



## Summary findings -

The Government of Bangladesh adopted a Health Care Financing Strategy (HCFS) that aspires for the universal coverage of all Bangladeshis by the year 2032. The strategy responds to the increasing demand for complex and expensive health care brought about by rising household income and an ageing population. The strategy provides for the introduction and implementation of eight comprehensive policy actions. The eight policy actions are expected to drive the establishment of a social health protection system with giving priority to the poor and vulnerable followed by the coverage of each and every citizen of Bangladesh.

In order to facilitate the implementation of the 8 proposed policy reforms and the strategy in general, they can be grouped into three sets of policy reforms as follows:

1. Design & implement Social Health Protection Scheme
2. Strengthen financing and provision of public health care services
3. Strengthen national capacity

A discussion note was prepared to raise and tackle issues in the HCFS. The discussion note generated consensus that increased funding for health should not be limited to increasing the health budget but should include work on generating efficiency gains such as closer linkage between government planning, budgeting and expenditures for health. Other efficiency gains measures are increased efficiency in the procurement, distribution and utilization of medicines and medical equipment; and improved performance delivered by government health workers.

With regards to new financing sources, this could include earmarked taxes and fees and innovative ways to mobilize money from formal sector and migrant workers such as a “percentage fee for the health protection fund” from export earnings and remittances from overseas Bangladeshi workers. The discussions confirmed the need for an autonomous government agency to drive the implementation of the HCFS. It acknowledged that although there was no explicit benefit package written up in the strategy, this should be determined and agreed soonest. Finally, questions on political will and implementation capacity should be immediately addressed. This implementation plan of priority action is from January 2014 to June 2016. First period is January 2014 to June 2014, then according to the financial year till the end of present sector program HPNSDP. Some activities are costed till 2021 and gradually HCFS implementation plan will be revisited for 2032.

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**Conducted by – HEU**  
Health Economics Unit and WHO.

# Communication Strategy for Universal Health Coverage (UHC) in Bangladesh (Draft)

*Published on: Yet to Publish*



## Summary findings -

Understanding about UHC among potential stakeholders and common citizen is required, which need extensive advocacy and communication intervention. Health Economics Unit (HEU) of the Health Services Division of the Ministry of Health and Family Welfare (MoHFW) developed an UHC Communication Strategy for the period of 2015-16. But this strategy needs to be revised to address the growing requirement of moving towards achieving UHC by 2030. As such, the HEU initiated to revise the strategy with technical support from the World Health Organization (WHO). The main purpose of recasting the strategy is to make it more action oriented by incorporating the UHC related latest developments along with ensuring concerted efforts from all relevant stakeholders. Re-enforcement of UHC messages among all level of stakeholders is imperative for promoting UHC in a sustainable manner. Series of communication intervention including interactive communication using behavioral change communication and social change communication, media advocacy and communication, social mobilization etc. should be implemented in a planned manner. A comprehensive and strategic UHC Communication Strategy is essential to implement all these advocacy and communication activities.

The communication strategy is guided by the plans of the Government of Bangladesh to achieve Universal Health Coverage (UHC) by 2032. The Health Economics Unit (HEU) of the Ministry of Health & Family Welfare (MoHFW) will play the central role in the implementation of this strategy, given their knowledge of the ground realities, and expertise in research activities. This is an evolving document designed to adapt to the changing organizational and communications needs. The communication strategy has been designed to increase awareness on the significance of UHC and mobilizing support for the implementation of the Health Care Financing Strategy (HCFS). The Social Ecological Model (SEM) has been taken under consideration as the theoretical framework during developing the Communication Strategy to address all communication needs starting from behavioral change communication to advocacy. The core messages have been formulated in clear, logical and easy to understand language. In addition, a section has been added which deals with common misperceptions on universal health coverage, i.e. What UHC is – and What UHC is not. Communication intervention will be monitored in every phase periodically to measure the progress and necessary adjustment will be made based on the monitoring findings. Specific indicators will be developed for conducting monitoring. The lessons learned of communication intervention will be captured to generate evidence-based results. The findings of monitoring and evaluation of communication strategy will be used to conduct strategic planning; promptly identify problems; appropriately allocate resources; and improve program quality, efficiency and effectiveness.

**Conducted by – HEU**

Health Economics Unit and WHO

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## Health Protection Act (Draft 2015)

*Published on: 2015*

### Summary findings -

There are some interventions stated in Health Care Financing Strategy related to the introduction of new financing mechanism that will require a legal basis. Therefore, MoHFW has drafted a social Health Protection Act to provide a legal framework to its UHC targets. This draft law has taken into account the country context, overall health care delivery goals, Health Financing Strategy and some elements of international experience. The objectives of the Act are to- (a) provide all citizens of Bangladesh standard, affordable, equitable and quality health services, (b) ensure mechanism for access to such health services and (c) fix up standards of health services to be so provided and to ensure mechanism for maintaining such standards. There are 10 chapters in the draft Act covering the area of National Health Protection Authority, Accreditation Committee, National Health Protection Fund, Financing, Health Services and Providers, Cardholders and Beneficiaries, Grievance Forum, Offences etc.



**HEU Publication  
Guidelines/Manuals  
UHC**

**Conducted by – SSK Cell**  
Health Economics Unit.





## SSK Clinical Management Protocols

*Published on: 2015*

### Summary findings –

The piloting of SSK required standardization of clinical protocols and therapeutic guidelines to support consistent decision-making processes in quality patient care which should be available with the users.

The general objective is to prepare recommendations for developing and producing standard treatment guidelines for the SSK Benefit Package (SBP) to assist providers in diagnosing and treating medical conditions and contribute to the improvement of service delivery at all levels.



**HEU Publication  
Guidelines/Manuals  
SSK**

**Conducted by – SSK Cell**

Health Economics Unit, GFA Consulting Group GmbH, Germany.



## HEU Publication Guidelines/Manuals QIS

### **National healthcare standard**

*Published on: 2015*

#### **Summary findings –**

National healthcare standard indicates the tier-wise expected standards of care in the health system of Bangladesh. Grossly healthcare in Bangladesh are being given in three tiers: Primary, Secondary and Tertiary. National healthcare standards are therefore created as a statement of what is expected to deliver in different level of facilities. The service must be safe and to be given respectfully. Through a national process of certification, it will formally assess each health establishment for compliance against these National health care Standards. Where health establishments meet the standards, a process of continuous improvement will be encouraged to further enhance outcomes for patients. And for those not up to standard, the relevant governance structures and managers will be expected to make improvements in service delivery.

These healthcare standards developed to measure compliance by the facilities. It is a kind of mechanism to push towards improvement. It is assumed that the push may give rise awareness among healthcare managers and service providers about what they should perform else they may face progressive punitive measures.

The National Core Standards have been based on the existing policy environment and tailored to the health care context. It also reflects international best practice and a strong evidence base. However, the critical challenge is to implement improvements at scale on the ground- to bridge the policy implementation gap. This gap is being addressed through a tool for managers, which makes clear what is expected of them both in terms of the systems and the outputs that should be delivered.

The document has five parts or chapters. The chapters contain a) Management standards, b) Service delivery standards, c) Support service standards, d) Infection control, hygiene & waste management standards and e) Safe and appropriate environmental standards. The main goal of the document is to develop core national standards and the tools for their assessment in health establishments.

#### **Policy relevance –**

Service delivery standards are a generic and strategic approach to verifying what services are available and being delivered against the Healthcare Quality ambitions. This can be used adequately in planning, management and monitoring of health services.

**Conducted by – QIS**  
Health Economics Unit.

## Training of trainer's TOT manual on MPDSR

*Published on: 2016*

### Summary findings -

Bangladesh has made encouraging progress in reducing maternal and neonatal mortality over the past two decades. The country was among the top seven countries around the world, which successfully followed the road map to achieve Millennium Developmental Goal (MDG) 4 and 5 by 2015. The Sustainable Developmental Goal (SDG) has set to reach by 2030, in where the new goal has set to reduce maternal mortality 70/100,000 live births and neonatal mortality 12 or below/1000 live births by 2030. To reduce the maternal and neonatal mortality, Bangladesh has been experienced to introduce Maternal and Perinatal Death Review (MPDR) in 2010 in one district of Bangladesh and gradually scaled up in 14 districts over last six years of period. The Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP), under the Ministry of Health and Family Welfare (MoHFW), had been working together to implement the MPDR system. In 2016, the country has shifted from MPDR to Maternal Perinatal Death Surveillance and Response (MPDSR) which aligned with the global Maternal Death Surveillance and Response (MDSR) developed by World Health Organization (WHO).

The aim of this Training of Trainers (TOT) Manual is to guide the training sessions methodically. To train all the workforces related to performing maternal and neonatal death review and reduction, we need to prepare a sufficient number of trainers throughout the country.

This TOT manual has seven sections for seven sessions. The first session introduced the methods of MPDSR, the second session discussed on Community death notification, the third session tells about the verbal autopsy, the fourth session focused on social autopsy, the fifth session reflected on facility death review, the sixth session talked over data entry, analysis & reporting and finally the seventh session considered mainly monitoring and evaluation.

### Policy relevance –

The national guideline on MPDSR has been approved by the (MoHFW) to implement all over the country. The government starts a national scale-up to establish a surveillance and response system to address maternal and newborn deaths. The review finding will be pivotal to mitigate social, geographical, cultural and other unknown reasons. Moreover, the results will help develop local and national policy planning.

**Conducted by – QIS  
Health Economics Unit**



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## PDCA manual for quality improvement

*Published on: 2017*

### Summary findings –

PDCA stands for Plan-Do-Check-Act. It is the basic tool for continuous quality improvement and monitor the quality of services at healthcare settings. PDCA is sometimes called the Kaizen process. PDCA is an evidence-based participatory problem solving approach by the frontline workers (with the support from the management) for continuous but incremental improvement of quality of services. PDCA approach is being used in the developed and developing countries, and is recommended by WHO.

The QIS has developed the PDCA Manual for quality improvement of hospital services in 2017 with the technical support from USAID's MaMoni Maternal and Neonatal Care Strengthening Project. It is designed for the hospital managers, trainers, Hospital Quality Improvement and Work Improvement Team (WIT) members. This manual describes the PDCA cycle, step-by-step, in a simple and understandable manner. Each step of the PDCA is described with examples, which makes the manual user friendly. The manual also provided the necessary tools and checklists for facility assessment and monitoring. So far a number of PDCA trainings have been completed for the hospital staff. Continuous support and monitoring are the keys for successful implementation of PDCA at the health facilities.

### Policy relevance –

The government has adopted the 5S-CQI-TQM as the strategy for quality improvement of hospital services. This approach is suitable for the countries with limited resources. It is a 3 step process beginning with 5S. PDCA is the tool for CQI (continuous quality improvement) and is evidence-based. To further improve the quality of services and achieve the targets of the current sector program, PDCA needs to be practiced at all the healthcare settings.



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**Conducted by – QIS  
Health Economics Unit**

## Hospital infection prevention and control manual

*Published on: 2019*

### Summary findings –

The hospital acquired infections (HAI), also called nosocomial infections, are infections that patients acquire during the course of receiving treatment from the health facilities. HAIs are a cause of significant morbidity and mortality in patients receiving healthcare both in developing and developed countries. However, HAIs are preventable through implementation of Infection Prevention and Control (IPC) practices. Infection prevention and control refers to measures aimed at preventing and controlling infections and transmission of infections in healthcare settings.

Prevention of HAI is an issue of patient safety. The overall aim of the IPC program is to ensure a safe hospital environment for both the patients and care providers by preventing and controlling infections. The hospital infection prevention and control manual, developed by QIS, is a comprehensive guide to the health managers and providers for the prevention of HAIs. The manual is developed based on the best available current evidences and is built on existing international guidelines and reviews, as well as systematic review of the evidences.

The manual consists of 10 chapters that includes IPC management structure, transmission cycle, standard precautions, decontamination, biosafety, housekeeping, hospital waste management and monitoring. Effective implementation and practice of the guidelines provided in the manual by the healthcare providers would substantially reduce the HAIs in the country.

### Policy relevance –

Government of Bangladesh is committed to achieve the Universal Health Coverage (UHC) by 2030. Ensuring quality of healthcare services is an important strategy to achieve the UHC. Among the domains of quality of care, infection prevention is an important issue of patient safety that has to be followed to improve the quality of services. Current COVID-19 pandemic is live example to demonstrate the importance of IPC in healthcare and other settings.

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## PDCA manual for quality improvement

*Published on: 2017*

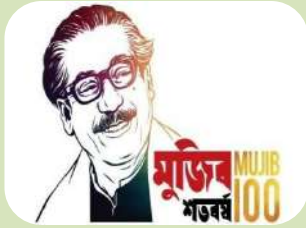
### Summary findings –

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**Conducted by – QIS  
Health Economics Unit**

## RMNCAH QI Framework

*Published on: 2019*

### Summary findings –

The Government of Bangladesh is committed to improve the quality of health services through strengthening the health system and effective utilization of available resources. One of the priority areas of the current sector program is reproductive, maternal, neonatal, child and adolescent health (RMNCAH). The development of the national RMNCAH QI Framework is an initiative of the Quality Improvement Secretariat with the technical support from the development partners.

The RMNCAH QI framework is linked with WHO's Regional Framework that proposes a QI system across the maternal, neonatal, child and adolescent health continuum and all levels of care. This document is developed based on the guiding principles of respecting human and reproductive health rights, promoting equity and gender equality, ensuring a responsive health system to client needs, and leadership and ownership at all levels. This document focuses on 2 important areas of quality of RMNCAH services, such as provision of care and experience of care. A number of quality standards and indicators have been included in the framework including the data requirements to measure the indicators. This document is useful for the policy makers, managers, and providers to understand the quality standards and their measurements for monitoring progress.

### Policy relevance –

This document provides a clear guideline to measure the quality of RMNCAH services. This document is aimed at the policy makers, managers and service providers to measure the facility level quality indicators and monitor the progress. Based on the indicators, the policy makers and managers can take evidence-based policy decisions to further improve the quality of services and achieve the SDG targets.

**Conducted by – QIS  
Health Economics Unit**



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## Training module of TQM

*Published on: 2019*

### Summary findings –

5S-CQI-TQM, a Japanese management technique, is the strategy of QIS to improve the quality of services. It is the management technique suitable for the countries with resource constraints. It uses the available resources for improvement of quality of services. It is a 3-step process beginning with 5S. 5S is said to be the gateway for quality improvement. 5S comprised of five words beginning with S – Sort, Set, Shine, Standardize and Sustain. Primary objective of 5S is to improve the working environment and transform positive mindset of the staff.

5S is simple and easy to understand by the staff. To implement 5S at the health facilities, QIS has developed the Training Module of TQM. The training module describes the step-by-step process (advocacy, facility assessment, staff orientation on 5S, and quarterly and annual reviews, etc.) of 5S implementation at the health facilities. This document also includes the checklists for facility assessment and monitoring. Currently, this module is being used for introduction of 5S at the health facilities including staff orientation.

### Policy relevance –

This document is directly linked with the current government policy for improvement of quality of services. This is a useful guideline for introduction of 5S at the health facilities and be used by the health care providers and managers.



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## National patient safety plan in Bangladesh

*Published on: 2019*

### Summary findings –

“Do no harm” principle remains central to the provision of high-quality health care. Patient safety can be defined as the freedom of patients from avoidable and unnecessary harm or potential harm associated with health care. Patient safety is also a right, securing patients a state of freedom from accidental or preventable injuries in medical care.

Medical errors can occur during various modalities of procedures, diagnosis, treatment and follow-up. Health care today is becoming increasingly complex and may include an array of complex procedures and processes, thereby increasing the probability of error. Protecting such errors require establishing systems that minimize the likelihood of errors while maximizing the likelihood of intercepting them. Although errors are unlikely to be completely eliminated, harm and impact to patients can be minimized.

Very little information is known regarding harms that happen to patients in developing countries. So the first step towards improvement is to understand the magnitude of the problem and the underlying factors. The main aim of this manual is to prevent all avoidable deaths and harm to patients.

The Quality Improvement Secretariat (QIS) of Ministry of Health and Family Welfare mandated to take the key responsibility to establish patient safety environment at the health facilities. Since the country does not have any structured model for patient safety, the QIS has taken the lead to develop the national strategic plan for patient safety.

The manual is composed of four chapters. Chapter one mentioned about objectives, Chapter two discussed subject matters, Chapter three tells about approaches, and finally, Chapter four described Domains of patient safety. This manual is developed with the financial and technical assistance of USAID's Ma Moni Health Systems Strengthening Project.

### Policy relevance –

This strategic plan will guide to introduce a wide range of actions in performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, blood safety, safe clinical practices and providing a safe environment of care.

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## **Standard Operating Procedure (SOP)**

*Published on: 2019*

### **Summary findings –**

A standard operating procedure (SOP) is a set of step-by-step instructions compiled by an organization to help service providers carry out complex hospital routine operations. SOPs aim to achieve efficiency, quality output and uniformity of performance, while reducing miscommunication and failure to comply with health service standard and clinical Quality.

Many hospitals are currently providing quality clinical services, which is a new intervention in the practice of health service delivery in the country. However, the services are not being provided in a standardized and uniform manner. Therefore, this standard operating procedure (SOP) manual has been developed to standardize and formalize the provision of Quality clinical services in the health service delivery. SOPs on how to provide clinical services for OPD, IPD, Emergency etc and to document and report the services provided are addressed in this manual. It is a written procedure prescribed for repetitive use as a practice.

### **Policy relevance –**

This SOP describes specific step by step procedures in clinical management like OPD, IPD Housekeeping, Emergency services, OT services, radiology services & pathology services. Finally the SOPs will ensure that standardized Quality clinical services are provided in all health facilities and at all times, Clarify roles and responsibilities of the service providers for clinical care, providers detailed description of how to perform clinical activities.

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## National Anti-Microbial Stewardship Quality Improvement (QI) Framework

*Published on: 2019*

### Summary findings –

Antimicrobial resistance (AMR) is a global public health concern. It occurs when microorganisms such as bacteria, viruses, fungi and parasites change in ways that render the medications used to cure the infections they cause ineffective. Antimicrobial stewardship is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance and decreases the spread of infections caused by multidrug-resistant organism in the facility level.

The overall aim of the AMS QI framework is to ensure patient safety by development of a QI monitoring and surveillance system that captures the emergence of resistance, trends in its spread and utilization of antimicrobial agents, to promote safe, appropriate and rational use of antimicrobial agents, to initiate the infection control measures to reduce the disease burden, to improve patient outcomes (e.g. reduce morbidity and mortality from infection), to limit the unintended consequences such as emergence of AMR and adverse drug events and to reduce healthcare cost without adversely impacting quality of care.

This document mainly focuses on facility level initiative to prevent antibiotics resistance and ensure Quality of Care and at the same time AMS activities will be abroad. It will also help to develop the culture of good and rational use of antibiotics in the facility level. This document consists of five parts that include National Anti-Microbial Stewardship QI framework initiative, Clinical standards of QI frameworks, AMS QI framework implementation Plan, roles and responsibilities and monitoring and evaluation.

### Policy relevance –

To achieve Sustainable development goal (SDG) 3 to "ensure healthy lives and promote well-being to all at all ages, we need to address a critical issue: The quality of health Care. MoHFW has duly emphasized the quality issue and Created Quality Improvement secretariat (QIS) in MoHFW is relentlessly trying to develop guidelines, protocols, frameworks etc to ensure expected actions by health providers of all level both in Govt. & private sector. Ant-microbial stewardship (AMS) framework is one of its appreciable endeavors. His framework presents principles that are developed to provide a coordinated approach to the prevention of the inappropriate use of antimicrobials. The principles are based on the best available current evidence and built on existing international guidelines and reviews, as well as systematic reviews of the evidence. Hope the AMS framework will have a great impact on preventing the indiscriminate use of antimicrobials in Bangladesh.

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## Total Quality Management (TQM) (5S guideline)

*Published on: 2019*

### Summary findings –

Quality of care is an integral part of Universal Health Coverage. A systematic ongoing process for ensuring and improving quality is an essential component of an effective, efficient and responsive health care system. Quality Improvement Secretariat (QIS) of MoHFW has started its journey to assist in achieving the objectives of Universal Health Coverage of Quality Healthcare. As part of its efforts, QIS has developed the National QI framework for ensuring the quality of care across the country. It has taken 5S-CQI-TQM approach for quality improvement.

The overall aim of TQM guideline is to improve work environment, build positive attitude and make leadership by utilizing limited resources in the hospitals. 5S-CQI-TQM is a worldwide recognized and famous approach for quality healthcare. At the beginning, it improves the work environment and then improves the total quality of Healthcare step by step.

For standard health care services TQM is a trusted management protocol for showcasing healthcare with quality in all tiers of health care facilities step by step. The steps are 5S-CQI-TQM. The text in this document is divided in two parts. In part-1—the idea of TQM with its component, the challenges of management of human resource & service protocol is narrated with steps of 5S-CQI-TQM. In the second part- here the tools of 5S and its monitoring & evaluation with implementation is described. The document successfully concluded with opportunity of capacity building of health care provider in the context of Bangladesh.

### Policy relevance –

Government of Bangladesh is committed to achieve the Universal Health Coverage (UHC) by 2030. Ensuring quality of healthcare services is an important strategy to achieve the UHC. Among the domains of quality of care, 5S-CQI-TQM is an important approach that has to be followed to improve the quality of services. 5S-CQI-TQM is a worldwide recognized and famous approach for quality healthcare. At the beginning, it improves the work environment and then improves the total quality of Healthcare step by step.

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## National ICU QI framework

*Published on: 2019*

### Summary findings –

An Intensive Care Unit (ICU), also known as an intensive therapy unit or Intensive Treatment Unit (ITU) or Critical Care Unit (CCU), is a special department of a hospital or healthcare facility that provides intensive treatment medicine. They are staffed by highly trained doctors and nurses who are specialized in caring for critically ill patients. In 1980, the first ICU in Bangladesh was established in NICVD. Thereafter, ICUs have been opened in many Govt. and private hospitals which are being unregulated, established without following standardized requirements and not being monitored.

Quality Improvement Secretariat has developed Quality Improvement framework for Intensive Care Unit (ICU) to outline the standards and requirements of ICU in different levels and to specify its functions, roles and responsibilities. With the rapid development of ICUs both in Govt. and private hospitals without following a defined structure and processes including levels and types have been created messy situation where this framework is a good solution. QIS has taken a great initiative for development of ICU QI framework which will help to ensure quality of care in ICU.

For standard Intensive care services, ICU QI framework is a pragmatic protocol for showcasing healthcare with quality in all tiers of health care facilities step by step. This document consists of five parts that include introduction and background, objectives, organizational policy, structure (ICU design/environmental requirements/lighting/light for procedure/light required for patient care/ noise control/furniture/ floor/walls/ceiling/storage/central nursing station /consultation room/waste disposal/hand hygiene /IPC/ Disaster preparedness /needs for doctors and nurses /HDU), waiting areas for ICU visitors, facilities, Human Resources (HR), dress code and quality indicators.

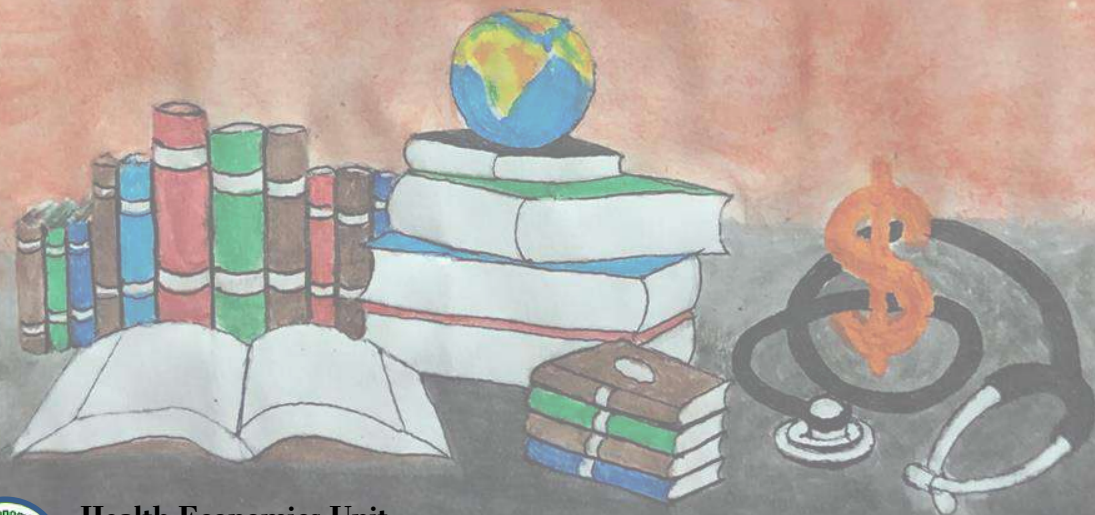
### Policy relevance –

Would like to thank QIS and all the specialists & experts who had been involved in developing this very important document. The document has clearly classified, categorized and specified the requirements of ICU. It is thus removed all the ambiguities making the ICU concept and structure understandable and Useful for assessment & monitoring. This sort of document on ICU was a long-required instrument which will have a great impact on improving the care of seriously ill patients. Hope this work will remain as a great landmark in quality improvement of critical care in Bangladesh.

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