Decisions on the allocation of scarce resources for health are rarely made by governments - or their development partners - purely on the basis of technical criteria. Political and other factors also shape the choices made. This is particularly apparent in Bangladesh, a country with bipartisan political support for reproductive, maternal, newborn and child health (RMNCH), but where this support is not been reflected in budget allocations. Non-government organisations (NGOs), often supported by development partners, have filled much of the service delivery space.

**Strategic context**

Bangladesh has made some remarkable achievements in RMNCH. Its maternal mortality ratio declined from 550 per 100,000 live births in 1990, to 170 in 2013 (1). Significantly, the reductions occurred across all wealth quintiles, in nearly all regions and for all the major causes of maternal death. The total fertility rate also fell from 6.3 per woman in the early 1970s to 2.5 in 2010 (2). The availability of family planning technologies, expansion of girls’ education and increased opportunities for women to work, especially in the garment industry, contributed to the preference for a smaller family.

Bangladesh has also reduced under-five mortality, including a reduction in child deaths from pneumonia, by a remarkable 80% over the period 1990 to 2013. UNICEF estimates that Bangladesh has had the largest percentage decline in child mortality of any high burden country (3).

But Bangladesh faces important challenges. Four non-communicable diseases (NCDs) are now in the top ten causes of premature years of lives lost, up from only two in 1990 (4). At the same time communicable, maternal, perinatal and nutritional conditions still account for 38% of all deaths (5). Up to 46% of children in Bangladesh are stunted, the highest rate among all low income countries, including those in sub-Saharan Africa (6).

**Key messages**

Much of Bangladesh’s substantial success in improving RMNCH outcomes can be explained by a collaborative effort between government and NGOs. Health outcomes improved through an expansion of government facilities and evidence-based programs such as immunisation; a particularly strong and outcomes-oriented NGO sector focused on health; and

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1 Chronic obstructive pulmonary disease is now ranked fifth; ischemic heart disease seventh, chronic kidney disease ninth and cirrhosis tenth.
improvements outside of the health sector such as improved female education, transport and communications (allowing more medical referrals to occur) and poverty reduction.

But Government needs to increase the level of public expenditure on health in absolute and relative terms if it is to achieve universal health coverage (UHC). Bangladesh spends less on health from all sources than the average for other low income countries globally, or other South Asian countries. Total health expenditure (THE) per capita was just $26 in 2012, below the $30 average for low income countries (7). Moreover, Bangladesh has consistently had the lowest rate of growth of health expenditure. THE in 2012 was just 3.5% of GDP, lower than the global average of 5.3% for low income countries and the 6.4% average for developing countries in sub-Saharan Africa (7). Importantly public expenditure on health was just 1.2% of GDP in 2012. This compares with the WHO finding that UHC “usually is attained in countries in which public financing of health is around 5% of gross domestic product” (8), a figure also recommended in a recent Chatham House report on health financing (9). Increases in THE in Bangladesh are driven mostly by households’ direct out of pocket expenditure (supported by a high level of international remittances), a barrier to essential care for the poor and a source of inequity for others.

Increasing public expenditure on health is a necessary but insufficient condition for improving health outcomes. Government also needs to significantly reform the process of planning and allocating resources. At present, health planning and resource allocation is an unusual mix. It is highly centralised in Dhaka while at the same time fragmented across two budgets and at least 32 different Operational Plans, with little or no flexibility to reallocate resources according to changing priorities. Despite trends in other countries in Asia there is little real effort - or incentive - to decentralise decision making in Bangladesh, perhaps a reflection of the densely populated, homogenous society and the de facto decentralisation operating through NGOs. There is a precedent for effective local government engagement: with World Bank support, the Bangladesh Ministry of Local Government has implemented a large-scale, innovative, pilot of performance based decentralised decision making and planning that extends down to the local village level.

Only 1% of Bangladesh’s population was covered by any form of health insurance in 2012, so its goals for achieving UHC by 2032 are extremely ambitious. They will require heavy investment in related policy, stronger regulation and better management, more public-sector health workers and supplies to meet increased demand, and new services designed to meet clinical challenges in NCDs and newborn health, and the public health challenge of undernutrition. Scaling up UHC also requires a strong and sustainable financing platform to collect, and pool premiums. That will be particularly challenging in Bangladesh when its own Health Economics Unit advises that among a population of around 156 million, 85.7 million work in the informal sector, 48 million are below the official poverty line, and only 18.8 million people work in the formal sector. Ensuring that payment systems align health worker incentives with public health objectives will also be challenging for UHC.

Development partners working in Bangladesh will need to engage more strategically if they are to support outcomes that are equitable, effective and truly sustainable. They need to be aware of the limitations in capacities – and incentives – that operate in both the public and private spheres. There are significant gaps and weaknesses in public financial management, and the quality of health service delivery in both the public and private for profit sectors. The NGO sector largely supports community-based preventive health. An effective and acceptable combination may involve strengthening government processes and systems (as UNICEF has been attempting with its investment case work), regulation, evidence-generation and the quality and use of locally owned data sources; engagement of the population and civil society in health program planning and performance appraisal; and using NGOs as implementing partners at both community level and, increasingly, in inpatient clinical care. This might require NGOs to participate as partners in any social health insurance schemes and develop technical and managerial skills to implement hospital-based care and address the rising health and financial burdens imposed by NCDs. The alternative is persistently under-funded and weak public health services and unregulated private services, funded mostly by fees for services paid out-of-pocket and unavailable to the poor. This leaves Bangladesh at risk of reversing its strong record of generally equitable progress in public health and RMNCH.

References