

# **Pre-budget 2007-08 Sessions Report**

## ***Stakeholders' Views from Six Selected Upazilas of Bangladesh***

### **Participants**

NGOs, Govt. official, local govt. representative, Journalist, Businessman, Local civil society, Social worker, Teacher, Student, Service recipients, health service providers

### **Prepared by**

Development Organization of the Poor (DORP)  
Bangladesh

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<b>Findings &amp; Recommendations At a Glance</b>	<i>sub-district</i>
A budget should be allocated in the name of Emergency Fund, which will be maintained by THFPO for emergency local expenditure. At the same time the authority of budget utilization should be given to the THFPO	CSC, Bakerganj
Upazila & Union health committee needs to be activated and organize meeting regularly.	Shadullapur, Gaibandha
Health budget should be declared in open forum by THFPO for the better understanding of the service recipients.	Dishari, Kaliakair
Demand side financing project should be strengthening in line with its Budget allocation at Upazila level to reduce Maternal and Child Mortality.	Dishari, Kaliakair
Tk. 45/patient/day for food allocation is not enough at present market price situation. budget should be allocated in line with Market price.	SF, Sreemongal
Availability of expired medicines in many Health Complexes encourages patients to buy medicine from outside, which increases the out-of-pocket expenditure. Same time it is long term health hazard for patients. Need a time oriented budget disbursement for better medicines available at upazila level.	SF, Sreemongal
Concern ministry could play a vital role to implement the Local Level Planning (LLP) policy to formulate the health budget at upazila level.	Shabolombi, Narail Sadar
Government circular is needed to make accountable to the health and Family Planning field worker to the Upazila and union level health committee for their better performance.	Shabolombi, Narail Sadar
Health, Nutrition, Population Sector Program (HNPS) is an excellent initiative of the government, but little attention is paid to make it operationalise at Upazila Health Complex and Union Centers	USAP, Ramgati
Field level Family Planning personnel do not get necessary TA, DA for field visit, therefore necessary budget utilisation is essential for this purpose.	USAP, Ramgati
The concern authority of the government should regulate Doctor's private practice and medical representative movement needs to be reduced in health complex.	Dishari Kaliakoir

## 1. Introduction

Improving access to basic health - both treatment and prevention - is a critical part of interrupting the poverty cycle. This premise is acknowledged by the international community and enshrined in the Millennium Development Goals (MDGs). Yet, in spite of considerable political commitment, financial investment and emphasis on good governance, the range and quality of health services available to those living in improvised and remote communities remains generally inadequate.

During recent years, identifying ways to improve access to healthcare services has received renewed attention in the light of the MDGs. It is widely recognized that access is not just about the physical availability and affordability of services. It also depends on factors such as the cultural and social acceptability of the services offered, beliefs about health and illness, social support networks facilitating use of services and the interactions between providers and patients.

In most of the developing countries, people living in poverty not only lack resources but also the information and political connections needed to ensure that health systems respond to their needs. It is often the poorest people whose rights disappear in the gap between theory and practice in a health system. While a health service might be designed to be delivered free of charge in order to make it theoretically available to all, for example, the reality might be somewhat different for the person actually trying to access that service.

Lack of access to appropriate affordable and quality healthcare is both a driver of poverty and a consequence of it. Ongoing poor health and vulnerability to disease undermine a person's ability to sustain a livelihood, to care for them and to care for others. As a result, there is a greater risk that people will fall into long-term poverty and that their children will inherit that legacy. Income poverty and exclusion from social and political networks often combine to prevent people from accessing even limited services. Efforts to improve access have tended to focus on funding and promoting good governance. The human factor is often overlooked. Thus, a pluralistic approach, combining policy, practice and human factors (both providers and beneficiaries) together has progressively been getting attention from the relevant actors in order to improve the healthcare system in developing countries. This paper starts with a brief overview of the macro scenario of the healthcare system of Bangladesh and then deals primarily with a synthesis of pre-budget recommendations of various stakeholders aiming at approaching the relevant policy makers to get these considered during the forthcoming (2007-2008) national budget.

## 2. Health Care System in Bangladesh: Macro Scenario

### 2.1 Background

Bangladesh is a signatory to the historic Alma Ata Declaration on Primary Health Care (PHC) in 1978. In 1988, in recognition to our roles, responsibilities and commitment to the ideas and principles enshrined in the declaration, Bangladesh Government adopted the PHC approach as a guiding principle to the health systems development in the country. Given the country's resource limitations, it was but prudent that a more pragmatic approach to the introduction of PHC be taken.

The formulation and implementation of PHC is being done in some specified levels, based on the administrative and management hierarchy. At *national level*, the Directorate of Primary Health Care and Line Director of ESP are responsible for the planning and implementation of PHC activities. At *district level*, the Civil Surgeon and the district team provide technical and administrative support by way of periodic supervision to the Upazila health care activities. They also coordinate management of referrals from Upazila level and below.

By sheer reason of population density, *Upazila* in Bangladesh is the equivalent of district elsewhere. It constitutes the first level of referral in the PHC system. Curative care is provided by specialists in obstetrics and gynaecology, medicine, surgery, a battery of medical officers, and supportive laboratory and supplies personnel. Promotive and preventive services are supported by Health Inspectors, Sanitary Inspectors and Assistant Health Inspectors. The Upazila level Health and Family Planning Officers is the overall administrative and technical head of the Upazila Health Complex, as well as all health services up to the community level through the *Union level* facilities run by field level health and family welfare workers. *Community* participation

being one of the pillars of PHC development is established through VHVs nominated by nominated by the community people and trained under the intensification project.

## 2.2 Health Service Reform and ESP

In the health sector of Bangladesh, there has been a central *command and control* management system, oriented towards inputs rather than outputs, outcomes or value for money. Significant levels of foreign aid have been granted on an individual project basis. Prior to HPSP, some 120 separate projects were being funded and coordinated was not always achieved. Services were provider-oriented rather than client-oriented. The magnet effect of urban centres, which attract staff and resources, has led to inequalities in resource distribution and access to services. Many trained staff is unwilling to work in rural areas; Bangladesh has a hierarchical society and most professionals come from upper-class urban background. Cultural traditions of patronage mean that many service providers have little knowledge of the needs of the urban and rural poor and conversely clients may not know of their rights and entitlements. There is little professional regulation in medicine, nursing and dentistry. There is wide use within families of traditional and homeopathic remedies. Traditions, beliefs and culture exert a strong influence in access to, and use of care, with gender roles a particular issue in both the provision and receipt of care.

## 2.3 Primary Health Care and Essential Service Package

Upazila Health Centres (UHCs) were established for more than two decades back as the cornerstones of primary health care. Over 400 of such were created to a standard design, including X-ray, pharmacy, basic laboratories, dental suites and delivery suites, and each has a 31 bedded ward. However, physical facilities have deteriorated in most UHCs and poor staff practices (e.g., high levels of absenteeism and informal user-charging) exist in many. Skilled doctors are unwilling to work there, regarding posting as *punishment*. Consequently, UHCs no longer enjoy public confidence and are underused. The low state salaries earned by doctors have led to growth in private practice. Doctors are thereby diverted from their UHC duties and a vicious circle has evolved whereby their vested interests may wish to keep public sector service quality relatively low.

The concept of an Essential Service Package (ESP) to be delivered in UHCs is well grounded, although the delivery is patchy. The ESP consists broadly of:

- reproductive health care;
- child health care;
- communicable disease control; and –
- limited curative care.

Health services and family planning services are run as two entirely separate arms of the Ministry of Health and Family Welfare (MoHFW) and duplication runs throughout the management hierarchy, reflecting this split. This is recognized to be an inefficient way to run modern services and reorganization has started.

## 2.4 Recent Reform in Health Care System

Both in the fourth and fifth Five-Year Plans (FYPs), Bangladesh Government incorporated various programmes and projects, many of which were supported by the World Bank and other donor consortia. Among others, the key objectives of these plans were to further reduce infant and child mortality, including major drives in immunization, the control of communicable diseases, attention to diarrhoeal and respiratory diseases in children, and contraceptive services. Upon review of the fourth FYP, a national Strategy was formulated in 1996/97 – the Health and Population Sector Strategy – in consultation with the development partners.

The aims of the strategy are to provide a sustainable universal package of essential health care services for the people of Bangladesh, and to slow population growth, with an emphasis on client-centred, accessible services, particularly for children, women and the poor. The feature of the strategy was the decision to move from a project-driven approach to a sector-wide approach (SWAp), now known as sector-wide management, where development partners work with the government in the implementation of a comprehensive and integrated programme. In the fifth FYP, this programme is titled as Health and Population Sector Programme (HPSP), and then

revised as Health, Nutrition and Population Sector Programme (HNPSP) to broaden its scope by incorporating nutrition related issues into it.

The thrust of the HNPSP is implementation of the ESP through decentralized delivery of one-stop service models, and with increased involvement of the private sector and NGOs. The ESP concept has been developed, and includes a prioritised list of interventions to be delivered at Upazila level and below. A wide range of activities is planned in pursuit of strategy implementation, and the following key component outputs of the HNPSP have been identified:

- the ESP defined, funded, promoted and implemented;
- service delivery mechanisms unified, restructured and decentralised;
- integrated support systems strengthened;
- hospital level services focused and improved;
- sector-wide programme management system established and operational policy and regulatory framework strengthened;
- other services of public health importance strengthened; and –
- other health and nutrition services strengthened.

## **2.5 Financing and Budgeting of HNPSP at Marco Level**

Government spending on HNPSP, during recent years, shows some modest growth relative to the overall government budget. The total spending on MoHFW including project aid represents around seven percent (up from 5.9 percent in 2003/04) while domestic resource spending (excluded project aid) represents around 5.4 percent (up from 4.8 percent in 2003/04). However, collection of financial information on programme budget and actual spending remains difficult with conflicting figures provided by different sources.

Although the revenue budget makes up more than 60 percent of spending on MoHFW health programmes and nearly 80 percent of government contributions, revenue allocations are more or less absent from HNPSP. The absence of the revenue budget from HNPSP is an important issue that has a negative effect on the ability to plan and monitor sector activities more particularly that fall under ESP. In per capita terms, after adjusting for consumer prices, overall public spending on health care, including both DP and GoB contribution, has fluctuated over the period, with a slight upward trend. The fluctuation is largely the result of variations in development spending.

Learning from past experiences, particularly regarding existing constraints of sectoral allocation and spending, in 2005/06, Bangladesh Government introduced a new system of budget management. The new system is known as Medium-term Budgetary Framework (MTBF). The MoHFW has been taken under this framework from 2007/08 financial year. According to the procedure laid down in this framework, year-wise both revenue and development expenditure of each respective ministry would be estimated and allocated under a common resource envelope for three (current and two subsequent) years.

## **3. DORP's Pre-budget Advocacy Programme**

### **3.1 Rationale for Pre-budget Advocacy**

As mentioned in earlier sections, it is commonly known that, public budgetary allocation and expenditure for health sector is quite low if it is compared to other countries of the South and South-East Asian region. In 2006/07 financial year, the total size of the national budget was BDT 697400 million, of which BDT 47840 million was allocated for the health sector. It was calculated that the average annual per-head allocation for this sector was only BDT 340.

It would be worthwhile to mention here that, ESD is one of the vital components of health sector that is directed primarily for the benefit of poorer sections of the population. ESD also takes a key position in the HNPSP. The major components of ESP include reproductive health, child health, limited curative service, urban health, hospital waste disposal and, service support and coordination. In 2005/06, the total budgetary allocation for ESD was BDT 2911 million, which was raised to BDT 3100 million in 2006/07. For a country having a population of 1140 million, indeed, this allocation is far less to achieve the objectives laid down in Poverty Reduction Strategy Paper (PRSP) as well as in the Millennium Development Goals (MDGs).

Since the preparatory stage of PRSP, DORP has been employing tremendous efforts to establish a strong linkage between actual health service demands of the grassroots people and public policy instruments of the national level. The present advocacy campaign is conducted, as a continuation of the whole process, to sensitise the relevant policy makers concerned in order to make the forthcoming budget pro-people through incorporating their perceptions and practical needs into it.

### 3.2 Methodology Used

Given the time and resource constraints, during April – May 2007, DORP conducted the pre-budget activities in six *Upazilas* (sub-districts), one each of six selected districts. Among others the major activity was organizing pre-budget seminar involving relevant local stakeholders to get their view, perceptions and recommendations on specific health care (ESD) issues related to forthcoming (2007/08) national budget. Prior to conducting these seminars, in collaboration with respective local NGOs, civil society and other organizations, the stakeholders (particularly the health service recipients) were discussed thoroughly to give them general ideas about public budget process, as well as to motivate them to formulate their views and recommendations for presenting in the seminar. The views and recommendations received from the six Upazilas were cross-checked, analysed and compiled systematically. These were then submitted to and discussed intensively with the relevant policy makers including officials of MoHFW, Ministry of Finance, Planning Commission, Directorate of Health and Family Welfare, and Directorate of Family Planning in view of considering these while preparing and finalizing the national budget, more particularly for health sector.

## 4. Field/ Seminar Findings

### 4.1 General Views/ Perceptions of the Stakeholders

The seminars were organized in the following Upazilas:

- *Sreemongal* Upazila of Moulavi Bazar district
- *Bakerganj* Upazila of Basisal District
- *Shadullapur* Upazila of Gaibandha district
- *Narail* Upazila of Narail district
- *Kaliakoir* Upazila of Gazipur district
- *Ramgati* Upazila of Laxmipur district.

Each of the seminars were participated by about 30 stakeholders representing different sections of population, such as physicians, nurses, hospital support staff, civil servants, NGO officials, civil societies, private entrepreneurs and common people. Despite diversity in way of presentation of ideas and perception, most of the stakeholders (of all six Upazilas) expressed their concern regarding the following issues, which they think are critical barriers/ drawbacks in existing health service delivery system of the country:

- Lack of awareness among local people about public budget process;
- Lack of adequate knowledge about budget preparation and efficient fund use and monitoring among both professionals and non-professional staff;
- Lack of access of people to budget allocation, spending and outcome;
- Lack of transparency in budget preparation and programme implementation;
- No consultation with relevant local stakeholders in any stage of budget preparation;
- Inadequate importance to regional diversity in allocating public budget (fund);
- Fraudulent activities in utilization of public resources;
- Inadequate budgetary allocation for ESD related expenditure, since major portion of the budget is allocated for revenue spending (e.g., staff salary);
- Lack of allocation for ambulance, laboratory, surgery, medicine and diet;
- Inadequate allocation for office maintenance, cleanliness and waste disposal;
- Inadequate allocation of reproductive and child health care services;
- Lack of adequate posting in the professional posts (e.g., physicians and nurses);
- Reluctance of physicians to stay in the remote areas;
- Unfair charge collection from patients;
- Referring patients in the private clinics rather than providing them public services in the hospitals;

- Unfriendly attitude of professionals and staff to patients;
- Lack of effective supervision, monitoring and evaluation of locally implemented ESD by the actor sitting at upper levels of administrative and management hierarchy.

#### 4.2 Recommendations

Following are the major specific recommendations suggested by the local stakeholders in order to make the forthcoming budget (particularly health sector budget) demand-oriented and poor-friendly. These are arranged in priority order based on the frequency of respondents:

- The budget process should be reversed from top-down to bottom-up in order to ensure active involvement/ participation of mass people;
- Appropriate measures should be taken to make service recipients as well as other actors well aware about both process and content of the budget;
- Continuous monitoring of the budget (both component-wise allocation and efficient expenditure) should be done both by the relevant government and non-government instruments in order to ensure its smooth and efficient utilization;
- All budget related information should be made accessible to the common people to ensure transparency of the actors concerned;
- A reasonable balance must be made between revenue and development expenditure in the (health) budget;
- The budget should be demand-driven (people-oriented) in stead of supply-oriented;
- Unlike a common financial allocation for every region, the budgetary allocation should be made based on regional diversity, particularly in terms of demographic, socio-economic and disease prevalence variation;
- Almost all respondents made strong demand for increased/ rational budgetary allocation for the following components:

- reproductive and child heal care
- ambulance
- surgery and medicine
- patient's diet
- communicable disease control
- nutrition
- cleanliness
- waste disposal
- telephone and electricity
- water supply
- transport and fuel

People's expectation from Pre-Budget Session 2007



