FINANCIAL ANALYSIS

A. Introduction

1. The financial analysis of the proposed additional financing of the Urban Primary Health Care Services Delivery Project has been prepared in accordance with the Guidelines for Financial Management and Analysis of Projects of the Asian Development Bank.[1] It covers overall health expenditures, urban health expenditures, fiscal impact analysis, health financing of urban local bodies (ULBs), and financial sustainability aspects.

B. Health Expenditures in Bangladesh

2. Health care financing in Bangladesh consists primarily of (i) household out-of-pocket payments; (ii) government expenditure by the Ministry of Health and Family Welfare and other ministries and local governments; (iii) voluntary health insurance; (iv) own financing by nongovernment organizations (NGOs), ULBs, autonomous bodies, and private companies; and (v) support from development partners through NGOs. According to provisional estimates made under the Fifth Bangladesh National Health Accounts, the total health expenditure for Bangladesh in 2015 was Tk452 billion.[2] As a share of gross domestic product, total health expenditure has remained steady at about 3% over the last decade (2007–2015). Table 1 compares selected health expenditure indicators for 1997, 2007, and 2015 (in nominal terms).

Table 1: Health Expenditures in Bangladesh (1997, 2007, 2015)

Indicators	1997	2007	2015
Total health expenditure (Taka million)	46,757	156,977	451,889
Total health expenditure as percent of GDP (%)	2.3	2.9	3.0
Per capita health expenditure (Taka)	382	1,104	2,882
Total government expenditure (Taka million)	17,139	42,227	102,424
Per capita government spending on health (Taka)	140	295	652
Household out-of-pocket expenditure (Taka million)	25,909	95,001	302,306

GDP = gross domestic product.

Source: Government of Bangladesh, Ministry of Health and Family Welfare. 2015. *Bangladesh National Health Accounts,1997–2012.* Dhaka; Government of Bangladesh, Ministry of Health and Family Welfare. 2017. *Provisional Estimates of the Fifth Bangladesh National Health Accounts.* Dhaka.

3. Households are the biggest financier of health expenditure in Bangladesh (67% of the total) followed by the government (23%), development partners (7%), and NGOs from own sources (3%). The government's allocation of funding for health care as a percentage of its own total spending has steadily declined. It accounted for 17.0% in 1997 and declined to 12.4% in 2015. The private sector has developed and out-of-pocket expenses by households have increased from 57% of total health expenditure in 1997 to 67% in 2015.

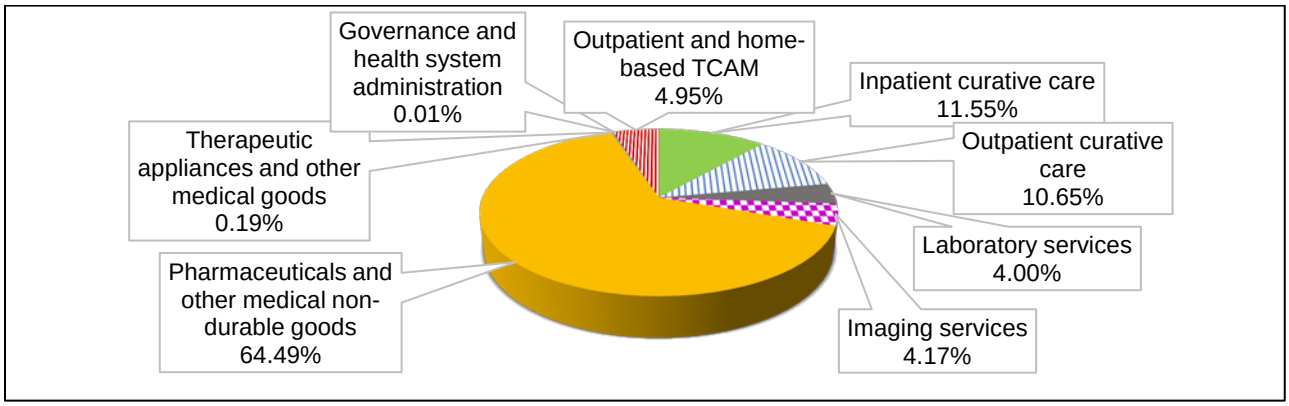
4. The government's role as the provider of a public health program has shrunk significantly from 14% of total health expenditure in 1997 to just 4% in 2015. Preventive care spending, through providers like secondary hospitals, is a major reason for the decline in spending by the provider of the public health program. Resource allocations to public hospitals are mainly based on a fixed number of beds rather than the disease burden, population size, and needs. Secondary and tertiary facilities receive a higher proportion of public funding at the expense of primary health care (PHC) facilities.

[1] Asian Development Bank. 2005. *Financial Management and Analysis of Projects.* Manila.

[2] Government of Bangladesh, Ministry of Health and Family Welfare. 2017. *Provisional Estimates of the Fifth Bangladesh National Health Accounts.* Dhaka.

5. Total health spending by the government in 2015 was Tk102 billion, which is Tk652 per citizen. Although government financing in health care has increased in nominal terms over the years, its relative share (in total public expenditures) has declined. The Ministry of Health and Family Welfare's share of total health spending by government is about 93.0%. The government provides most health care services free, although households pay nominal user fees for some services. Expenditure on drugs is the biggest out-of-pocket (69.3%) household health expense. Hospitals and outpatient care are each about 10.0%, and 8.0% is spent on ancillary services. Sales of drugs are higher in urban areas than in rural areas since access to pharmacies and retail drug outlets is much higher in urban areas.

Figure: Breakdown of Household Out-of-Pocket Health Care Expenditure by Function, 2015



TCAM = traditional, complementary, and alternative medicines.
Source: Government of Bangladesh, Ministry of Health and Family Welfare. 2017. *Provisional Estimates of the Fifth Bangladesh National Health Accounts.* Dhaka.

C. Urban Health Expenditure

6. Bangladesh's urban population is growing faster than the rural population. About 33% of the population currently reside in urban locations, but the share is expected to reach 50% by 2039, mainly because of migration. Cities are characterized by large inequalities in health-related conditions. About one-third of the urban population lives in slums where living and hygiene conditions are inauspicious to health and nutrition outcomes.

7. Urban households spend on average 4.3% of their total consumption expenditure on health, but spending differs widely depending on household income. Data from the Bangladesh Bureau of Statistics' Household Income & Expenditure Survey (2011) shows that while health care expenditure in the richest segment of the populace (quintile 5) is 5.5%, it is 3.7% for quintile 4 and 3.1% for quintiles 1–3.[3] The largest health expenditure in urban areas is incurred at pharmacies and/or retail drug outlets, while the second largest is in general hospitals. According to the Fifth Bangladesh National Health Accounts, urban residents spent Tk163 billion on health care in 2015, which constituted 36% of total health expenditure. Urban per capita expenditure was estimated at Tk4,869, compared with Tk2,341 for rural individuals (Table 2). The national per capita out-of-pocket payments on health care were Tk1,932 in 2015, but Tk4,765 in urban areas. Per capita out-of-pocket outlays for hospitals and providers of services differ significantly between urban and rural areas.

[3] Bangladesh Bureau of Statistics. 2011. *Household Income & Expenditure Survey 2010*. Dhaka.

Table 2: Total Health Expenditure and Urban Health Expenditure, 2015

Indicator	Urban	Rural	Total
Total health expenditure (Taka million)	163,426	288,462	451,889
Population (million)	33.56	123.2	156.8
Urban expenditure as % of total health expenditure	36%	64%	100%
Per capita total health expenditure	4,869	2,341	2,887

Source: Government of Bangladesh, Ministry of Health and Family Welfare. 2017. *Provisional Estimates of the Fifth Bangladesh National Health Accounts.* Dhaka; *World Health Organization Global Health Expenditure Database.*

D. Fiscal Impact Analysis

8. Bangladesh's economy has achieved sustained growth of 6.3% per year since FY2007. In the Seventh Five-Year Plan, FY2016–FY2020, the government aims to accelerate the average annual growth rate to 7.4%.[4] In support of the Bangladesh National Urban Health Strategy (NUHS), $142 million is being committed over a 5-year period (1 April 2018 to 31 March 2023) under the additional financing for the Urban Primary Health Care Services Delivery Project.

9. Table 3 shows the fiscal impact of the project financial plan. It also indicates the funds needed to finance project expenditures during and beyond the project period. By the end of the project, gains from efficiency and better quality will have positive long-term effects that are not susceptible to short-term resource constraints. Over FY2018–FY2022, the government's annual commitment to the project averages 0.05% (as a percentage of total government expenditure) and 0.80% of the budget of the Local Government Division (LGD). The project is expected to spend about Tk19.3 billion as recurrent expenditure during 2023–2037 and serve 66.5 million beneficiaries. On average, this translates to an expenditure of $3.6 per beneficiary or Tk290. Although the health facilities generate income from user fees, the overall recovery from user fees represent only about 27% of the operating cost including depreciation. Consequently, the government should allocate additional funds after the project to sustain the current level of service coverage. A total of Tk1.3 billion per year will be required as recurrent expenditure from 2023.

Table 3: Fiscal Impact, FY2018–FY2022

	Projection					
Indicator	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**Total**
GDP at current price[a]	22,127	25,003	28,254	31,927	36,077	143,389
Government revenue[b]	2,655	3,000	3,390	3,831	4,329	17,207
Government revenue as % of GDP	12%	12%	12%	12%	12%	
Government expenditure[c]	3,762	4,251	4,803	5,428	6,133	24,376
Development[d]	831	922	1,024	1,136	1,261	5,174
Sector expenditure						
LGD budget[e]	235	258	286	318	353	1,450
Nondevelopment[e]	31	34	37	41	46	189
Development[e]	204	224	249	277	307	1,261
11 city corporations[e]	14.0	15.6	17.3	19.2	21.3	87.4
Additional financing cost	**1.29**	**2.45**	**2.82**	**2.41**	**2.39**	**11.36**
						Average
% of government expenditure	0.03%	0.06%	0.06%	0.04%	0.04%	0.05%
% of GED	0.2%	0.3%	0.3%	0.2%	0.2%	0.2%
% of LGD budget	0.5%	1.0%	1.0%	0.8%	0.7%	0.8%
% of LGD nondevelopment budget	4.2%	7.3%	7.6%	5.8%	5.2%	6.0%
% of LGD development budget	0.6%	1.1%	1.1%	0.9%	0.8%	0.9%
% of 11 city corporations	9.2%	15.7%	16.3%	12.6%	11.2%	13.0%

GDP = gross domestic product, GED = government expenditure for development, LGD = Local Government Division.
Notes:
1. Tk in billion unless otherwise noted.

[4] Government of Bangladesh, Planning Commission. 2015. *Seventh Five Year Plan FY2016–FY2020*. Dhaka.

2. Total project resource envelope is $142 million.
3. Exchange rate: $1 = Tk80.
[a] Assumed to grow at 13% annually over the projection period based on the GDP average annual growth rate of 7.2% and inflation rate of 5.8% for FY2007–FY2022.
[b] Government revenue as a percentage of GDP over the projection period assumed at 12% based on the average proportion of government revenue to GDP during FY2016–FY2022.
[c] Government expenditure as a percentage of GDP over the projection period assumed at 17% based on the average proportion of government expenditure to GDP during FY2016–FY2022.
[d] Assumed to grow at 11% annually over the projection period based on the development average annual growth rate during FY2017–FY2022.
[e] Assumed to grow at 11% annually over the projection period, FY2020–FY2022.
Source: Government of Bangladesh, Ministry of Finance, Finance Division, Medium Term Budget Framework; Government of Bangladesh, Bangladesh Bureau of Statistics; Asian Development Bank estimates.

E. Health Financing of Urban Local Bodies

10. The city corporations and municipalities depend on contributions from the central government. About 90% of their total budget is funded through the LGD, while about 8% is generated through user fees and drug sales. For some ULBs, the entire health budget is funded by the central government.[5] In nominal terms, the cumulative health budget of the nine city corporations under the project in 2015 was Tk671 million, and the average budget per city corporation was Tk75 million.[6]

11. The nine city corporations collectively spent Tk659 million on health care in 2015. The expenditure ranged from Tk3.4 million (Comilla City Corporation) to Tk159 million (Dhaka South City Corporation [DSCC]). The activities across ULBs have a high degree of heterogeneity regarding health care services, which is evident when comparing expenditure shares for different types of health-related expenditures. Outlays on inpatient care are expected from DSCC with its three hospitals and for Rajshahi City Corporation (RCC) with its one hospital. Dhaka North City Corporation's main health service activity is mosquito control, which constitutes 94% of its total expenditure. Narayanganj City Corporation's focus is the Expanded Program on Immunization (EPI, 70% of total expenditure) and mosquito control (25% of total expenditure). Comilla City Corporation, Rangpur City Corporation, and Sylhet City Corporation also use much of their budgets for the EPI.

12. Only a selected number of city corporations have outpatient facilities. DSCC and Khulna City Corporation each have three active outdoor clinics, with DSCC serving over 171,500 patient visits in 2015. Sylhet City Corporation and RCC each have an outdoor clinic, with RCC serving a significantly higher number of patients. Of the six municipalities, two have outpatient services. Two city corporations have inpatient care facilities—DSCC with three hospitals and RCC with one hospital. Bed capacity, as well as bed occupancy rates, are higher at DSCC facilities than those under RCC.

13. The municipalities are more heavily dependent on central government funding. A sample of six municipalities receive 99% of their budget through the central government and have much lower revenue earning capacity (1%).[7] In nominal terms, the cumulative health budget of six municipalities in 2015 was Tk109 million and the average budget was Tk18 million. Health expenditure constitutes less than 10% of municipalities' total annual expenditure. For example, the health expenditure was 9.7% (2013) for Faridpur and 6.4% (2015) for Coxsbazar

[5] The proportion of the health budget funded by the central government to city corporations was Dhaka North (100%), Narayanganj (100%), Sylhet (100%), Chittagong (100%), Khulna (95%), RCC (95%), Barisal (92%), Rangpur (92%), and Dhaka South (76%).
[6] Excludes Gazipur because of lack of data.
[7] The six municipalities are Kishoregonj, Sirajgonj, Faridpur, Jessore, Pabna, and Coxsbazar.

municipalities.

14. Like city corporations, municipalities have variations in their health functional activities. Most allocate their budget to EPI activities, although Sirajgonj Municipality incurred 20% of its total health outlay on mosquito control, while Kishoregonj Municipality uses funds for outpatient services (10%) and mosquito control (10%). During 2013–2015, health expenditure constituted less than 10% of the ULBs' annual expenditure. In general, the ULBs have very limited allocation or no allocation for PHC services. Considering that 90% of ULBs' budget originates from the central government, the ULBs will not be able to sustain PHC services after completion of the project without a substantial financial injection from the LGD.

F. Ensuring Sustainability of the Project and the Sector

15. The financial sustainability of the project and the sector is sought to be ensured through specific interventions, including key actions for the implementation of the NUHS and revitalizing the Urban Primary Health Care Sustainability Fund (UPHCSF).[8]

16. The action plan for implementation of the NUHS includes activities that aim at establishing the foundation for improved financial sustainability. The main activity (no. 2) in this regard is for the LGD to develop a revenue (nondevelopment) budget line for urban PHC and provide supplementary financing for PHC (salaries, administration, overhead, and service delivery) from its budget through the Urban Development Wing to ULBs. Related activities for ULBs include establishing a priority for PHC by preparing urban health plans and ensuring increased budget allocations (no. 3), and strengthening the ULBs' health departments with additional and upgraded staff through adequate budgets and staffing (no. 4). The LGD also aims to improve ULB financial sustainability by institutionalizing the UPHCSF through ULBs allocating revenue funds and the LGD providing block grants for urban PHC services (no. 9).

17. The UPHCSF was established in 2009 under the Second Urban Primary Health Care Project to fund operation and maintenance costs of urban PHC services. Each ULB was to allocate 1% of its total annual revenue budget to the fund, but the target has not been met, and the amounts contributed among the ULBs vary considerably.[9] So far, no funds have been used, and the balances are insufficient to meet actual needs. Nevertheless, the UPHCSF should be continued within an improved setup to facilitate utilization through revised operational guidelines.

18. As outlined in the NUHS implementation action plan, the financing of the UPHCSF should be strengthened through ULB contributions and complemented by LGD block allocations. If done as matching grants, this would signal the LGD's commitment to sustaining urban PHC activities after the end of the additional financing of the Urban Primary Health Care Services Delivery Project as well as create an incentive for ULBs to increase their contributions. This complementary financing could apply alternative mixes of contributory financing, e.g., a simple 50:50 split between ULBs and LGD, or formula-based funding (e.g., the ULB population share below the poverty line).[10]

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[8] Government of Bangladesh, Ministry of Local Government, Rural Development and Cooperatives, Local Government Division. Forthcoming. *Action Plan for Implementation of the National Urban Health Strategy, 2018–2023*. Dhaka.

[9] As of July 2017, total funding amounted to Tk105.3 million. This consisted of Tk59.9 million deposited by ULBs, Tk31.0 million in transfers from partnership agreement NGOs, and Tk14.4 million generated from interest.

[10] Specific recommendations for the sustainability fund have been made in the Project Administration Manual (accessible from the list of linked documents in Appendix 2 of the Report and Recommendation of the President), Annex 22.