Health Economics Unit
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Public Expenditure Review of the Health and Population Sector Programme

Research Paper 19

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Health Economics Unit (HEU)
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Also available:

Public-private mix for health sector development: proceedings of the fourth annual conference, 25-26th July 1999

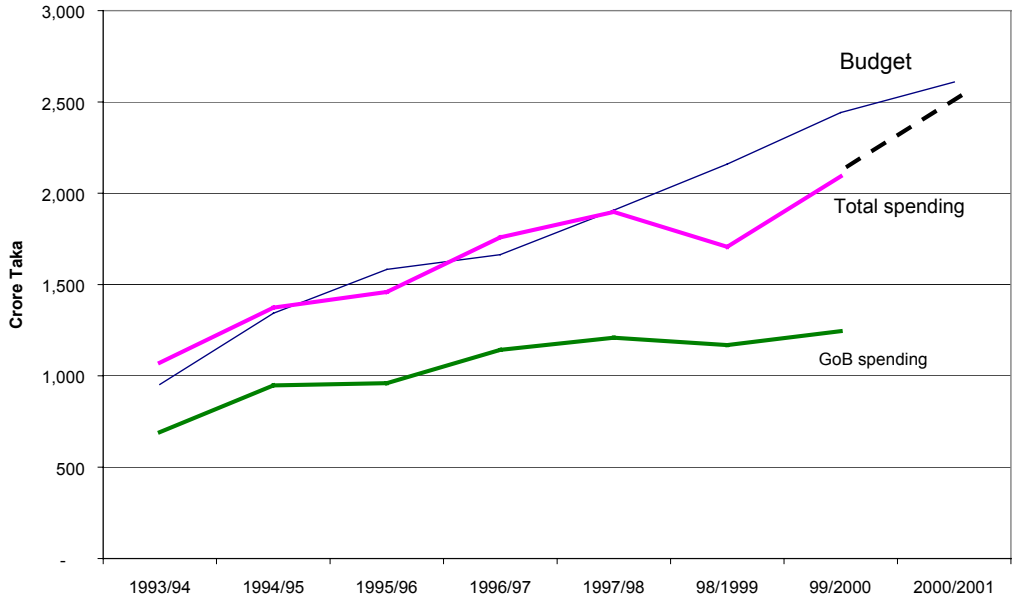
Bangladesh National Health Accounts 1996/97, Final report, Data International/ Health Economics Unit.

Contents

Executive summary

1. Macro overview of spending

- Total spending for 1999/2000 on HPSP was 1,984 Crore Taka. This is 85% of the original budget.
- Much of the under-spend was in the other RPA (part of the 'pooled funding') spending, which was only 25 percent of budget.
- During HPSP spending on health has significantly fallen short of the approved budgets (see figure below).
- To restore real per capita funding to 1996 levels requires an increase in spending during 2000-2001 of 12.4 percent.
- To restore 1996 funding as a percentage of GDP (1.36%) requires an increase in spending of around 30 percent in 2000-2001.



- 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%).

2. Equity

- There are significant differences in the distribution of public spending by geographic region.

- There is little evidence that resources are distributed according to need as measured by simple indices of poverty and human development. More work is required to compare distribution with health indicators.

- Services at ESP facility levels are mostly used by the poorest income groups.

- There is evidence that there are inequities in the process of obtaining care both through high user payments and longer waiting times for the poorest groups.

- Males and boys appear to utilise non-reproductive primary level services more than women and girls.

3. Resource envelope

- The estimates of future resources for public services indicate that the main source of funding will continue to be overwhelmingly tax and donor financed.

- User charges may become an important form of additional revenue for local facilities, but for the country as a whole the percentage will remain small in the medium term.

- Insurance does have potential to provide significant additional funding, mostly through gradual coverage of the formal sector.

- Both user charges and insurance have other important purposes, such as channelling existing out of pocket spending in a more effective way.

Authorship and acknowledgements

A large number of people contributed to the production of this report. Staff of the Management Accounting Unit (MAU), particularly Dr Abedin Khan, formerly Deputy Chief Accounts Officer, Mr Mohaimen, IT consultant, Mr Joe Martin, Consultant and the Programme Coordination Cell (PCC), particularly Mr Md. Shahjahan, provided much of the raw expenditure data used in the aggregate and geographic analysis. Data were analysed by Ms Atia Hossain, Local Consultant, HEU.

The Beneficiary Incidence Analysis (BIA) was carried out jointly by HEU staff members (Dr Shamim Ara Begum, Senior Assistant Chief, Mr Quazi Liaquat Ali, Senior Assistant Chief and Mr Abdul Hamid Moral, Assistant Chief) and staff of Data International Ltd, supervised by Ms Tahmina Begum.

The ESP costing study, which was used to analyse the revenue budget by ESP sub-component, was carried out by the Institute for Economic and Private Sector Development (IEPSD) under the leadership of Dr Shawkat Ferdousi.

The report was put together by Ms Priti Dave Sen and Dr Tim Ensor under the leadership of Mr Abul Qasem, Joint Chief and Line Director, PRU.

We are most grateful to those staff and patients attending public health facilities who gave up their time in order to make the surveys used in this report possible.

Abbreviations

ADP	Annual Development Programme
ARI	Acute Respiratory Infection
BBS	Bangladesh Bureau of Statistics
BCC	Behavioural Change Communication
BIA	Beneficiary Incidence Analysis
BINP	Bangladesh Integrated Nutrition Project
CIET	Community Information Epidemiological Technology
CMMU	Construction Management & Maintenance Unit
CMR	Crude Mortality Rate
CPR	Contraceptive Prevalence Rate
DDO	Drawing and Disbursing Officer
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DPA	Direct Project Aid
ESP	Essential Services Package
EOC	Emergency Obstetric Care
FYP	Five Year Plan
GDP	Gross Domestic Product
GIO	Gender Issues Office
GOB	Government of Bangladesh
HDI	Human Development Index
HEU	Health Economics Unit
HPSP	Health and Population Sector Programme
IEPSD	Institute for Economic and Private Sector Development
IMR	Infant Mortality Rate
JICA	Japan International Cooperation Agency
MACS	Management Accounting System
MAU	Management Accounting Unit
MIS	Management Information Systems
MOHFW	Ministry of Health and Family Welfare
NHA	National Health Accounts
NGO	Non-Government Organisation
PER	Public Expenditure Review
PIP	Project Implementation Plan
PCC	Programme Co-ordination Cell
RPA	Reimbursable Project Aid
SOE	Statement of Expenditure
SWAp	Sector Wide Approach
STD	Sexually Transmitted Disease
TFIPP	Thana Functional Improvement Project
UHC	Upazila Health Complexes (formerly Thana Health Complexes)
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund

Introduction

The Health and Population Sector Programme (HPSP) completed its second year of a five-year programme at the end of June 2000. This report looks back at the financial allocations for the core HPSP activities over the past year.

HPSP places a strong emphasis on the Essential Service Package (ESP) as a way of delivering cost-effective health care, particularly to vulnerable groups. For convenience the ESP has been defined as all primary care interventions delivered at thana levels and below. On this basis between 60 and 70 percent of funding is now provided for ESP services (see table below). As observed in previous PERs, however, it is important to be aware that ESP services are also delivered in hospitals, particularly district hospitals[1]. It is also likely that many of the resources spent at thana levels and below are not used effectively. The financial definition of ESP must, therefore, be treated with caution.

In addition to ESP services, HPSP also provides funding for a range of other activities. This includes the development of improved approaches to the management of hospitals and changes to the way medical staff are trained. Although it is not yet possible to measure impact, in the future these interventions should yield improvements in the efficiency of the public sector through quality and cost enhancements.

Financial Indicators of the HPSP[2]

Indicators	Base Level 1997	Final Level 2003	1998/1999	1999/2000
Total Spending on the Essential Services Package (delivery and support) as a proportion of total health sector spending	60 percent	65 percent	65 percent	60-70 percent
Proportion of health sector recurrent expenditure going to important non-salary components (esp. medicine, maintenance) versus going into salary component	23 percent	30 percent	43 percent	51 percent
Proportion of health sector expenditure for recurrent rather than capital expenditure	75 percent	80 percent	85 percent	91 percent

This is the fifth Public Expenditure Review conducted by the Health Economics Unit and this year it is produced jointly with the Management Accounting Unit. In addition to the national review of spending under HPSP, the report focuses in depth on the question of equity, in particular on the allocation of funding by geography, gender and income. The final section of the report examines the question of future resources available for the health sector through some projections of funding from the public budget, health insurance and user charges.

[1] A recent study, for example, carried out by the Institute of Health Economics at Dhaka University found that in two district hospitals up to 30 percent of the outpatient caseload could be categorised as ESP services.

[2] The second and third indicator definitions have both changed since the original baselines were set. This means that comparison of the current indicator with the baseline is somewhat misleading. The indicators may, however, be useful in their own right at monitoring the input composition of HPSP spending.

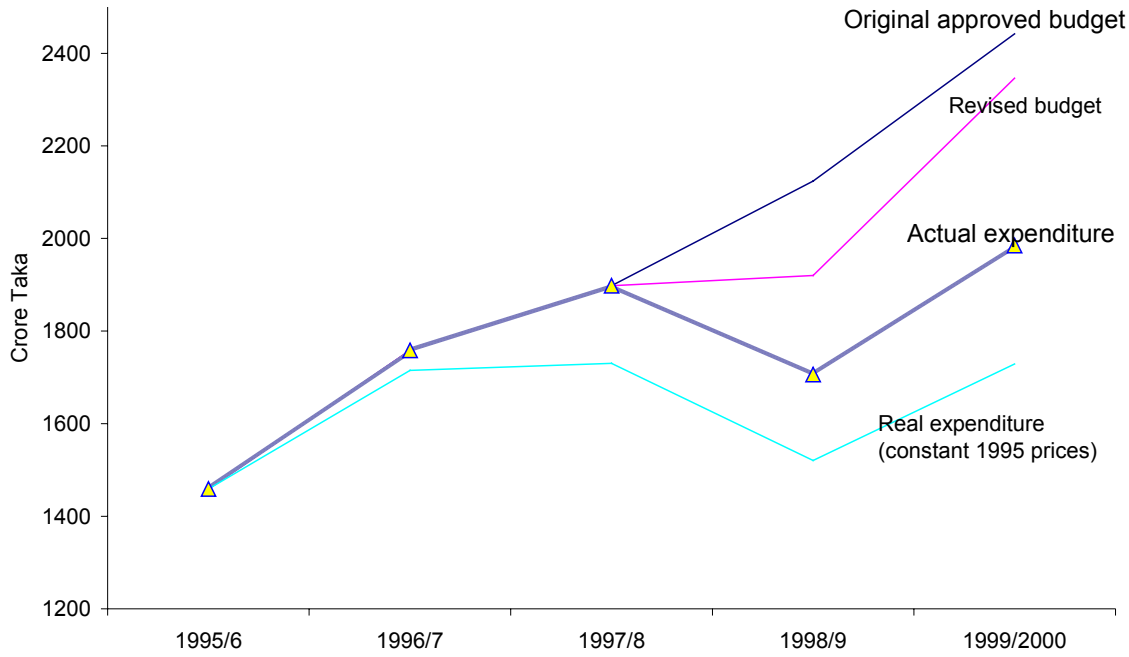
This PER summarises the early results of several surveys, including a geographic resource analysis, beneficiary incidence survey and costing of ESP. Once each of these products are finalised they will be disseminated as separate reports.

It is important to set the PER in context of the current budgetary process. A notable milestone during the past year was establishing the Budget Committee of the MOHFW. More details on the process and the contribution of the PER to this process is provided in annex four.

1. National expenditure review of HPSP

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, spending close to the planned allocation to health of just over seven percent forecasted for the fifth five year plan (annex table A1.1).

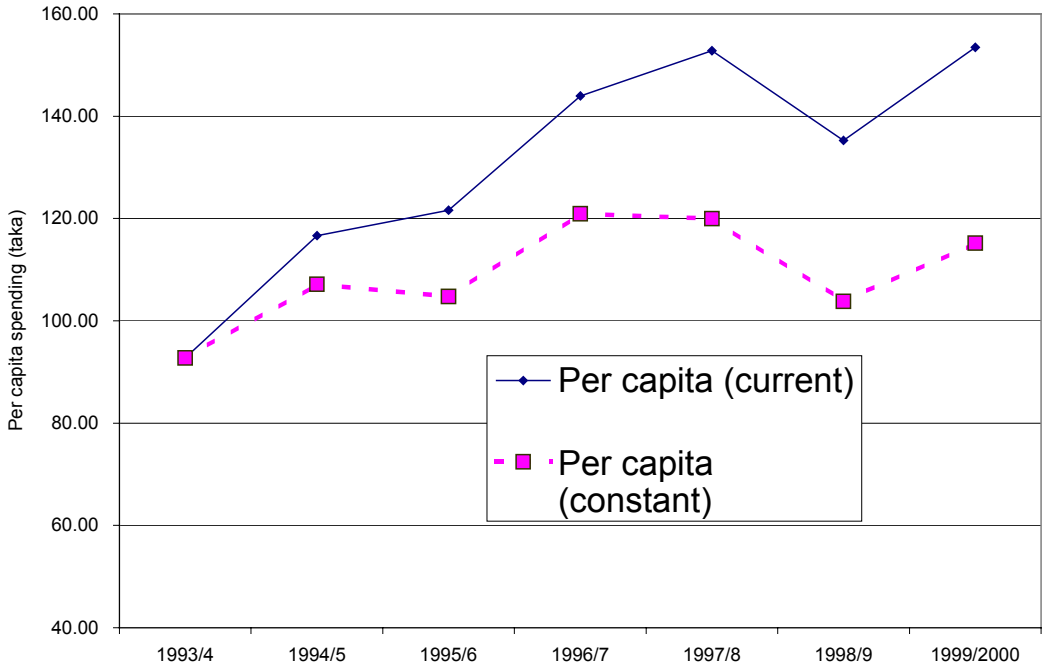
Figure 1.1: revenue and development spending 1995 – 2000, original and revised budget[3]



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 terms increase of 3.7 percent on last year's spending, it is 85 percent of the original approved budget (figure 1.1 and table A1.3).

[3] The ***original approved budget*** is the budget approved at the start of the financial year. The budget was revised half way through the year based on expenditures for the first six months. This new budget is referred to as the ***revised budget***. ***Actual expenditure*** is based on reports of line directors, CGA and PFC for the year end June 2000.

Figure 1.2: MOHFW per capita spending (1993-2000), current and constant (1993) prices



During the two years of HPSP total annual spending has declined slightly in real terms by about 0.1 percent. This compares to a real terms increase of 18 percent in the two years prior to the start of HPSP.

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 (figure 1.2). This is a small real terms increase but still means public (HPSP) health care spending per capita remains below 1996 levels. Public spending accounts for 1.1% of GDP, the lowest share since 1992. This rises to 1.22% if an estimate of other ministry spending is included (see box 1).

Box 1: Other Ministry Health Spending

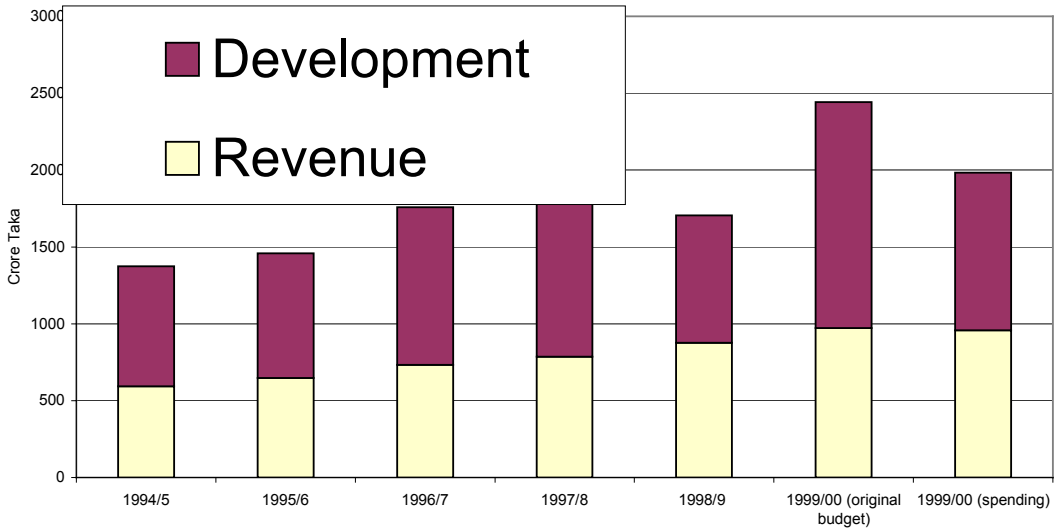
In addition to health care spending through the Ministry of Health and Family Welfare (HPSP spending), other ministries also contribute to public expenditure. The 1997 National Health Accounts (NHA) suggested that other line ministries, together with local government, account for about 7.5 percent of public spending (around 0.12% of GDP). The main ministries spending money on health services, mostly for their own employees, are Home Affairs, Defence, Railways and Local Government.

For the 1999/2000 year complete information was not yet available for some categories of spending, particularly hospitals run by the Ministry of Defence or Railways. Statistics were available on spending by Local Government and the ministries of Home Affairs and Social Welfare. This adds up to around 85 Crore. Estimating Ministry of Defence and Railway spending based on the NHA 1996 estimates gives a total other ministry spending of no more than 200 Crore Taka. This would increase per capita public health spending to about 169 Taka per person (127 Taka at constant 1993 prices) or 1.22% of GDP.

Two main reasons have been cited from the significant shortfalls in spending this year. First, a general and continuing lack of understanding about procedures of procurement. This is exacerbated by a lack of capacity within CMSD, arising through an acute

shortage of trained procurement experts. Second, the guidelines for procurement of supplies and services, particularly through the pool (RPA-Other), have been criticised as cumbersome and time-consuming. Both these factors appear to persist more than two years into the sector programme. This is despite significant investment in procurement training provided through the sector programme.

Figure 1.3: total funding of the health sector in the ADP and revenue budget, 1994/95 – 1998/99, 1999/00 budget and actual, Crore taka

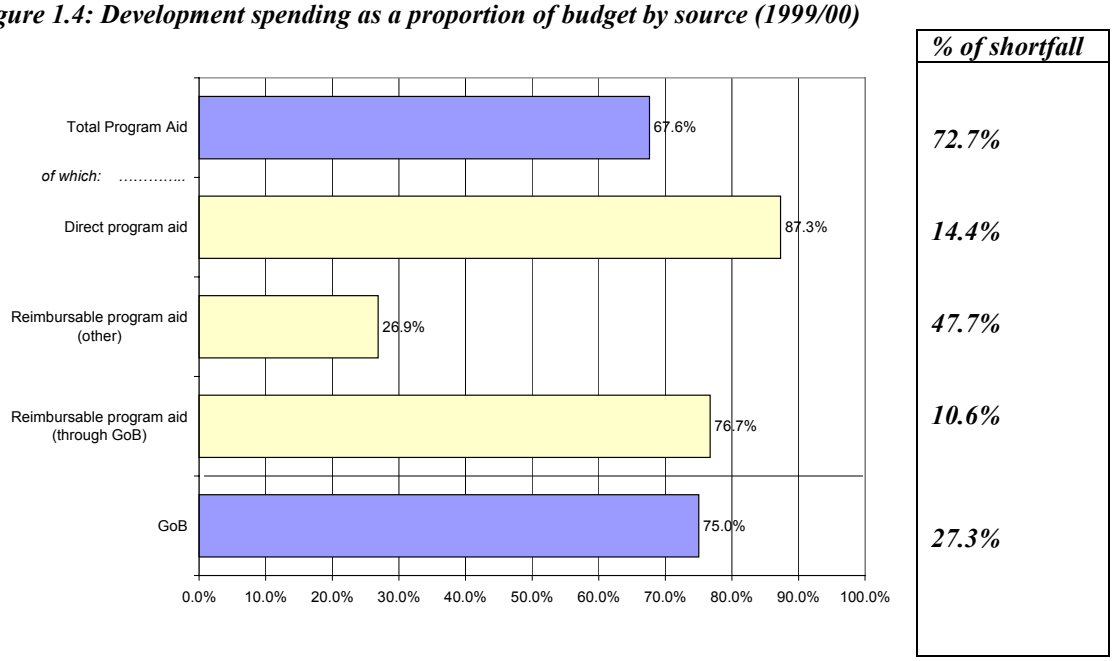


Most of the shortfall in actual relative to budgeted spending is accounted for in lower than anticipated development expenditure (figure 1.3 and table A1.5). Direct development spending by development partners (DPA) was more than 86 per cent and reimbursable programme aid more than 76 per cent of planned spending (figure 1.4). Development spending through government was around 70 percent of budget.

The main shortfall was in the other RPA provided through the donor pool administered by the World Bank. This was just over a quarter of what was planned. This under-spend in 'pool funding' accounts for more than 47 percent of the total shortfall in spending for the year. The under-spend on RPA mostly relates to the procurement procedures, which continue to be misunderstood, are under-resourced and lead to long delays in obtaining services.

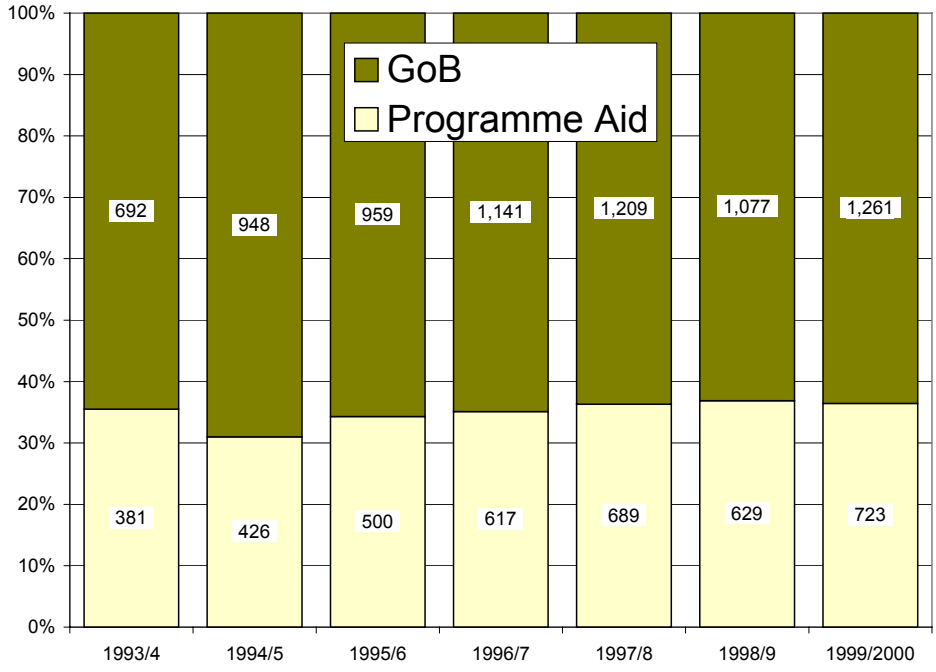
It has been suggested that some of the shortfall, particularly on DPA funding, is accounted for by under-reporting by line directors because bilateral funding is not always properly reflected in operational plans. The problem merits further investigation.

Figure 1.4: Development spending as a proportion of budget by source (1999/00)



Reimbursable Programme Aid through GoB is linked proportionately to the GoB Development budget so any shortfall on the latter will be reflected as a similar shortfall in the former.

Figure 1.5: health spending by funding source, percent and Crore Taka

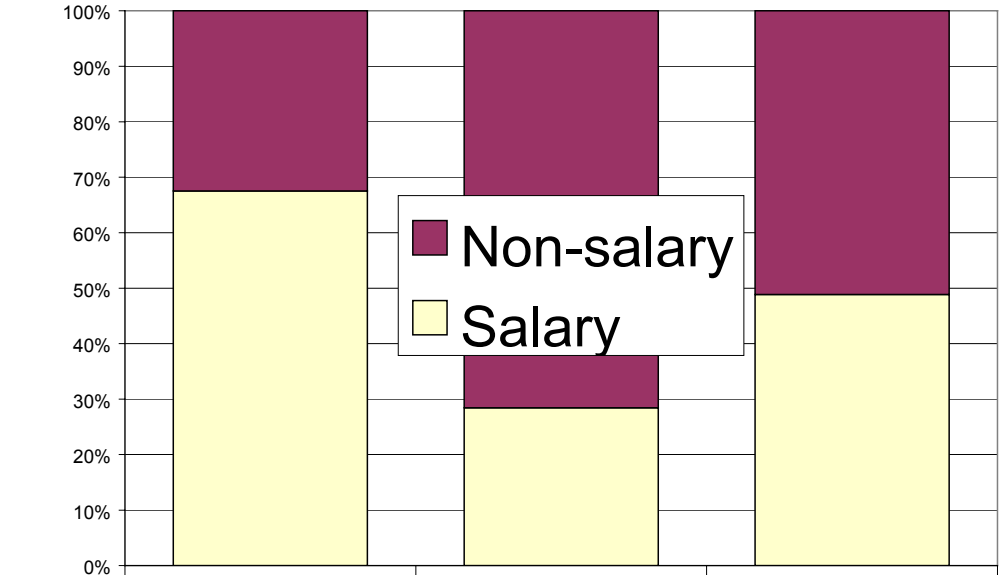


Total programme aid, as a proportion of total HPSP spending, accounted for just under 37 percent (figure 1.5). This is the highest level since the beginning of the 1990s although the ratio has varied little during this time. It should be noted, however, that the planned proportion of spending from programme aid was 42 percent and the lower proportion mostly reflects the under-spending on the development (other RPA) budget.

There is an additional argument that, pre-HPSP, much donor funding that is now reflected in total health spending was not fully included before. The apparent increase in

donor share may, therefore, simply reflect better reporting. The conclusion, perhaps, is that while it is too early to start worrying too much about excess donor dependence, the situation needs monitoring in future years, particularly as the goal of financial sustainability requires that more recurrent donor funding be transferred to the government's revenue budget.

Figure 1.6: distribution of recurrent expenditure by salary and non-salary items (percent and Crore Taka)



	Revenue	Development	Total
Non-salary	302.26	608.29	910.55
Salary	628.25	241.90	870.15

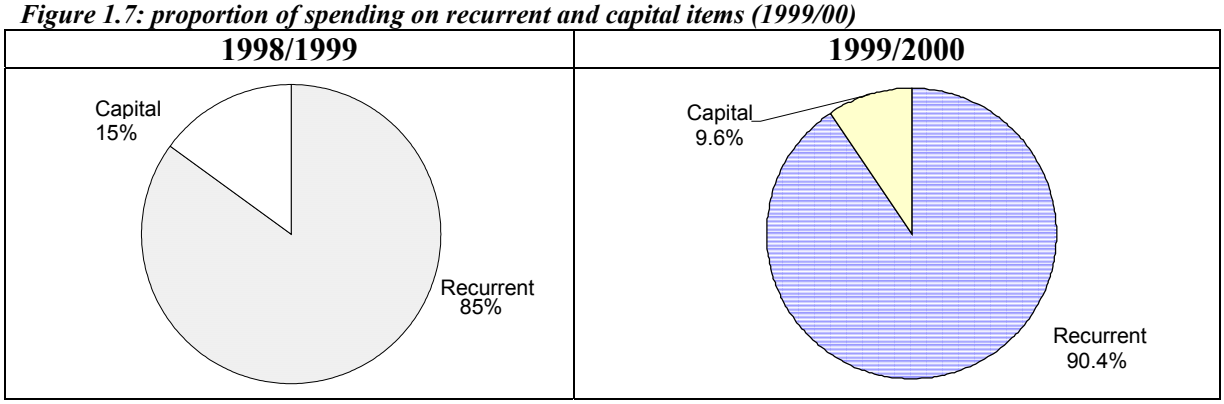
Spending on non-salary items, at 51 percent, represents a larger proportion of total spending than in last year's total spending (43 percent) (figure 1.6 and table A1.6). This is explained by the greater share of development spending this year, which is largely used for non-salary items such as commodities and equipment. It is difficult to say what share of spending constitutes a reasonable level for salaries. Internationally, ratios for salary spending vary widely from 20-30 percent in some Central Asian countries to more than 70 percent in some OECD, and also some African, countries (Barnum and Kutzin, 1993)[4].

The main question, at least at the macroeconomic level, concerns whether the proportion devoted to supplies is sufficient for the existing staff to do their job satisfactorily while at the same time providing adequate remuneration to ensure that they work effectively. Presently, around 0.35% of GDP (salary component of the revenue budget) finances around 75,000 health workers, constituting more than 1.2 percent of the formal workforce. This raises important human resource questions including whether this is sufficient funding to motivate the workforce and whether there is the right balance of skills to deliver the planned HPSP services.

[4] The high ratios are for different reasons. In OECD countries a high proportionate spending on staff is the result of relatively high salaries. In contrast, in the low-income country examples, while salaries are often low, relative to average incomes, the level of spending is also so low that spending on medical supplies gets 'crowded out'.

An additional point is that the plan to transfer the family planning staff from the development to the revenue is not budget neutral since staff paid from the revenue side enjoy pension benefits and enhanced pay scales. These increases must be factored in to the estimates of required revenue funding in future years.

Figure 1.7: proportion of spending on recurrent and capital items (1999/00)



Capital spending accounted for 9.6 percent of total HPSP spending in 1999/2000, much of which is investment in community clinics. Spending is lower than in 1998/99 (figure 1.7 and table A1.6).

Most capital spending is financed from the Government funded part of the development budget. Capital funding for ESP services was 75 percent financed by government, and more than half was used to finance the building of the first wave of community clinics. The remaining 25 percent largely financed the construction of the Institute of Mother and Child Health at Azimpur (DPA mainly through JICA).

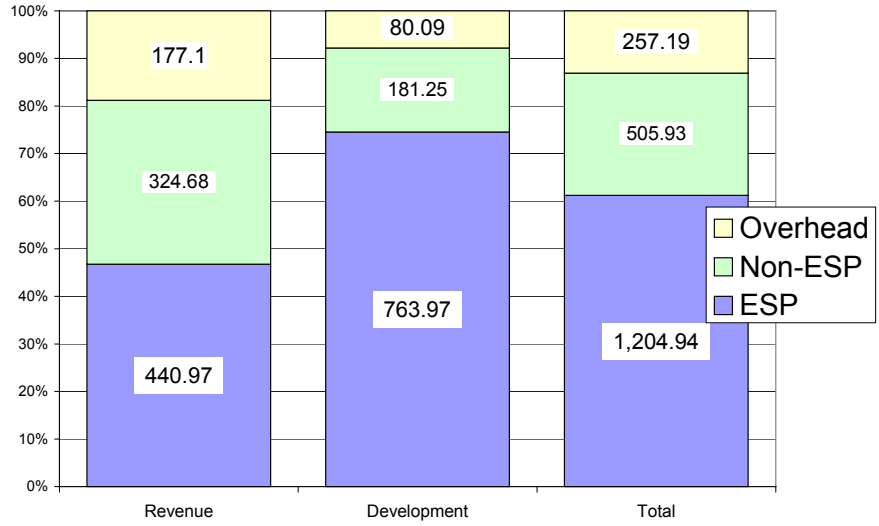
Given that there is considerable investment activity planning during the early stages of HPSP the amount spent on capital appears low.

Spending on the Essential Service Package (ESP)

In order to allocate spending to ESP and non-ESP items, expenditure on operational plan sub-components were allocated into three categories – ESP, non-ESP or overhead. The overhead category was included because there is substantial expenditure, through certain operational plans, that supports both ESP and non-ESP activities. Examples are: various research and training activities, MIS and procurement. A complete listing of the operational plan sub-components together with the assumptions used on allocation to ESP/non-ESP/overhead are given in annex table A1.8.

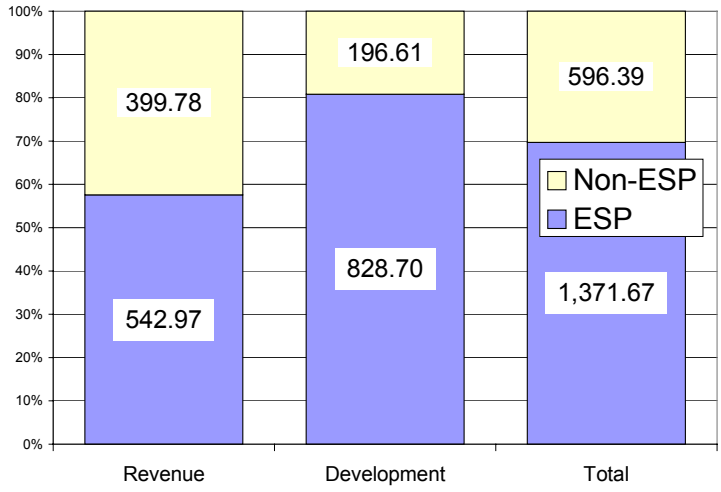
To maintain consistency with the PIP and last year's estimation, the definition of ESP is maintained as services delivered at thana level and below. It may be remarked, however, that this excludes ESP services being delivered in hospitals. It also assumes that all spending at thana and below is on essential services.

Figure 1.8: ESP, non-ESP and 'super overhead' expenditure (1999/2000, proportion of total revenue and development spending & Taka Crore)



If overhead expenditure is not allocated and only direct ESP service expenditure is included then the proportion is estimated to be just over 60 percent (table 1.8). Allocating overhead expenditure in the same proportion as direct service expenditure suggests that around 70 percent of HPSP spending is on the Essential Service Package (figure 1.9).

Figure 1.9: ESP and non-ESP spending in the HPSP assuming proportionate overhead allocation (1999/2000, proportion of total spending & Taka Crore)



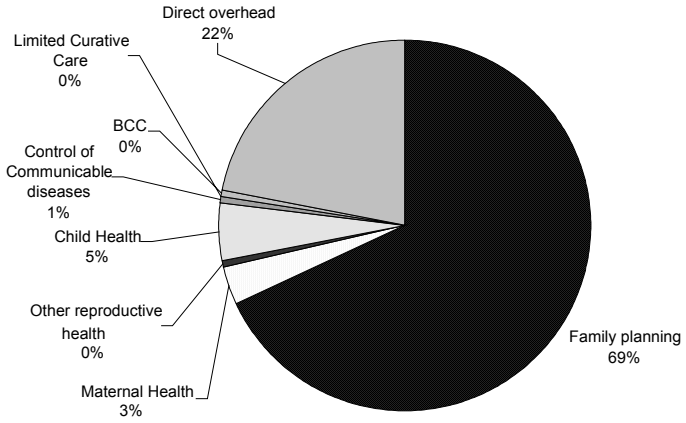
Total ESP spending, based on the assumptions above, was therefore somewhere between 60 and 70 percent for the financial year 1999/2000.

Spending by component

There are five main operational plans that are partly or wholly involved in directly delivering ESP services: ESP-Health, ESP-Reproductive Health, BCC, Nutrition and Construction (including construction of community clinics). Other plans have an indirect involvement through shared overheads. These five plans are analysed for the purposes of the component-wise analysis in order to examine the distribution of expenditure by ESP sub-component. BINP spending is excluded because it proved difficult to allocate expenditure to ESP sub-components.

The level three National Accounting Classification codes mean that dis-aggregating the main operational plans by ESP sub-component is relatively straightforward. The main difficulty is in allocating the shared direct cost of constructing community clinics and renovating other thana level facilities which represent a significant share of the Government financed development budget.

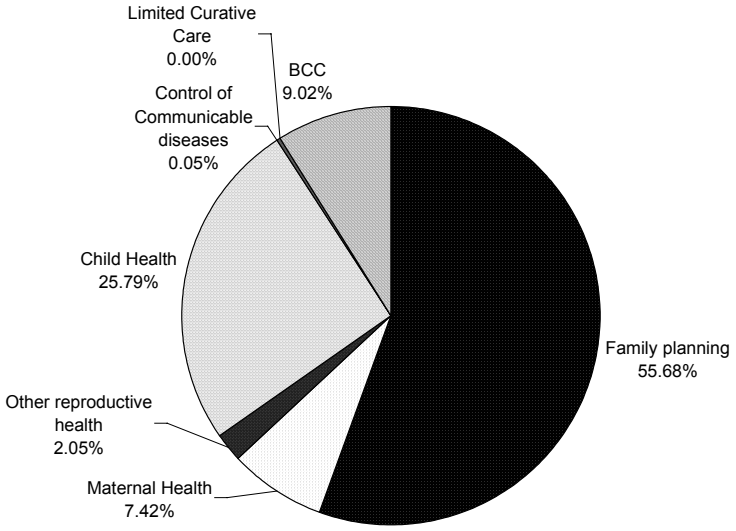
Figure 1.10: breakdown of Development Budget by ESP sub-component for GoB and direct RPA funding



Source: MAU

Component-wise spending by ESP component in the development budget is shown in figures 1.10 and 1.11 (annex table A1.9). The Government development budget can be seen to be dominated by family planning expenditure and also construction. In the case of funding by development partners through DPA and other RPA, spending is more evenly distributed although it is still dominated by family planning and, to a lesser extent, maternal and child health.

Figure 1.11: breakdown of Development Budget by ESP sub-component for Other RPA and DPA funding



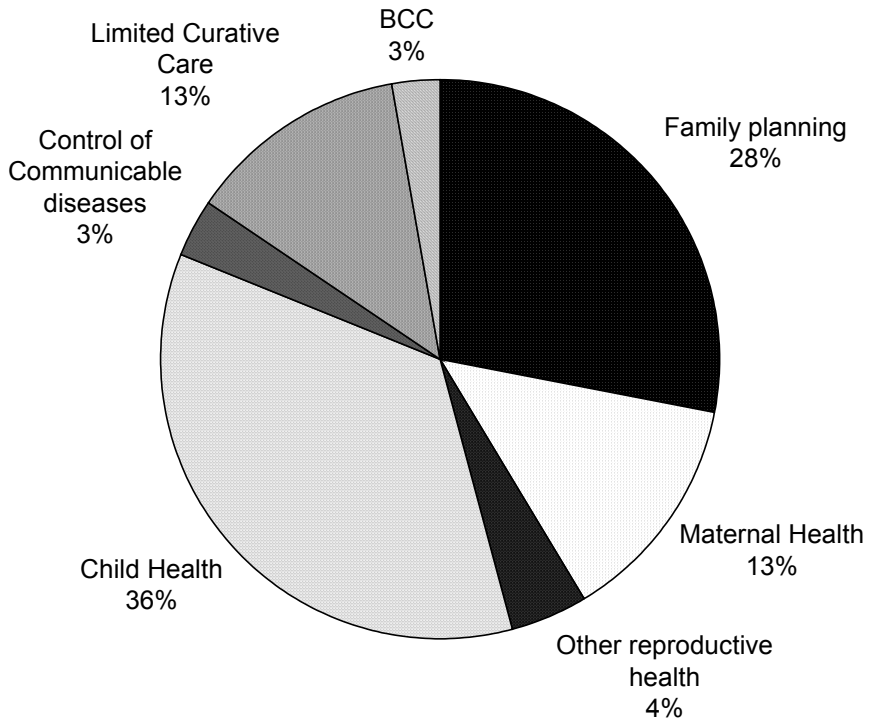
Source: MAU

There are two main problems with this approach. First, the revenue budget is not included in the calculations since it is not coded in the same level three format as the development budget activities. Second, the ESP-Reproductive Health Plan (development budget) includes a substantial salary element that finances staff that work on both family planning and also other reproductive health care and ESP components. In the case of the

ESP-Reproductive Health, staff costs account for more than 45 percent of development spending whereas for ESP-Health Services it is less than five percent. This tends to exaggerate the level of funding spent on family planning services.

In order to adjust for both factors, survey data from a recent study on the costs of ESP care was used. The survey obtained information on the use and costs of staff time, both clinical and field staff, spent on each ESP sub-component at thana and below. The proportionate allocation was used to allocate the staff portion of both the revenue and the development budget to each ESP sub-component. This gives a more accurate picture of how the spending was actually distributed between components (figure 1.12).

Figure 1.12: distribution of revenue and development spending by ESP component (salary spending allocated according to work pattern analysis) – provisional estimates.

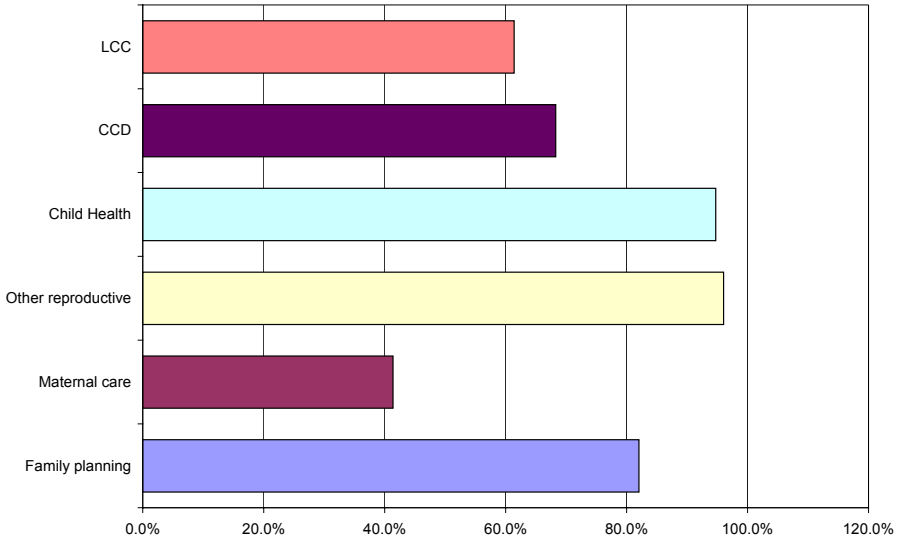


Source: MAU and ESP cost survey, HEU & IEPSD.
Notes:
1. Construction costs are allocated in proportion to time distribution.
2. BCC is also included as a hidden activity in each component so the figure is probably an under-estimate.

The allocations indicate a much wider distribution of funding than suggested by development spending alone. Family planning spending still constitutes a substantial proportion but the work pattern analysis suggested that at the clinical level (non-field) staff time spent on child health dominated activity. Maternal health receives the third largest share of spending – 13 percent –equal to spending on limited curative care.

It is difficult from these figures to judge whether this is adequate. The World Development Report suggests that on average $3.8 per capita should be spent on prenatal and delivery care out of a low income country package of $12 per capita (31%).

Figure 1.13: actual spending as a proportion of planned (PIP) annualised estimates



Another way to measure relative spending is to compare expenditure with the budget estimates (annualised) provided in the PIP. These are limited in that they assume that the pattern of staffing is appropriate for services, but they do provide a reasonable estimate of equipment and supplies required to provide the ESP based, as they were, on quite detailed calculations of need. The comparison suggests that while spending on child health and family planning is close to target, there are under-spends on other categories of expenditure, notably maternal health, where there is a short-fall of nearly 60 per cent. Many of the reasons for this under-spend can be traced back to the procurement issues mentioned earlier in the chapter. Close monitoring of these trends will be required in future years to monitor whether these short-falls are being made up.

2. Distribution of public expenditure

A central objective of the HPSP is to target public services on the most vulnerable: women, young children and the poor. It is important to assess the extent to which this is taking place through the allocation of public subsidies as indicated by use of services by these target groups.

The analysis of public expenditures by activity and line item provides an aggregate picture of how public funds are allocated. In order to examine how funding is used in practice it is necessary to map the flow of funds through the system to the final beneficiary of service using dis-aggregated data on spending and users.

There are two key equity requirements:

- That public services be distributed according to need - in the case of HPSP the needy groups are defined as women of reproductive age, particularly around the time of pregnancy, children under five and the poor. Access to services can be measured by numbers receiving appropriate, good quality medical attention.

- That services are financed according to income (ability to pay). Finance includes both tax revenues and out of pocket expenditures.

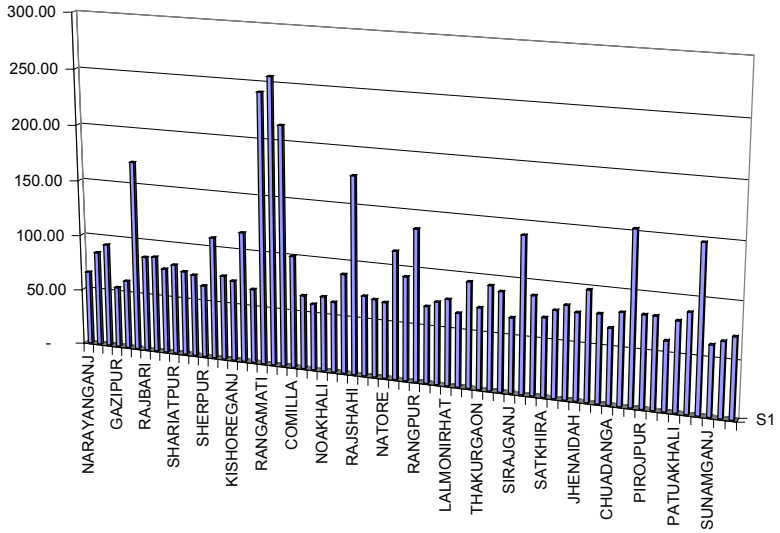
The new MIS permits some dis-aggregation of admission and consultation rates by level of facility and gender. It does not, however, permit dis-aggregation by income group of ESP category. To enable further dis-aggregation of utilisation and expenditures by beneficiary and service, a beneficiary incidence analysis survey (BIA) was carried out to complement the MIS data. A total of 1,100 patients were surveyed across nine districts at thana and union levels.

The next three sections analyse equity from three viewpoints: geography, gender and poverty.

Geographic analysis of public health spending

Analysis of public expenditures by district indicates significant variation[5]. Figure 2.1 and annex A2.1 show per capita annual expenditures for all districts during 1999/2000.

Figure 2.1: per capita annual public expenditure on health (1999-2000)

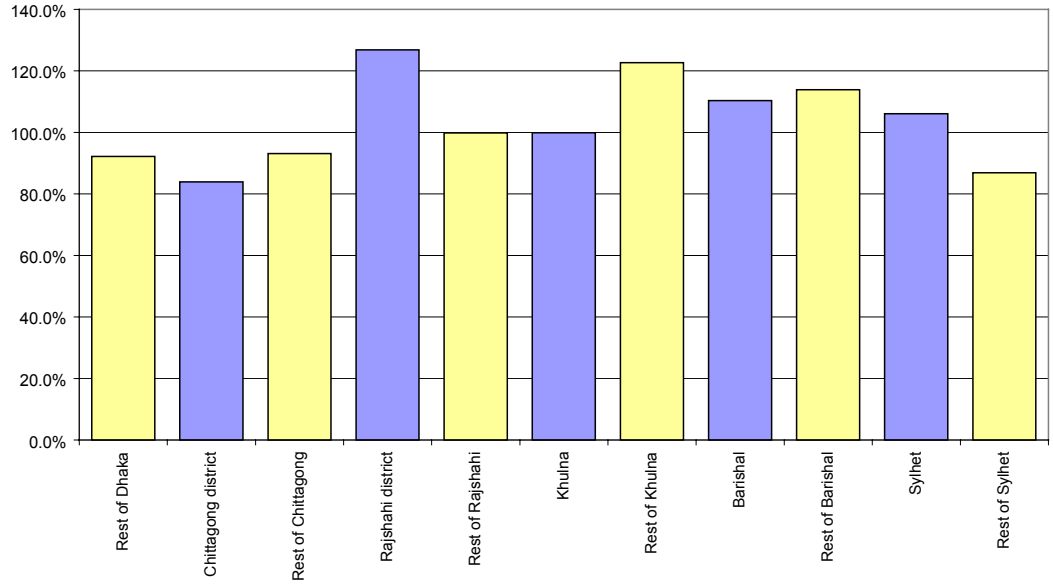


Dhaka district, with per capita expenditures exceeding 400 Taka, is excluded from the analysis. This is because Dhaka has the largest concentration of public tertiary facilities, whichare used by residents from all parts of the country. The same is also true, to a lesser extent, for division capital districts such as Chittagong and Rajshahi. In all divisions, with the exception of Chittagong, the 'capital district' has higher per capita expenditures, reflecting the higher concentration of facilities. In Chittagong, the districts of Rangamati, Bhandarban and Cox's Bazar all have higher expenditures than Chittagong itself, largely because of the additional allocations given to the hill tract areas.

In order to correct for the higher allocations to division, towns districts were separated into two groups: the main division districts and all others. In the absence of other data we assume that the target should be to equalise expenditures in each group. The current situation is that some are in excess of the average and some are below. This is represented in figure 2.2, which shows those divisions with districts that are above and below the average target.

[5] This analysis is based on expenditures through Government including the revenue budget, Government funded development budget and RPA through Government. DPA and other RPA funding by district was not available at the time of report preparation.

Figure 2.2: distance from equal per capita targets (division and all other districts).



It can be seen that only in Chittagong are per capita expenditures below target for both the main division district and all other districts. This is despite the fact that 'hill tract' districts receive a preferential allocation. Khulna is right on target, while Barisal exceeds the target in both urban and rural areas.

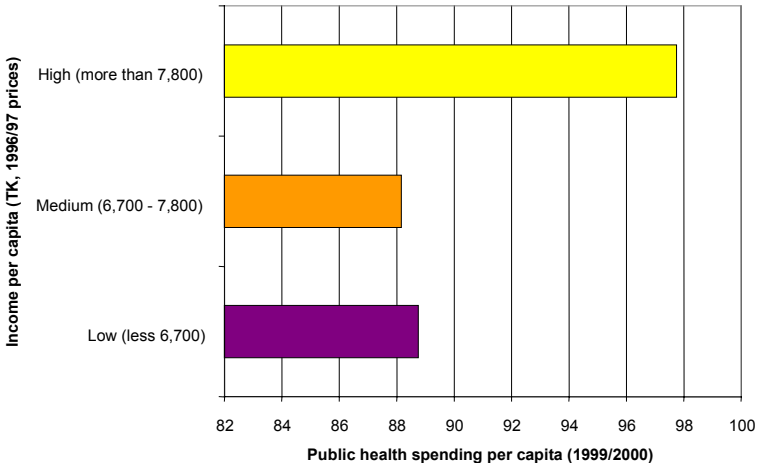
These targets are mostly illustrative. They show what would happen if per capita allocations were equalised across the country *other things being equal*. An important qualification is that other things may not be equal. In particular, differential per capita need and patterns of facility use that traverse district boundaries may mean that equal per capita allocations are not appropriate.

Need

An ideal resource allocation formula will take account of the needs of the district. Per capita expenditures only take account of one aspect of need – size of population. Other indicators of need that may be included are health status – more spending goes to districts with poorer health indicators – and income – more public funding is provided for poorer areas with lower capacity to finance care out of pocket.

One proxy of health need that proves robust in many circumstances, and is used in several countries, is the standardised (adjusted for age and gender) mortality rate. This may be considered a proxy for the extent of illness in the population. These rates are not readily available by district but will be considered in a further analysis when data become available.

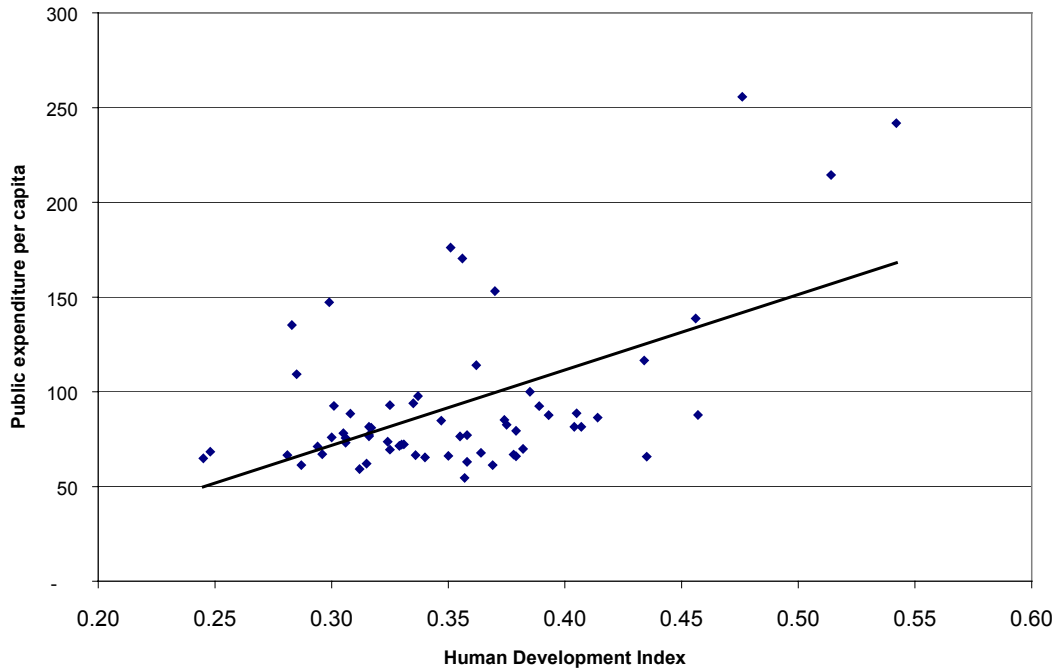
Figure 2.3: per capita public health expenditures by income of district



Source: MAU, 1999/2000
Note: data exclude Dhaka district.

Some information on income per capita was available based on the 21 former districts. Grouping these districts into three categories, while excluding Dhaka (new) district, suggests that current allocations are not inversely related to income and, in fact, the richest six districts are allocated more funding per capita than the poorest six districts (see figure 2.3).

Figure 2.4: relationship between Human Development Index and public spending per capita



A more sophisticated measure of general development is provided by the Human Development Index which incorporates infant mortality, literacy and GDP per capita into a single index (1 is the highest level possible, 0 the lowest). UNDP computed HDIs for each district of the country (UNDP, 1996). The relationship between the HDI and public spending per capita is illustrated in figure 2.4. The general trend suggests that districts with weaker development, as measured by the HDI, receive lower funding. The picture is slightly more complex. Those districts with highest HDI (above 0.43) receive the highest allocation (118 Taka per capita). Districts with lowest HDI (less than 0.3) receive around 93 Taka and the middle districts receive, on average, 83 Taka per capita.

Cross boundary flows

A key claim, made in many countries, is that greater resources per capita are required in urban areas to support the concentrated secondary and tertiary services used by citizens of both urban and rural areas. This is an important point since it is clearly not possible or economic to site specialist services in areas with relatively low population density.

In many countries, both rich and poor, evidence has demonstrated thaturban citizens use such services disproportionately to those in rural areas. This is often for two reasons: first, location since urban citizens are closer to facilities. Second, urban citizens often use secondary and tertiary facilities for their primary care needs. This means that relatively expensive facilities are being used by patients who could easily use lower level facilities. One reason for this is that urban primary care is often relatively underdeveloped.

In Bangladesh there is little information available on the residency of those that use urban level facilities and types of services provided. It is important that such information is collected in order to examine whether facilities in these areas are justifying the relatively higher public funding provided. Some selected patient surveys examining treatment obtained and residency of patients can provide such data.

Conclusion

The absence of district-wise health status information and information on cross-boundary flows mean that the conclusions of this analysis must remain tentative. A first analysis suggests that the largely bed-based criteria for allocations mean that there are considerable differences in per capita allocations. This holds even when account is taken of the need for greater expenditures in urban areas to finance the supply of secondary and tertiary facilities.

There are clearly differences in need, as reflected in health status indicators and per capita incomes, that may modify the aim for equality of resource distribution. For this exercise detailed district-wise health data were not available. Data on income per capita and the broader Human Development Index suggest that resources are not inversely distributed according to incomes – the opposite appears to be closer to the truth. More sophisticated analysis will be possible once data on health status, particularly standardised mortality rates, are obtained.

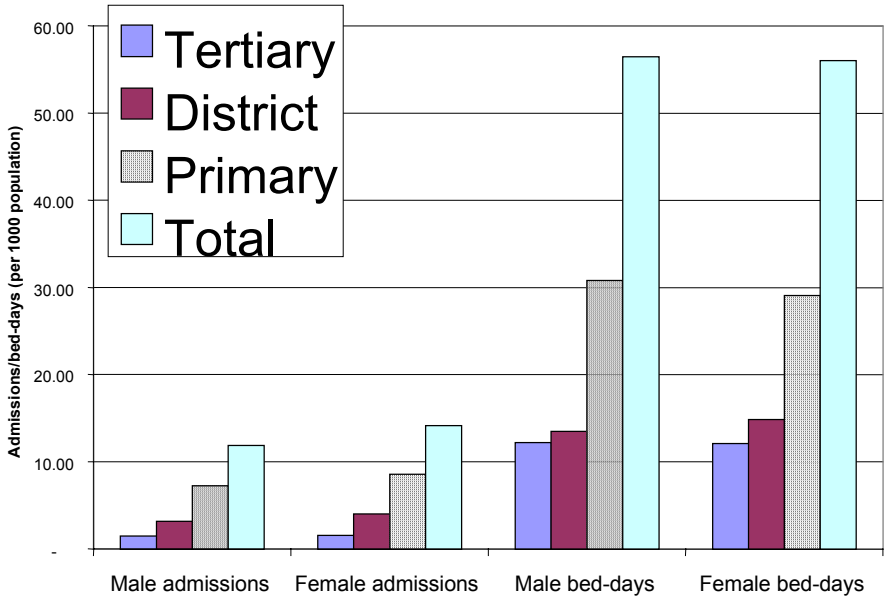
Dhaka City has deliberately been left out of the analysis because it distorts the analysis so significantly. It could indeed be argued that Dhaka is a special case in serving the entire country with more sophisticated services. This assumption should itself be tested by examining the case mix and originating district of those using the facilities.

Further analysis of geographic resource allocation and ways of making allocations more responsive to need will be provided in a future research paper.

Equity towards vulnerable groups: gender and the poor

Services distributed according to need: gender use of services

Figure 2.5: hospital admission rates by level of facility (per 1000 population)



Source: MIS, DG Health Services

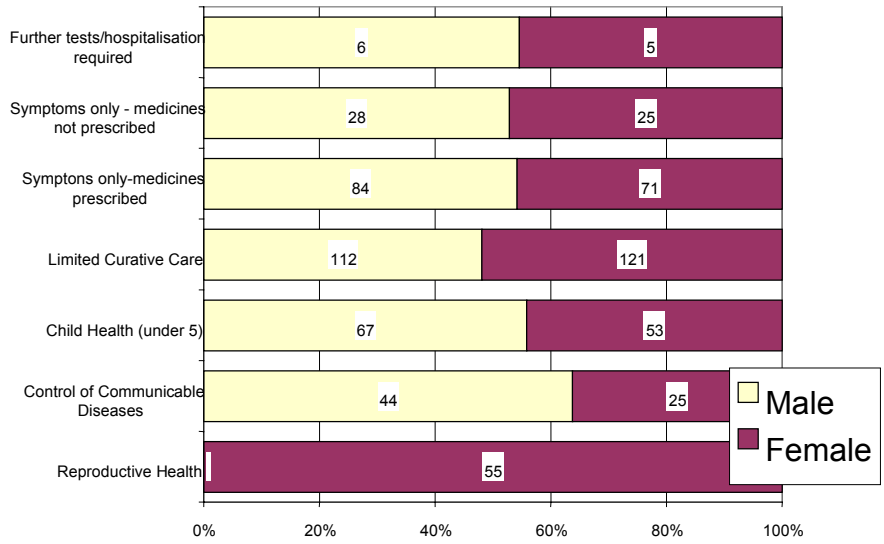
Based on district MIS data, females have a higher rate of consultation and hospital admission than males (see figure 2.5). Males, however, account for a larger proportion of bed-days (17 percent higher) than females. This is probably partly accounted for by the type of admission (case mix). Many of the female admissions will be for child-birth which usually has a short length of stay. In contrast many of the male admissions will be for diseases of life style such as cardiovascular disease and also trauma. It may also be a product of social-cultural factors that mean that men spend longer as inpatients than women.

At the primary level (thana and below) similar patterns emerge with a higher proportionate admission rate of women but with men accounting for a larger proportion of bed days.

In terms of per capita expenditures, there is much district variation. In the majority of districts (53 percent) per capita expenditures on women exceed men, which can be accounted for by use of child-birth and other reproductive services. In a significant minority of cases (47 percent) expenditures are actually higher for males despite the greater need for health care amongst women.

Based on expenditure analysis in section one, together with the BIA in this section, it is possible to make a tentative analysis of the distribution of expenditure by gender and ESP service. *It is assumed that family planning services benefit both men and women proportionate to population size although most services are obtained by women.*

Figure 2.6: service attendance by ESP category and gender



In a number of cases it proved difficult to assign patients to one of the ESP categories. This was for a variety of reasons. One was that the consultation found nothing wrong. Another was that the patient reported presenting with a general symptom such as headache or diarrhoea but the consultation did not yield any definite diagnosis that was shared with the patient. In a large number of these cases medicines were prescribed. For illnesses where no diagnosis was provided, use was higher for men/boys.

Some differences were found in expenditures by gender. Total attendance was slightly higher for women (figure 2.6). However if use of reproductive services are excluded then use is actually higher for men rather women. If the patterns of use found in this survey were reflected throughout the country then this would suggest that the majority of non-reproductive health spending is directed towards men/boys (55 percent). Greater use by men/boys was found for child health care (under 5) and communicable diseases. For limited curative care, where a diagnosis was possible use was slightly greater for women (table 2.1).

Table 2.1: public expenditure allocation of benefits by gender and type of service (Crore Taka)

	Male	Female	Total	%
Reproductive Health				
Family Planning	165.65	155.61	321.26	29.0%
Maternal Health	-	151.17	151.17	13.6%
Other reproductive health	26.15	23.80	49.95	4.5%
Child Health	226.06	178.83	404.89	36.5%
Control of Communicable Diseases	24.68	14.02	38.70	3.5%
Limited Curative Care	68.81	74.33	143.14	12.9%
			-	
Total	511.35	597.8	1,109	100.0%
	46.1%	53.9%		
Total (non-reproductive health)	319.6	267.2	586.73	
%	55%	45%		

Further work is required to determine whether the rates of admission and consultation amongst women are sufficient to meet the generally greater needs for health care, particularly reproductive health services. Section one found that around 14 percent of total ESP spending was devoted to maternal health compared, for example, to 26 percent for family planning. Given that HPSP gives particular priority to reducing maternal mortality, further work is required to estimate an adequate level of spending related to

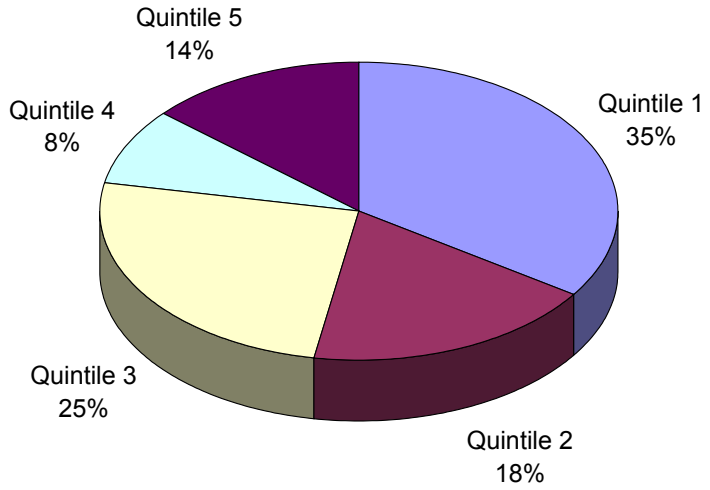
needs. Investigating the full cost of providing key obstetric services such as EOC is required.

Service use by the poor

Analysis, using the BIA data, was carried out by dividing the sample into income quartiles based on national data on rural income distribution. The quartiles are based on total household consumption rather than income. This is because estimates of consumption proved easier to obtain than estimates of income, where there is a multiplicity of overlapping sources[6].

Utilisation of public primary care facilities as reflected in attendance rates suggests that these services are primarily used by lower income groups. The bottom quintile accounts for more than 35 percent of visits while the richest group accounts for only fourteen percent (figure 2.7).

Figure 2.7: use of services by income quintile

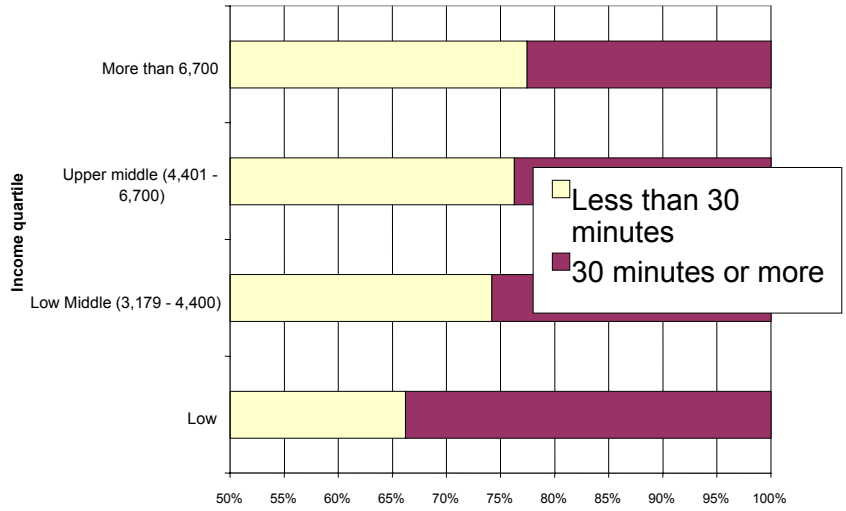


Source: BIA survey, HEU, 2000

Once at the health facility, patients have different experiences. Those in the richest quartile, for example, have to wait for less time before they are seen by a health professional (see figure 2.8).

[6] It should be noted, however, that national data suggest that on average the poorest group consume up to 50% more than their income, while the rich consume around eight percent less. The effect is to dampen any perceived income effect.

Figure 2.8: waiting time to see health professional by income group

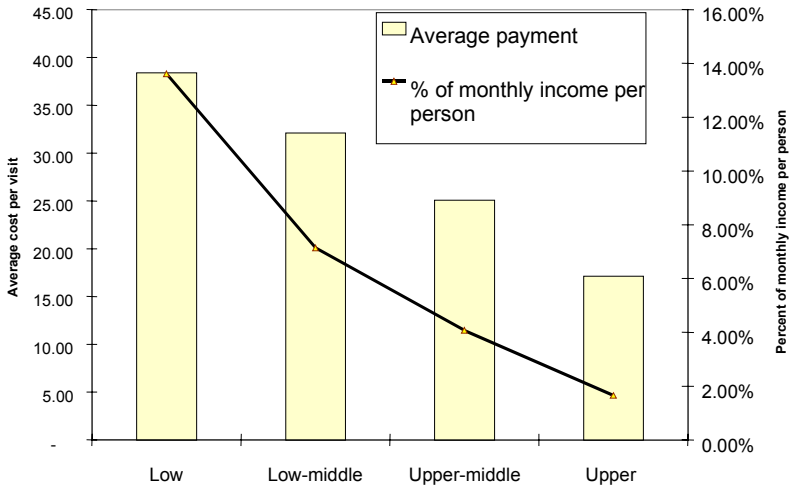


Source: BIA survey, HEU 2000.

Paying for services

There is also some evidence of inequity in the payment for services. For outpatient services the survey suggested that on average people in different income groups make similar payments - a total of about 16 Taka per visit. Just under a third of patients reported making a payment. Equal payments by income group do, however, imply unequal proportionate spending. One visit to a public facility costs a poor household about 19% percent of per capita household income compared with four percent for the richest quartile.

Figure 2.9: average patient cost per visit, percent of per capita monthly income



With inpatient services, provided by thana health complexes, the average payment made by the poorest income group rises. For all patients using facilities the amount is nearly 40 Taka (13% of per capita monthly income) compared to about 17 Taka for the richest group (less than 2 percent of income, see figure 2.9). If only those that made a payment are included, the amount rises to around 49% of per capita household income for the poorest household.

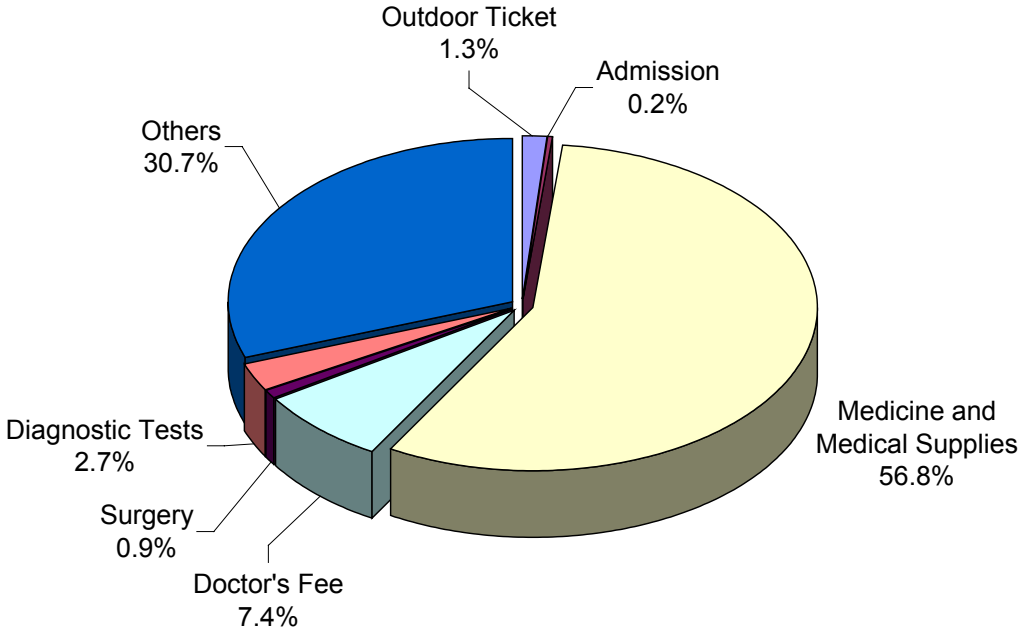
Some differences in per capita spending were also found between men and women. On average, men paid more for the treatment at both outpatient level (22 compared to 9.5 Taka) and both levels (51 compared to 17 Taka).

Table 2.2: average payments per user by income group and ESP category (Taka)

	Low	Low-middle	Upper middle	Upper	Total
Reproductive health - family planning	23.00		0.33	2.00	12.53
Reproductive health - maternal health	1.44	9.40	3.00		4.20
Reproductive health - other RH	0.38	125.10	34.75	60.00	63.04
Control of Communicable Diseases	79.29	109.67	24.75	1.40	73.05
Child Health (under 5)	2.19	56.77	12.73	3.29	13.77
Limited Curative Care	59.37	15.30	13.50	6.24	41.28
Symptoms only-medicines prescribed	33.74	12.11	38.64	28.27	29.10
Symptoms only – medicines not prescribed	1.55	-	-	13.00	1.58
Further tests/hospitalisation required	21.29	21.60	9.00	2.00	17.30

Payments varied considerably by type of service provided. The largest payments recorded were for communicable diseases (average 73 Taka) and limited curative care (41 Taka). Low payments were found for maternal care and family planning (less than 12 Taka on average). Of concern is the fact that higher payments were found for communicable diseases among the poorest group compared to other income groups (table 2.2).

Figure 2.10: composition of patient payments for public medical treatment



Source: BIA, Health Economics Unit, 2000

The reasons for these payments, and likely barriers they create to access, are complex and require more extensive investigation. It is clear, however, that most of the spending (more than 56 percent) is on medicines and other medical supplies required for treatment (figure 2.10). Around 10 percent of these payments were 'unofficial' payments to doctors and other medical staff.

Box two: prescribing practices – survey experiences

Drugs handed out often bear no relation to the medical complaint. A few common drugs such as paracetamol and anti-histamines are often given to most patients whether or not they are needed.
Patients are rarely referred to other facilities.
Patients receive little information on the cause or nature of their illness. Little advice is given on the proper use of drugs prescribed.
In several unions, signposts advertising a practitioner's private chambers were hung within the health facility.

Prescribing practices of providers were examined in some more detail. In many cases it was found that the medicines prescribed were inappropriate for the symptom or illness, were prescribed in the wrong dose or were given to the patient with inappropriate advice (see box two). In total, more than 91 percent of patients were prescribed some medicine as a result of their consultation, 7 percent of which were antibiotics. These general findings are confirmed by other surveys. A recent survey, for example, found that antibiotics are routinely prescribed for a high proportion of disorders based on extremely short consultation times (Ahmed, Chowdhury et al., 2000).

Key findings

A number of tentative conclusions arise from this analysis and can be summarised below.

- There appears to be some inequality in the use of non-reproductive health services. Males make up around 51 percent of the population yet consume about 58 percent of public spending. The difference is particularly marked for communicable disease control where males constitute 64 percent of users. Whether this difference constitutes inequity depends upon whether males have greater needs for these types of services.

- The poor make most use of services at thana levels and below, as measured by the number of patients presenting at public facilities.

There is some evidence of differential experience of the rich and poor once at the health facility and during the course of treatment. The poor wait longer than the rich for treatment. They also pay considerably more for services both in relative and absolute terms. Payments for communicable diseases are high and, given the large externalities involved, of particular concern. More investigation of the process of obtaining key services such as TB care is required to improve the access to care.

There is little evidence that public subsidies favour poorer areas. Indeed the reverse appears to be currently the case. Further work on methods for allocating resources by geographic region is required.

3. Medium term resource projections

According to the 1996/97 National Health Accounts, Bangladesh spends almost $11 dollars per capita on health care (Heath Economics Unit and Data International, 1998). More than two-thirds of this spending is out of pocket. There is evidence that considerable out of pocket spending is on ineffective drugs. In addition, several studies have shown that people already pay considerable sums for public services on an unofficial basis. Also, a variety of reports have pointed to the need for systems of risk pooling that protect people from the high costs of unexpected illness. While increases in total health spending will mainly result from increasing national income, it may be possible to channel some of the existing spending in ways that are more effective.

Two key additional sources of funding that could improve the effectiveness of the health care system are formalised user charges and health insurance. It should be emphasised that both of these have 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 (Khan and Quayyum, 2000;(Routh, Hossain et al., 2000). 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.

In this section some crude projections are made of the resources available to the public sector from the four main sources: government's own revenue, donor financing, user charges and health insurance. These projections are made on the basis of a series of assumptions. The main assumptions are set out in the boxes below. Further details are provided in annex 3.1.

Government's own revenue: total government revenue is assumed to increase with the growth of the economy (currently 3.5-4 percent rising to 5 percent by 2005). The existing efficiency of tax collection is 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. The projections assume that the government deficit rises to just over 6 percent in 2000/2001 but declines to 4.5 percent by 2005.

The proportion going to the health sector is assumed to remain constant at just over seven percent of GDP.

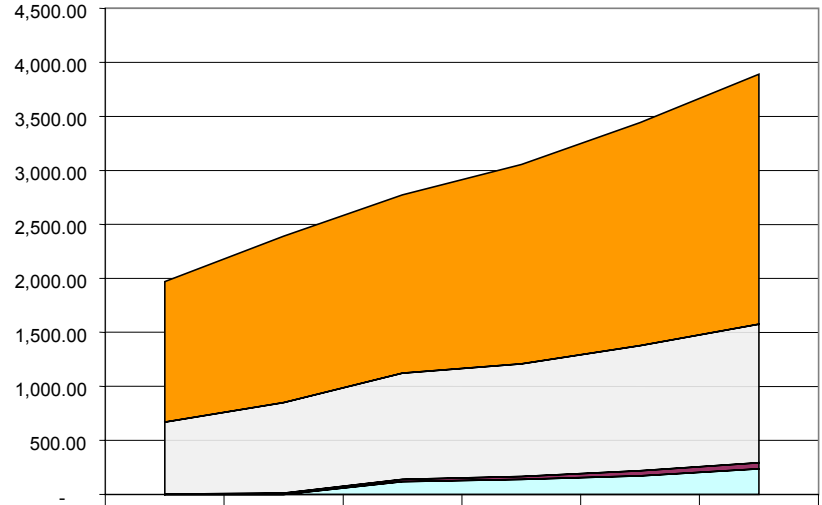
Donor funding: projecting funding by development partners is complicated by the fact that during the two years of HPSP the donor development budget has far exceeded actual spending. This has mostly been due to problems in procurement. It is assumed that during the next financial year these problems decline and that funding rises to 75 percent and then 80 percent of budget (in 1999/2000 spending was around 65 percent of budget).

User charges: It is assumed that the current submission to the Ministry of Finance for the return of user fee revenue in the next financial year is successful (Dave-Sen, Karim et al., 2000). The simulations assume that a user fee is initially piloted in about 10 percent of facilities before being extended to the majority of facilities by 2005. Charges are initially set at the current official admission ticket levels but, in addition, charges are introduced for outpatient treatment and inpatient admissions based on existing evidence of what people are willing to pay. Substantial exemptions for the poor and vulnerable are assumed, ranging from 60 percent of cases in primary to 20 percent of cases at tertiary level. No exemptions are given for entrance tickets.

Health insurance: it is assumed that insurance is developed in two ways. For the formal industrial sector, representing around 6 percent of the population, this is in the form of payroll based social health insurance (Ensor, 2000). Coverage is extended first to civil servants, by transferring part of the monthly medical allowance to a health fund (Killingsworth, 1999) and, later, to the formal private sector. Over a five year period coverage is assumed to rise to 50 percent of this sector.

Second, it is assumed voluntary community insurance is developed through multiple schemes for the 35 percent of the population employed in the informal sector. Premiums are assumed to be set at a similar level to those of existing NGO based schemes (Desmet, Chowdhury et al., 1999). Coverage is assumed to rise to five percent of this sector in five years.

Figure 3.1: finance available for publicly funded health care (1999 – 2005)



	1999/00	2000/01	2001/02	2002/2003	2003/04	2004/05
Government revenues (ADP & Revenue)	1,302.33	1,543.48	1,653.74	1,844.29	2,063.25	2,315.43
Donor ADP	666.07	837.00	981.37	1,046.12	1,157.42	1,284.74
User charges	1.40	12.32	20.12	27.27	49.84	55.15
Insurance	-	-	118.90	136.61	170.08	236.13

Figure 3.1 shows the evolution of revenue available for the public health sector over a five year period until 2005. Figures are given in nominal terms and assume a constant 5.5 percent inflation rate.

The most notable aspect of the projections is the continued dominance of government and development partner funding even once insurance and user charges begin to be implemented.

It shows that available resource grows by 92 percent over the five years (50% in real terms). Government revenue and development partner funding remains the dominant source, accounting for 93 percent of finance. Insurance accounts for 6.1 and user fees for 1.4 percent by 2005. Without the new sources of funding, resources would grow by around 82 percent (40% in real terms).

Alternative scenarios

There are clearly many points of uncertainty in these estimates and so the scope for sensitivity (sensitive?) analysis is potentially wide. Two further scenarios were carried out (detailed in annex table A3.1).

Scenario 2: macroeconomic variables are assumed to remain the same. Revenue from insurance increases as a result of:

- higher community insurance coverage - rising to 15% of target population;
- larger formal (word missing?)– rising to 12% of the population;
- larger community contribution – increasing from 50 to 100 Taka per person, per year (constant prices).

Scenario 3: macroeconomic variables are assumed to remain the same. Revenue from user fees increases as a result of:

- inpatient fees rising to 1,000 Taka for tertiary and 150 Taka for district hospital admissions by 2005;
- outpatient treatment charges rising to 70 Taka (average) at tertiary and 30 Taka at district hospitals.

Table 3.1: revenue projections under different assumptions (Crore Taka)

	Baseline (2001)	2005 (S1)	2005 (S2)	2005 (S3)
Insurance	-	236	536	236
User charges	12	55	55	76
Donor ADP	837	1,285	1,285	1,285
Government revenues (ADP & Revenue)	1,543	2,315	2,315	2,315
Total	2,393	3,891	4,192	3,912
Percentage shares:				
Insurance	0.0%	6.1%	12.8%	6.0%
User charges	0.5%	1.4%	1.3%	1.9%
Donor ADP	35.0%	33.0%	30.6%	32.8%
Government revenues (ADP & Revenue)	64.5%	59.5%	55.2%	59.2%
Increase in revenue		97.0%	112.0%	98.0%
Increase in real revenue		51.0%	62.0%	52.0%

Revenue projections under each scenario are shown in table 3.1. A notable feature is that, even with relatively high user charges, overall revenue generation from this source remains small. This could be increased if exemptions were reduced but much care would have to be exercised to ensure that access by vulnerable groups was not affected detrimentally.

Revenue from insurance does have the potential to contribute a significant amount of revenue to the health sector. The qualification here is that increasing coverage even to the modest levels suggested in the scenarios is a significant task that may prove difficult to achieve within the time frame of the scenarios. A second important qualification is that obtaining insurance contributions, particularly on a voluntary basis in the case of community insurance, requires that the insured receive valued and significant benefits. Often the benefits that are required relate to high cost hospital treatment. It is therefore important to be aware that much of this revenue may not be retained to improve essential care as currently defined by the ESP.

An important question is whether the revenue projections are sufficient to cover the long-term sustainable costs of the essential service package and other services offered by government. To answer this question comprehensively, it is necessary to obtain an accurate full-cost estimate of good quality ESP services. This will take into account the necessary recurrent costs of the package together with the ongoing replacement costs of equipment purchased under HPSP. The ESP study mentioned earlier would provide some of this information but the final analysis was not available at the time of writing this report. A more detailed analysis will be produced later.

Conclusion

Macro overview of spending

Sections one and two provide a varied picture of resource allocation and utilisation in the health sector.

Section one indicates that as much as two thirds of HPSP finance is being channelled into the Essential Service Package. On the development side this is dominated by spending on family planning, child health and general investments in infrastructure. When the revenue budget is included substantial resources are seen to be expended through the use of staff time on family planning, child health, limited curative care and, to a lesser extent, maternal health.

Section two presents a slightly different picture. It suggests that, in terms of patient load, patients that fit into the Child Health, Limited Curative Care and Symptoms Only categories make up the majority of users. These different pictures are not necessarily incompatible. Most of the Symptoms Only and LCC patients will receive little in terms of staff time and clinic resources, although most are advised to purchase medicines. Nevertheless, an interesting aspect of HPSP's attempt to prioritise services is that most patients using the ESP level facilities are not actually demanding ESP services that receive the most development funding.

Equity analysis

The equity analysis supports the view that ESP level services are mostly being demanded by those in the lowest income groups. Most patients presenting for treatment are from the lower income groups, a fact that lends credence to the view that reasonably effective pro-poor targeting can be achieved through general subsidies to primary care facilities.

This judgement must, however, be qualified by the observation that there are inequalities in the process of obtaining care, as indicated by factors such as waiting times and patient payments. Geographic targeting of needier areas also appears weak, although the lack of district wise data on DPA funding means that this conclusion is tentative.

Although services and expenditure flows appear to be reasonably equally divided according to gender, some potential inequities are apparent. When reproductive health care is excluded, men and boys appear to use more child health, communicable disease and un-categorised primary level services than women and girls.

Resource envelope

The estimates of future resources for public services indicate that the source of funding will continue to be overwhelmingly tax and donor financed. User charges may become an important form of additional revenue for local facilities, but for the country as a whole the percentage will remain small in the medium term. Insurance does have the potential to provide significant additional funding, mostly through gradual coverage of the formal sector. The other important purposes of both of these sources are ways of channelling existing out of pocket spending in a more effective way.

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Annex: 1: Detailed expenditure tables

A1.1 Health and Population Allocation and Expenditure in Five-Year Plans (Crore Taka)

Categories	First FYP (1973-78)	Two Year Plan (1978-80)	Second FYP (1980-85)	Third FYP (1985-90)	Fourth FYP (1990-95/97)	Fifth FYP (1997-2002)
Total FYP Allocation	3,952	3,261	16,060	25,000	34,700	85,894
Health and FW Allocation	147.8	117.6	781.0	1,420.0	2,658.0	9,086.2
Share of H&FW Allocation in Total FYP Allocation	3.74%	3.61%	4.86%	5.68%	7.66%	10.58%
Total FYP Expenditure	1,635	2,402	13,929	16,757.3	32,244	
Health & FW Expenditure	133.17	114.57	717	917.5	2,499	n.a.
Share of H&FW Expenditure in Total FYP Expenditure	8.14%	4.77%	5.15%	5.48%	7.75%	n.a.

Source: Various Five -Year Plans

* The figures are based on the prices of the first year of the Five-Year Plans

A1.2 Per Capita Expenditures by MOHFW, 1993/94-1999/2000

Period	Per capita expenditures on health and family welfare		Share in GDP
	At current price	At constant price (1993-94=100)	
1993-94	92.71	92.71	1.12
1994-95	116.58	107.09	1.27
1995-96	121.63	104.75	1.21
1996-97	143.95	120.93	1.36
1997-98	152.82	119.99	1.34
1998-99	135.3	103.8	1.15
1999-00	153.5	115.18	1.10

Source: MAU and HEU estimates

A1.3: Trends in MOHFW Revenue and ADP Expenditures (Crore Taka)

Categories / Year	1993/94		1994/95		1995/96		1996/97		1997/98		1998/99		1999/00 (revised budget)			
	Allocation	Expend.	Allocation	Expend.	Allocation	Expend.	Allocation	Expend.	Allocation	Expend.	Allocation	Expend.	Net		Revenue (or non-capital)	
													Allocation	Expend.	Allocation	Expend.
Total GOB revenue*	7,063	7,595	8,555	9,623	10,073	10,751	11,497	11,908	14,544	13,108	14,708	14,596	26,228.9	29,717.0	18,443.9	21,510.7
MOHFW revenue	431	504	575	593	686	647	711	733	776	786	851	876	972.4	957.7	972.4	957.7
MOHFW share in total revenue (in %)	6.1%	6.6%	6.7%	6.2%	6.8%	6.0%	6.2%	6.2%	5.3%	6.0%	5.8%	6.0%	3.7%	3.2%	5.3%	4.5%
Total GOB ADP	6,740	8,549	9,460	9,589	11,011	9,507	11,875	11,115	12,890	12,324	13,695	14,122	17,056.0	12,351.5	3,478.4	6,679.7
MOHFW ADP **	523	569	768	781	897	812	953	1,025	1,131	1,112	1,272	981	1,373.0	1,120.7	1,351.4	1,104.9
MOHFW share in total ADP (in %)	7.8%	6.7%	8.1%	8.1%	8.1%	8.5%	8.0%	9.2%	8.8%	9.0%	9.3%	6.9%	8.0%	9.1%	38.9%	16.5%
Total GOB expenditure (rev + ADP)	13,803	16,144	18,015	19,212	21,084	20,257	23,372	23,023	27,434	25,432	28,403	28,718	43,284.9	42,068.5	21,922.3	28,190.4
Total MOHFW expenditure (rev + ADP)	954	1,072	1,343	1,374	1,583	1,459	1,664	1,758	1,907	1,898	2,123	1,857	2,345.4	2,078.4	2,323.8	2,062.7
MOHFW share in total GOB expenditure (in %)	6.9%	6.6%	7.5%	7.2%	7.5%	7.2%	7.1%	7.6%	7.0%	7.5%	7.5%	6.5%	5.4%	4.9%	10.6%	7.3%

Source: Budget documents 2000-2001, ADP report 2000-2001 and MAU (CGA, PFC and LD SOEs).
Notes: Total GOB / MOHFW revenue and ADP figures include GOB and Project Aid.

* GOB Revenue Budget / Expenditure or the Non-Development Budget / Expenditure has two components: 'revenue account' and 'capital account'. When the budget includes all allocations including those in CD/VAT or other forms of investment incomes, it's called the '*Gross Budget*'. On the other hand, '*Revenue Budget'* excludes such income through investments which are known as 'capital account expenditure'. In addition to these, the budget or expenditure of the 'income earning sectors' or alternatively, known as, 'lending sectors' (for example, T&T board; Railway department, etc) are excluded in '*Net Budget'* calculation. (throughout the PER, the 'net' figures have been used)

** Tk. 15 Crore was allocated to Planning Commission from MOHFW ADP revised budget allocation during June 1999/00. This caused the original revised budget of Tk. 1,391Crore to come down to Tk. 1,376 Crore. This new revised allocation includes allocation for NIPHP (Taka 93.96 Crore), in addition to allocation of Tk. 3 Crore to Red Crescent Hospital. Tk. 1,373 Crore, is therefore, the share of HPSP in the MOHFWs' development budget allocation.

MOHFWs ADP expenditure for 1999/2000 includes NIPHP expenditure.

A1.4: GOB and Donor Expenditure in MOHFW Financing and for all Government (Crore Taka)

Categories / Year	1993/94	1994/95	1995/96	1996/97	1997/98	Budget		Expenditure	
						1998/99	1999/00	1998/99	1999/00
Total MOHFW expenditure (rev. + Devt.)	1,072.4	1,373.7	1,458.9	1,758.2	1,897.9	2,160.0	2,346.2	1,856.9	2,078.4
GOB contribution in MOHFW expenditure (Rev. + Devt.)	691.7	947.9	960.0	1,142.8	1,208.9	1,298.3	1,371.2	1,227.8	1,287.9
Total donor contribution in MOHFW expenditure *	380.7	425.9	500.4	617.1	688.9	861.7	975.0	629.2	790.5
GOB share in total MOHFW expenditure (%)	**64.5%**	**69.0%**	**65.8%**	**65.0%**	**63.7%**	**60.1%**	**58.4%**	**66.1%**	**62.0%**
Donor's share in total MOHFW expenditure (%)	**35.5%**	**31.0%**	**34.3%**	**35.1%**	**36.3%**	**39.9%**	**41.6%**	**33.9%**	**38.0%**

Source: PCC and MAU (CGA, PFC and LD SOEs).
Note: Both budget and expenditure figures include accounting exclusively for HPSP.
* includes NIPHP expenditure (Taka 93.96 crore) for the year 1999/2000.

A1.5: Government and Donor's Contribution in the MOHFW Expenditure and Allocation in Health and Population Sector (Crore Taka)

Source of Fund	Revenue		Development			Total		
	Budget (1)	Expenditure (2)	Approved budget (3)	Revised budget (4)	Expenditure (5)	Approved budget allocation (1+3)	Revised budget (1+4)	Expenditure (2+5)
			Made up of					
GOB *(% of d)*	**972.4**	**957.7**	**439.9** *(30.0%)*	**398.8** *(29.0%)*	**330.2** *(31.1%)*	**1,412.3** *(57.8%)*	**1,371.2** *(58.4%)*	**1,287.9** *(64.9%)*
Reimbursable program aid (through GOB) (a)			208.5	219.9	160.4	208.5	219.9	160.4
Reimbursable program aid (other) (b)			299.0	186.6	80.4	299.0	186.6	80.4
Direct program aid (c)*			521.9	568.4	549.6	521.9	568.4	549.6
Total Program Aid (a+b+c) *(% of d)*			**1,029.4** *(70.1%)*	**974.9** *(71.0%)*	**790.4** *(70.5%)*	**1,029.4** *(42.2%)*	**974.9** *(41.6%)*	**790.4** *(38.0%)*
Total (d)	972.4	957.7	1,469.3	1,373.7	1,120.6	2,441.7	2,346.1	2,078.3

Source: GOB Budget Documents 2000-2001, PCC and MAU.
Notes: Both budget and expenditure figures include accounting exclusively for HPSP.

1. Reimbursable Program Aid (GOB) - directly reimbursed by development partners to GOB to the value of 10% of GOB allocations for FY 1999-2000.
2. Reimbursable Program Aid (other) – pooled funding allocated by the donor consortium.
3. Direct Program Aid – other bilateral aid from development partners.

*DPA expenditure includes expenditure incurred under NIPHP for the year 1999/2000.

A1.6: Distribution of Total Salary and Non-Salary Recurrent and for Capital Expenditures, 1999/00 (Crore Taka)

Categories	Revenue (1)	Development (2)	Total Expenditure (1+2)
Recurrent *	**945.6**	**943.1**	**1,888.7**
(% in Total)	**(98.7%)**	**(84.2%)**	**(90.9%)**
Salary	632.4	326.8	959.2
Non-salary	313.2	616.3	929.5
Capital	**12.0**	**177.6**	**189.6**
(% in Total)	**(1.3%)**	**(15.8%)**	**(9.1%)**
Total sector (available breakdown)	***957.6***	***1,120.7***	***2,078.3***

Source: MAU (CGA, PFC and LD SOEs) and PCC
Note: ADP figures include GOB and Project Aid.
* Assuming that Salary to Non Salary ratio in NIPHP expenditure is 9:1 and no expenditure occurred under Capital heading.

A1.7: Development Expenditure by Source and Operational Plan for 1999/00 (Million Taka)

Operational Plan	Yearly budget					GOB Development	RPA through GOB	Other RPA	DPA	Total
	GOB	RPA (GOB)	RPA (Others)	DPA	Total	Expenditure	Expenditure	Expenditure	Expenditure	Expenditure
ESP (Other than RH)	319	0	756	803	1,878	204	0	256	788	1,248
ESP (RH)	1,791	1,298	132	2,672	5,893	1,591	875	93	2,400	4,959
Reorganisation Of Service Delivery	0	0	0	107	107	0	0	0	82	82
HRM, MOHFW(DGHS+DGFP)	2	0	18	0	20	1	0	1	4	6
Pre Service Education	128	0	21	20	169	96	0	3	12	111
In Service Training	56	0	102	68	226	26	0	134	518	678
Nursing Services And Education	5	0	1	30	36	2	0	0	13	15
CMMU	1,135	901	31	110	2,177	863	621	115	0	1,598
Procurement, Storage And Supply – DGFP	243	0	6	67	316	235	0	0	67	302
Procurement, Storage And Supply – DGHS	19	0	1	0	20	101	0	0	0	101
Quality Assurance	2	0	13	0	15	3	0	16	19	38
Unified BCC	25	0	1	321	347	22	0	0	316	338
Unified MIS	26	0	9	10	45	17	0	0	0	17
R & D – DGHS	4	0	43	21	68	2	0	29	3	34
R & D – DGFP	3	0	16	242	261	1	0	5	179	186
Hospital Services	340	0	13	78	431	323	0	1	49	373

A1.7: Development Expenditure by Source and Operational Plan for 1999/00 (Million Taka) (Contd.)

Operational Plan	Yearly budget					GOB Development	RPA through GOB	Other RPA	DPA	Total
	GOB	RPA (GOB)	RPA (Others)	DPA	Total	Expenditure	Expenditure	Expenditure	Expenditure	Expenditure
Alternative Medical Care Facilities	5	0	2	1	8	6	0	0	0	6
SWM, MOHFW(DGHS+DGFP)	4	0	9	32	45	2	0	1	2	5
Improved Financial Management, MOHFW	4	0	0	18	22	3	0	0	17	20
Improved Financial Management, DGHS	1	0	1	0	2	0	0	0	0	0
Improved Financial Management, DGFP	3	0	0	0	3	2	0	0	0	2
Policy Research Unit (PRU)	3	1	4	72	80	1	1	0	51	53
Drug Administration	0	0	4	0	4	0	0	0	0	0
Regulation	1	0	2	0	3	0	0	0	0	0
Environmental And Occupational Health	2	0	1	26	29	0	0	1	23	24
Inter-Sectoral Multi-Sectoral Collaboration	0	0	1	0	1	0	0	0	0	0
BINP	18	0	682	27	727	14	0	622	0	636
Micro-Nutrient Supplementation	0	0	0	21	21	0	0	0	14	14
USAID supported NIPHP program activities				*940*	*940*				*940*	*940*
TOTAL	4,138	2,220	1,866	5,685	13,894	3,515	1,497	1,277	5,496	11,786

Source: MAU (Budgets from revised Operational Plan, 1999-00 and the expenditures from (LD SOEs).
Note: The figures differ from those provided in the earlier tables because of the difference between the sources of information.

A1.8: Allocation of operational plan sub-components to the ESP spending

Development/non-development	Level 2	Level 3	Allocation
Non-Development	Secretariat	Secretariat	Overhead
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh Homeopathy Board	0%
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh Unani and Ayurvedic Board	0%
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh Medical Research Council	0%
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh National Medical Institute	0%
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh College of Physicians and Surgeons	0%
Non-Development	Autonomous Bodies & Other Institutions	Dhaka Shishu Hospital	0%
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh Child Health Institute	0%
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh Medical and Dental Council	Overhead
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh National Nutrition Council	0%
Non-Development	Autonomous Bodies & Other Institutions	Bangabandhu Seikh Mujib Medical University	0%
Non-Development	Autonomous Bodies & Other Institutions	Chittagong Eye Hospital and Training Complex	0%
Non-Development	Autonomous Bodies & Other Institutions	Inst. of Applied Health Science & Bangabandhu Memorial Hospital, Chittagong	0%
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh Association for the Aged	0%
Non-Development	Autonomous Bodies & Other Institutions	ICDDR-B	Overhead
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh Institute of Herbal Medicine	0%
Non-Development	Autonomous Bodies & Other Institutions	National Heart Foundation	0%
Non-Development	Autonomous Bodies & Other Institutions	Shishu Sasthya Foundation, Bangladesh	0%
Non-Development	Autonomous Bodies & Other Institutions	Khulna Shishu hospital	0%
Non-Development	Autonomous Bodies & Other Institutions	Dr. Zahed Shishu Hospital, Faridpur	0%
Non-Development	Autonomous Bodies & Other Institutions	Society for Assistance to Hearing Impaired Children	0%
Non-Development	Autonomous Bodies & Other Institutions	Moulavibazar BNSB Eye Hospital	0%
Non-Development	Autonomous Bodies & Other Institutions	Khulna BNSB Eye Hospital	0%
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh Family Planning Association	100%
Non-Development	Autonomous Bodies & Other Institutions	Bangladesh Diabetic Association	0%
Non-Development	International Organisations	WHO	Overhead
Non-Development	International Organisations	Eye Programme	0%
Non-Development	International Organisations	Population & Development	Overhead
Non-Development	Department of Health Services	Department of Health Services	Overhead
Non-Development	Divisional Establishments	Divisional Establishments	Overhead
Non-Development	Civil Surgeons Offices	Civil Surgeons Offices	Overhead
Non-Development	Thana Health Offices	Thana Health Offices	100%
Non-Development	Directorate of Drug Administration	Directorate of Drug Administration	Overhead
Non-Development	Directorate of Nursing	Directorate of Nursing	Overhead
Non-Development	Medical Colleges	Dhaka Medical College, Dhaka	0%
Non-Development	Medical Colleges	Sir Salimullah Medical College, Dhaka	0%
Non-Development	Medical Colleges	Rajshahi Medical College, Rajshahi	0%
Non-Development	Medical Colleges	Rangpur Medical College, Rangpur	0%
Non-Development	Medical Colleges	Mymensingh Medical College, Mymensingh	0%
Non-Development	Medical Colleges	Chittagong Medical College, Chittagong	0%
Non-Development	Medical Colleges	Sylhet Medical College, Sylhet	0%
Non-Development	Medical Colleges	Sher-e-Bangla Medical College, Barisal	0%
Non-Development	Paramedical Institutes	Para Medical Institutes	100%
Non-Development	Medical Assistant Training Schools	Medical Assistant Training Schools	Overhead
Non-Development	TB Control and Training Institute	TB Control and Training Institutes	100%
Non-Development	Dental Colleges	Dhaka Dental College	0%
Non-Development	College of Nursing	College of Nursing	Overhead

Non-Development	Sylhet Ayurved & Tibbia College	Sylhet Ayurved & Tibbia College	0%
Non-Development	Dhaka Homeopathic Medical College	Dhaka Homeopathic Medical College	0%
Non-Development	Medical College Hospitals	Dhaka Medical College Hospital	0%
Non-Development	Medical College Hospitals	Sir Salimullah Medical College Hospital	0%
Non-Development	Medical College Hospitals	Rajshahi Medical College Hospital	0%
Non-Development	Medical College Hospitals	Rangpur Medical College Hospital	0%
Non-Development	Medical College Hospitals	Mymensingh Medical College Hospital	0%
Non-Development	Medical College Hospitals	Chittagong Medical College Hospital	0%
Non-Development	Medical College Hospitals	Sylhet Medical College Hospital	0%
Non-Development	Medical College Hospitals	Sher-e-Bangla Medical College Hospital, Barisal	0%
Non-Development	District Hospitals	District Hospitals	0%
Non-Development	Other District Hospitals	Thana Hospitals	100%
Non-Development	Other District Hospitals	Narayanganj Hospital (200 bed)	0%
Non-Development	Other District Hospitals	Comilla (250 bed)	0%
Non-Development	Thana Health Complex and Sub Centres	Thana Health Complex and Sub Centres	100%
Non-Development	Union Health & Family Welfare Centres	Union Health & Family Welfare Centres	100%
Non-Development	Specialised Hospitals and Institutions	Shaheed Suhrawardy Hospital , Dhaka	0%
Non-Development	Specialised Hospitals and Institutions	Rehabilitation institute and Hospital for disabled, Dhaka	0%
Non-Development	Specialised Hospitals and Institutions	Institute of Ophthalmology	0%
Non-Development	Specialised Hospitals and Institutions	Institute of Diseases of the Chest & Hospital, Dhaka	0%
Non-Development	Specialised Hospitals and Institutions	Infectious Diseases Hospital, Dhaka	0%
Non-Development	Specialised Hospitals and Institutions	Institute of Cardiovascular Diseases, Dhaka	0%
Non-Development	Specialised Hospitals and Institutions	National Institute of Preventive and Social Medicine, Dhaka	0%
Non-Development	Specialised Hospitals and Institutions	Institute of Public Health Nutrition, Dhaka	0%
Non-Development	Specialised Hospitals and Institutions	Institute of Public Health	0%
Non-Development	Specialised Hospitals and Institutions	Mental Hospital , Pabna	0%
Non-Development	Specialised Hospitals and Institutions	Inst. of Epidermiology, Disease Control & Research	0%
Non-Development	Specialised Hospitals and Institutions	National Centre for Control of Rheumatic Fever	0%
Non-Development	Specialised Hospitals and Institutions	Cancer Institute and Research Hospital, Dhaka	0%
Non-Development	Specialised Hospitals and Institutions	Institute of Mental Health & Research	0%
Non-Development	Specialised Hospitals and Institutions	TB Segregation Hospitals	100%
Non-Development	Specialised Hospitals and Institutions	Other TB Hospitals	100%
Non-Development	Specialised Hospitals and Institutions	Leprosy Hospitals	100%
Non-Development	Epidemic Disease Control Centres	Airport Health , Dhaka	0%
Non-Development	Epidemic Disease Control Centres	Port Health, Chittagong	0%
Non-Development	Epidemic Disease Control Centres	Port Health, Chalna	0%
Non-Development	TB Centres (42)	TB Centres	100%
Non-Development	School Health Centres	School Health Clinics	100%
Non-Development	Other Facilities	Skin and Social Hygiene Centre , Chittagong	0%
Non-Development	Other Facilities	Secretariat Hospital	0%
Non-Development	Other Facilities	Prime Minister Secretariat Clinic	0%
Non-Development	Other Facilities	Shangshad Bhaban Dispensary	0%
Non-Development	Other Facilities	Maternity Centre, Motijheel	0%
Non-Development	Other Facilities	Model Family Planning Clinic (8)	100%
Non-Development	Other Facilities	Government Employees Hospital , Dhaka	0%
Non-Development	Other Facilities	National Library and Documentation Centre	0%
Non-Development	Other Facilities	Transport and Equipment Maintenance Organisation	0%
Non-Development	Other Facilities	Electro-Medical Equipment Maintenance Centre	0%
Non-Development	Urban Dispensary	Urban Dispensary (34)	100%
Non-Development	Department of Family Planning	Department of Family Planning	Overhead
Non-Development	Divisional Offices	Divisional Offices	Overhead
Non-Development	District Offices	District Offices	Overhead
Non-Development	Thana Offices	Thana Offices	100%
Non-Development	Hospitals and Dispensaries	Hospitals and Dispensaries	Overhead

Non-Development	Other Family Welfare Facilities	Model Family Planning Clinic	100%
Non-Development	Other Family Welfare Facilities	NIPORT	Overhead
Development	HPSP	Child Health	100%
Development	HPSP	Support Services and NGO Grant	100%
Development	HPSP	Reproductive Health	100%
Development	HPSP	Child Health	100%
Development	HPSP	Limited Curative Care	100%
Development	HPSP	Communicable Disease Control	100%
Development	HPSP	STD/AIDS	100%
Development	HPSP	Support Services and NGO Grant	100%
Development	HPSP	Clinical F. P. Service Delivery	100%
Development	HPSP	Maternal Health Care	100%
Development	HPSP	Maternal Nutrition Services	100%
Development	HPSP	Adolescent Health Services	100%
Development	HPSP	Family Planing Service Delivery	100%
Development	HPSP	Muhammadpur Fertility Services and Training Centre	100%
Development	HPSP	Maternal and Child Health Institute, Azimpur	100%
Development	HPSP	Reorganisation of Service Delivery (MCU)	Overhead
Development	HPSP	Strengthening of Logistics Management System	Overhead
Development	HPSP	Procurement Processing	Overhead
Development	HPSP	Improve and Strengthen Storage and Distribution System	Overhead
Development	HPSP	Continue and Strengthening of Logistics Operation System	Overhead
Development	HPSP	Procurement Processing	Overhead
Development	HPSP	Improve Storage and Distribution System	Overhead
Development	HPSP	Support Services (SS)	Overhead
Development	HPSP	Hospital Information System	0%
Development	HPSP	System Support	0%
Development	HPSP	Other MIS Management	Overhead
Development	HPSP	Strengthening the BCC Unit	100%
Development	HPSP	Subcontract different activities related to BCC production and development	100%
Development	HPSP	Monitoring and Evaluation	Overhead
Development	HPSP	Health and Population Nutrition Cell (Radio)	100%
Development	HPSP	Centre For BCC	100%
Development	HPSP	Strengthening In-service Training	Overhead
Development	HPSP	National Institute of Population Research and Training (NIPORT)	Overhead
Development	HPSP	Regional Training Centre (RTC)	Overhead
Development	HPSP	FWV Training Institute (FWVTI)	Overhead
Development	HPSP	National Institute of Kidney Diseases and Urology, Dhaka	0%
Development	HPSP	National Institute of Cardio Vascular Disease (NICVD), Dhaka	0%
Development	HPSP	National Institute of Mental Health Research and establishment of 100 bed hospital at Pabna	0%
Development	HPSP	Strengthening HRM -Health Service	Overhead
Development	HPSP	Strengthening HRM -Family Planning	Overhead
Development	HPSP	Strengthen and upgrade hospitals selected for Improved Hospital Management	0%
Development	HPSP	Strengthening of MCH care in district Hospitals	0%
Development	HPSP	Khulna Medical College Hospital	0%
Development	HPSP	250 Bedded Specialised Hospital at Khalishpur, Khulna	0%
Development	HPSP	Vaccine Testing Unit of DTL	0%
Development	HPSP	National Institute of Mental Health Research 100 bed Hospital	0%
Development	HPSP	National Institute of Cardiovascular Diseases	0%
Development	HPSP	Comilla Medical College Hospital	0%
Development	HPSP	Bogra Medical College Hospital	0%
Development	HPSP	ADB Assisted 2nd Health and Family Planning Service	0%
Development	HPSP	Strengthening Nursing Directorate	Overhead
Development	HPSP	Strengthening Nursing Education	Overhead
Development	HPSP	Bangladesh College of Nursing	Overhead
Development	HPSP	Nurses Training Centre (NTC)	Overhead
Development	HPSP	Strengthening Quality Assurance Services	Overhead
Development	HPSP	Strengthening of Medical Education	Overhead
Development	HPSP	Faridpur Medical College, Faridpur	Overhead
Development	HPSP	Bogra Medical College, Bogra	Overhead
Development	HPSP	Comilla Medical College, Comilla	Overhead
Development	HPSP	Paramedical Institutes	Overhead
Development	HPSP	Development & Strengthening capacity for research	Overhead
Development	HPSP	Bangladesh Medical Research Council (BMRC)	8%
Development	HPSP	Strengthening SWM -Health Service	Overhead

Development	HPSP	Establishment of Centre for Environmental and Occupational Health	0%
Development	HPSP	Improving Environmental and Occupational Health	0%
Development	HPSP	Poultry Nutrition	100%
Development	HPSP	Household food security through Nutrition Gardening	100%
Development	HPSP	Nutrition communication activities	100%
Development	HPSP	Nutrition Information & Communication activities through BTV	100%
Development	HPSP	Development of nutrition programme through intensive publicity and exhibition of documentary films	100%
Development	HPSP	Reduction of Malnutrition of Women and Children in Bangladesh	100%
Development	HPSP	Strengthening of Nutrition unit of DGHS	100%
Development	HPSP	Pilot alternative medical care (Homeo, Unani and Ayurvedi) in selected Hospitals	0%
Development	HPSP	Upgradation of Health and Family Welfare Centres - HFWCs at Union Level	100%
Development	HPSP	Upgradation of Thana Health Complex	100%
Development	HPSP	Upgradation of District Hospitals	0%
Development	HPSP	Remodelling of Union Health and Family Welfare Centres -HFWCs	100%
Development	HPSP	Remodelling of Thana Health Complexes	100%
Development	HPSP	Construction of Community Clinics	100%
Development	HPSP	Construction of Health & Population Bhaban	0%
Development	HPSP	Establishment of 250 bed Medical College at Dinajpur	0%
Development	HPSP	Establishment of 50 bedded Burn Unit at Dhaka Medical College Hospital	0%
Development	HPSP	Establishment of 250 bedded Specialised Hospital at Khalishpur, Khulna	0%
Development	HPSP	Upgradation of 250 bedded Faridpur Medical Hospital to 500 bedded Medical College Hospital	0%
Development	HPSP	Establishment of National Centre for Control of Rheumatic Fever and Heart Diseases	0%
Development	HPSP	Further Development of National Institute of Mental Health Research & Establishment of 100 bed Hospital	0%
Development	HPSP	Establishment of National Institute of Cardiovascular Diseases	0%
Development	HPSP	Establishment of 20 bedded hospital at Ullapara	0%
Development	HPSP	Establishment of 5 Medical Colleges at Comilla, Dinajpur, Bogra, Faridpur and Khulna	0%
Development	HPSP	Establishment of 31 bed hospital at Haragacha	100%
Development	HPSP	Establishment of Health Complexes with 31 bed at Godagari, Fulgazi and Dumki	100%
Development	HPSP	Establishment of 25 bedded Diabetic Hospitals in 7 Districts	0%
Development	HPSP	Block Allocation for Post Flood Rehabilitation	0%
Development	HPSP	Establish MAU & implement financial management system including training	Overhead
Development	HPSP	Strengthening Financial Management System -Health Service	Overhead
Development	HPSP	Strengthening Financial Management System -DGFP	Overhead
Development	HPSP	Strengthening Capacity in Health Economics	Overhead
Development	HPSP	HRD Policy Unit	Overhead
Development	HPSP	Gender Unit	Overhead
Development	HPSP	Stakeholder Unit	Overhead
Development	HPSP	Strengthening Planning and Research	Overhead
Development	HPSP	Coordination of research activities of NIPORT	Overhead
Development	HPSP	Capacity building for SWM	Overhead
Development	HPSP	Programme Coordination Cell	Overhead
Development	HPSP	Family planning service delivery	100%
Development	HPSP	Family planning service delivery	100%
Development	HPSP	Family planning service delivery	100%

Source: MAU and HEU calculations

A1.9: ESP development spending by component and apportioned revenue spending (Crore Taka)[7]

.	Development Budget					
1	2	3	4	5	6	7
	GoB.	RPA (other) + DPA	Total	%	Development plus apportioned revenue	%
Reproductive Health	.	.	.	.	.	.
Family planning	234.40	195.21	429.61	61.1%	321.3	28.1%
Maternal Health	11.33	26.00	37.33	5.3%	151.2	13.2%
Other reproductive health	1.28	7.19	8.47	1.2%	49.1	4.3%
Child Health	16.76	90.42	107.18	15.2%	404.9	35.5%
Control of Communicable diseases	2.34	0.16	2.51	0.4%	38.7	3.4%
Limited Curative Care	0.12	-	0.12	0.0%	143.1	12.5%
BCC	1.48	31.62	33.10	4.7%	33.1	2.9%
Direct overhead	75.93	8.88	84.82	12.1%	-	
Total	343.65	359.48	703.13	100%	1,143.4	100%

Notes to columns:

1. ESP sub-component
2. GoB and RPA through government development spending.
3. Pooled funding and DPA development spending.
4. Total Development spending
5. Sub-component shares based on development spending.
6. Apportioned revenue spending and salary component of development spending, according to work pattern analysis.
7. Sub-component shares based on total ESP spending.

Note also: there is a BCC component in many of the other sub-components that is hard to separate. Total spending on BCC is, therefore, likely to be under-estimated.

[7] Excludes BINP.

Annex: 2: Detailed equity analysis tables

A2.1: district-wise public expenditures per capita (total, male & female), Taka

			Per capita			Bed-days base		
	Division	District	Non-development	Development	Total	Expenditure per male	Expenditure per female	Male as % female
BANGLADESH			75.91	39.39	115.30	83.80	86.17	
1	Dhaka	DHAKA	284.39	121.91	406.31	-	-	
2	Rest of Dhaka	NARAYANGANJ	45.77	20.17	65.94	63.22	69.06	91.5%
3		MUNSHIANJ	55.94	28.82	84.76	82.26	87.37	94.2%
4		MANIKGANJ	65.59	27.37	92.95	88.97	96.97	91.7%
5		GAZIPUR	37.02	17.48	54.50	49.94	59.43	84.0%
6		NARSINGDI	33.88	27.46	61.33	57.31	65.64	87.3%
7		FARIDPUR	86.57	83.79	170.36	156.93	184.31	85.1%
8		RAJBARI	56.23	28.93	85.16	82.87	87.59	94.6%
9		GOPALGANJ	58.95	27.40	86.35	89.44	83.23	107.5%
10		MADARIPUR	49.72	26.74	76.46	82.72	70.01	118.2%
11		SHARIATPUR	54.30	26.67	80.97	85.79	76.08	112.8%
12		TANGAIL	50.88	25.00	75.88	74.17	77.64	95.5%
13		JAMALPUR	44.88	28.78	73.66	78.95	68.12	115.9%
14		SHERPUR	45.32	19.60	64.92	69.28	60.39	114.7%
15		MYMENSINGH	69.80	39.43	109.23	106.10	112.49	94.3%
16		NETROKONA	50.76	24.87	75.63	79.84	71.26	112.0%
17		KISHOREGANJ	47.28	24.84	72.12	78.39	65.65	119.4%
18	Chittagong	CHITTAGONG	73.43	43.13	116.56	115.55	117.71	98.2%
19	Rest of Chittagong	COX'S BAZAR	49.49	17.09	66.59	67.72	65.34	103.6%
20		RANGAMATI	180.37	61.40	241.77	224.93	262.11	85.8%
21		BANDARBAN	191.68	64.05	255.73	255.10	256.43	99.5%
22		KHAGRACHORI	166.79	47.66	214.44	217.60	210.98	103.1%
23		COMILLA	50.88	49.14	100.02	97.37	102.86	94.7%
24		CHANDPUR	41.64	24.14	65.78	69.25	62.33	111.1%
25		BRAHMANBARIA	43.28	15.88	59.17	64.10	54.08	118.5%
26		NOAKHALI	49.81	17.08	66.89	74.10	59.83	123.9%
27		LAKSHMIPUR	43.09	19.90	62.98	69.75	56.17	124.2%
28		FENI	58.09	30.62	88.71	84.34	93.09	90.6%
29	Rajshahi	RAJSHAHI	135.98	40.15	176.12	133.50	220.45	60.6%
30	Rest of Rajshahi	NAOGAON	45.65	25.75	71.40	73.58	69.13	106.4%
31		NAWABGANJ	45.32	24.09	69.41	69.65	69.16	100.7%
32		NATORE	45.98	21.78	67.76	60.04	75.82	79.2%
33		BOGRA	56.53	57.45	113.99	114.05	113.92	100.1%
34		JAIPURHAT	62.42	30.01	92.44	90.61	94.38	96.0%
35		RANGPUR	96.10	39.10	135.21	139.84	130.33	107.3%
36		NILPHAMARI	46.25	22.14	68.39	68.18	68.61	99.4%
37		KURIGRAM	44.45	28.65	73.11	80.43	65.74	122.3%
38		LALMONIRHAT	47.18	29.37	76.54	79.01	73.93	106.9%
39		GAIBANDHA	37.55	27.83	65.39	70.11	60.58	115.7%
40		DINAJPUR	55.10	38.80	93.90	90.20	97.83	92.2%
41		THAKURGAON	45.60	26.68	72.28	65.77	79.17	83.1%
42		PANCHAGARH	57.26	35.30	92.56	90.51	94.70	95.6%
43		PABNA	64.86	23.56	88.43	100.94	75.11	134.4%
44		SIRAJGANJ	46.25	20.27	66.52	67.01	66.01	101.5%
45	Khulna	KHULNA	86.36	52.34	138.70	128.97	149.40	86.3%
46	Rest of Khulna	BAGERHAT	59.67	28.07	87.74	78.49	97.40	80.6%

A2.1: district-wise public expenditures per capita (total, male & female), Taka (contd.)

			Per capita	Bed-days base

	Division	District	Non-development	Development	Total	Expenditure per male	Expenditure per female	Male as % female
47		SATKHIRA	47.95	21.89	69.84	65.67	74.13	88.6%
48		JESSORE	49.33	27.82	77.14	74.60	79.86	93.4%
49		NARAIL	57.25	25.31	82.56	77.28	87.91	87.9%
50		JHENAIDAH	41.42	35.79	77.21	69.57	85.27	81.6%
51		MAGURA	64.84	32.90	97.74	98.94	96.49	102.5%
52		KUSHTIA	51.22	26.93	78.16	73.12	83.51	87.6%
53		CHUADANGA	48.80	18.23	67.03	58.45	76.11	76.8%
54		MEHERPUR	52.60	28.85	81.44	78.62	84.39	93.2%
55	Barisal	BARISAL	111.24	41.94	153.18	152.89	153.48	99.6%
56	Rest of Barisal	PIROJPUR	56.93	24.52	81.45	84.71	78.15	108.4%
57		JHALOKATI	59.01	22.44	81.45	80.14	82.76	96.8%
58		BHOLA	41.92	19.32	61.25	65.71	56.51	116.3%
59		PATUAKHALI	55.17	24.27	79.44	79.89	78.98	101.2%
60		BARGUNA	58.68	28.95	87.63	95.98	79.25	121.1%
61	Sylhet	SYLHET	115.15	32.09	147.24	149.03	145.35	102.5%
62	Rest of Sylhet	SUNAMGANJ	44.55	17.57	62.12	65.28	58.84	110.9%
63		MOULVIBAZAR	44.68	21.52	66.20	64.53	67.93	95.0%
64		HABIGANJ	47.21	23.89	71.10	75.09	67.03	112.0%

Note: only government revenue and development expenditures are included since RPA and DPA estimates were not available by district at the time of writing.

Annex 3: Resource envelope

Table A3.1: Assumptions used to make the resource projections

	Scenario 1	Scenario 2	Scenario 3
Summary change:	Baseline	Increased insurance revenue through greater coverage and larger community premiums.	Increased user charge revenue through higher inpatient and outpatient treatment charges.
General revenue			
Growth of economy (real GDP)	3.7 - 5.5%	3.7 - 5.5%	3.7 - 5.5%
Inflation	Average 5.5%	Average 5.5%	Average 5.5%
Revenue as % GDP	8.9% rising to 11%	8.9% rising to 11%	8.9% rising to 11%
Government deficit	6% falling to 4.5%	6% falling to 4.5%	6% falling to 4.5%
Allocation of health sector			
Revenue budget	Growing at same rate as economy	Growing at same rate as economy	Growing at same rate as economy
Government ADP (budget)	ADP growing at same rate as revenue receipts	ADP growing at same rate as revenue receipts	ADP growing at same rate as revenue receipts
Government ADP (spending)	Current 80% of budget, 2000/01 90% rising to 100% by 2005.	Current 80% of budget, 2000/01 90% rising to 100% by 2005.	Current 80% of budget, 2000/01 90% rising to 100% by 2005.
Donor ADP	Budget rising with total ADP, spending increasing from current 65% spend to 85% by 2002/03.	Budget rising with total ADP, spending increasing from current 65% spend to 85% by 2002/03.	Budget rising with total ADP, spending increasing from current 65% spend to 85% by 2002/03.
Insurance			
Social insurance			
Eligible population	6% of the population (formal sector workers)	6% rising to 12% of the population (formal sector workers plus dependants)	6% of the population (formal sector workers)
Numbers covered	33% by 2002 (state sector), rising to 60% by 2005 (to include some of the private formal sector).	33% by 2002 (state sector), rising to 60% by 2005 (to include some of the private formal sector).	33% by 2002 (state sector), rising to 60% by 2005 (to include some of the private formal sector).
Premium charged	Average 400 Taka per annum, increasing with inflation (based on current average contributions in civil servants medical funds).	Average 400 Taka per annum, increasing with inflation.	Average 400 Taka per annum, increasing with inflation (based on current average contributions in civil servants medical funds).
Community insurance			
Eligible population	35% of the population	35% of the population	35% of the population
Numbers covered	1% of the eligible group in 2001, rising to 5% by 2005 (1.8% of the total population)..	1% of the eligible group in 2001, rising to 15% by 2005 (5% of the total population)..	1% of the eligible group in 2001, rising to 5% by 2005 (1.8% of the total population)..
Premium charged	50 Taka per person, increasing in line with inflation (based on premiums charged by existing schemes).	100 Taka per person, increasing in line with inflation.	50 Taka per person, increasing in line with inflation (based on premiums charged by existing schemes).

	Scenario 1	Scenario 2	Scenario 3
User charges			
Inpatient charges			
Charges	Introduction of 500, 100 and 50 Taka charges for an admission at tertiary, district and thana level facilities respectively.	Introduction of 500, 100 and 50 Taka charges for an admission at tertiary, district and thana level facilities respectively.	Charges rising to 1000, 150 and 50 Taka per admission at the three levels of care.
Exemptions	50% at tertiary, 60% district, 70% at primary.	50% at tertiary, 60% district, 70% at primary.	50% at tertiary, 60% district, 70% at primary.
Coverage of facilities	10% in 2001 rising to 100% by 2005	10% in 2001 rising to 100% by 2005	10% in 2001 rising to 100% by 2005
Outpatient charges			
Charges	Ticket charges rising to 30Tk at tertiary and 15Tk at district hospitals. No ticket charge at thana level. Treatment charges 10Tk at primary -30Tk at tertiary (base on willingness to pay surveys)	Ticket charges rising to 30Tk at tertiary and 15Tk at district hospitals. No ticket charge at thana level. Treatment charges 10Tk at primary -30Tk at tertiary (base on willingness to pay surveys)	Treatment charges rising to 70 Taka for tertiary and 50 Taka for district (at constant 1999/2000 prices).
Exemptions	As for inpatients. No exemptions for tickets.	As for inpatients. No exemptions for tickets.	As for inpatients. No exemptions for tickets.
Coverage of facilities	10% in 2001 rising to 100% by 2005	10% in 2001 rising to 100% by 2005	10% in 2001 rising to 100% by 2005

Annex 4: PER and the budget process

The PER is a valuable tool for strengthening the budgeting process. In addition to generating valuable information and analysis to guide resource allocations, it can be used to highlight weaknesses in, and help strengthen institutional aspects of, the existing budgeting process. This chapter explores how the PER can be used to strengthen the MOHFW budget. Its aim is to clarify budgetary structures and systems and existing constraints, examine recently adopted reforms in financial management, and then recommend how the PER can be used to support improvements in the budgeting process. It provides a framework to guide the work of future PERs.

Budgeting process

GOB prepares two separate budgets: the Development Budget and the Revenue Budget. The two budgets are prepared by different institutes and staff, and at different times of the year. Prior to HPSP, individual Project Directors prepared the development budget, along with the planning cell of MOHFW and the Planning Commission. Post HPSP, development budget preparation is now the responsibility of a newly created cadre of Line Directors who prepare operational plans, under the coordination of the Joint Chiefs of Planning in the MOHFW. The revenue budget continues to be prepared by the Director General offices of Health and Family Planning. Both budgets contain aspects of revenue and capital expenditures.

Revenue budget preparation starts 31st August with call notices from the DGs to drawing and disbursing officers (DDOs) (located at district and thana levels) further preparation of financial estimates for the next financial year. It culminates in the first week of June with presentation of the budget to Parliament. In comparison, the development budget cycle starts later. Line Directors request DDOs to start estimating the following year's financial requirements in the middle of February. The budget estimates are presented to Parliament in the first week of June. However they are not finally approved by the National Steering Committee until 31st July. The delay in development programme implementation is caused by the uncertainty of resource availability until the revenue budget is finalised.

Development and revenue budgets are prepared on the basis of estimated likely volume of resources likely to be available, which are calculated by the Budget Monitoring Resource Committee. However the committee does not estimate resources on the basis of macro-economic variables such as economic growth or price stability. For both revenue and development budgets, DDOs follow a historical incremental budgeting approach. That is, they prepare estimates largely on the basis of past expenditures, adjusting for inflation and any policy or programme directives. Budgeting at the start of HPSP was obviously undertaken on the basis of specific policy and resource priority guidelines. However, in subsequent years it appears to have resorted back to an incremental approach.

Financial classifications used by the two budgets are different. The revenue budget follows a typical line item based approach (e.g. salaries, supplies, repairs and maintenance etc.), which is ideally suited for accounting and auditing purposes but does not support management decision making. In contrast, for the development budget the MOHFW has recently introduced a cost centre based classification system reflecting specific HPSP programme activities. This aims to facilitate programme planning, monitoring and evaluation, particularly by helping link financial inputs to measures of service output and ultimately health

improvements. Cost centres are further classified on the basis of line item expenditures, as well as by source of funding.

Key constraints in budgeting process

HPSP takes a sector wide approach to health and population sector planning and management. It considers the sector as a whole, in terms of the integration of health and family planning activities, and in the consideration of all sources of available funding in overall priority setting. The overall objective of HPSP is to maximise health outcomes with available resources. The current budgeting system does not support HPSP implementation for several reasons (MAU 1999 and Aide Memoire, APR April 2000):

1. The separation of the revenue and development budgets does not allow resources to be allocated on the basis of overall sector policy and priorities. HPSP priorities are not considered during preparation of the revenue budget. Lines of communication between Line Directors and DDOs (for development budget) and Directorates and DDOs (for revenue budget) are rigid and formal. The bid process contains few incentives to promote better budgetary outcomes. By the time the Ministry is aware of all submissions and resources under its control, it is at too advanced a stage to effect any substantial change.

In addition, the two parallel budgeting systems result in:

- **Delay in finalisation of the development budget:** this is caused by uncertainty in resource availability until revenue budget is finalised. As a result operational plans generally undergo several revisions before final submission. Typically, this can lead to arbitrary changes that are not always consistent with sector priorities.

- **Lack of consideration of future recurrent cost implications for activities included in the development budget:** HPSP addresses this to some extent by outlining a phased transfer of certain salary components from the development to revenue budget. Nevertheless, the lack of overall control over both budgets does restrict recurrent cost planning.

- **In-compatible financial classification systems:** this makes it difficult to map revenue budget in terms of HPSP policy and priorities. The revenue budget does not allow financial inputs to be related to discrete and measurable programme outputs. For this reason the current classification also does not promote transparency of health expenditures. Financial information is reported in a form that is not meaningful in service delivery terms.

- **Uncoordinated human resource planning:** particularly since the bulk of the revenue budget is comprised of salaries.

2. Incremental nature of budgeting for both development and revenue does not allow policy makers to plan for re-allocation of the resource base on the basis of sector policy and priorities. It reinforces resource allocation on the basis of local needs over overall sector needs and priorities. Ideally, resources should be allocated on the basis of locally identified needs but within a defined policy framework, with adjustments to ensure horizontal equity. Incremental budgeting also encourages submission of inflated bids in the knowledge that they are likely to be cut. Bids are normally made without consideration of the availability of the resource base or the likely sustainability of activities. As a result,

incremental budgeting can lead to the perpetuation of inconsistent and inefficient resource allocation.

3. Absence of timely and reliable resource projections and financial ceilings to guide budgeting. Ideally, sound budgeting requires a rolling medium term projection of all likely sources and levels of funding. This facilitates the planning of a sustainable level of public service delivery.

Other constraints identified in the present budgeting system include:

4. No criteria or guidelines to assist resource allocations over and above initial HPSP priorities. These should cover aspects of allocative efficiency and equity, as well as technical efficiency. For example, in terms of allocative efficiency, HPSP sets a target for overall ESP spending but gives no guidance on ideal levels of spending on different ESP components. Broadly, equity is concerned with the allocation of resources on the basis of needs of different social groupings, including those based on gender, poverty and geography. HPSP gives priority to meeting needs of women, children and the poor, and so it is important to ensure that allocations reflect this policy objective. Technical efficiency is concerned with the resource input-mix to produce a certain level of programme activity. For example, the most cost efficient delivery for child immunisation (outreach versus clinic based), or the optimal balance between salary and non-salary inputs.

5. No mechanism to ensure resource priorities match beneficiary preferences. It is important that institutional mechanisms are created that help reveal civil society preferences and budgetary priorities (Pradhan, 1996). An important aspect of this is presenting the budget in a more meaningful manner, and then providing a mechanism for civil society to comment on, and discuss, budget priorities. This also promotes greater transparency and local accountability in the budgetary process.

6. Limited participation in the budgetary process. There is a need to broaden the participation base in the budget, including decision-makers at lower levels within the Ministry as well as other key stakeholders. Since local level managers have a better idea of local needs, they can ensure resources are allocated both on the basis of local needs and broad sectoral priorities.

Recent budgetary reforms

MOHFW has recently introduced a number of reforms aimed at addressing some of the identified budgetary weaknesses.

1. **Establishment of a Management Accounting Unit (MAU):** this aims to develop and strengthen financial management systems and skills in support of a sector wide approach. MAU seeks to capture expenditure information from all sources in order to gain a more complete financial picture to guide implementation of HPSP reforms.

2. **Introduction of a new accounting and financial classification system for the development budget:** this comprises a cost centre structure based on main HPSP outputs. This was achieved through the introduction of a new code at level 3 of the CGA national accounts classification. The new code will facilitate financial reporting against activity, as well as support other relevant analysis to guide resource planning and management. This

PER uses the new classification system for the first time to report against financial progress in HPSP.

3. **Establishment of a Budget Committee:** this has the broad aim of promoting better coordination of the revenue and development budgets and bringing them under one financial management system in support of HPSP policies and priorities. The Committee was established in the belief that the two budgets are unlikely to be merged in the near future (at least not during the lifetime of HPSP). Therefore in the interim it was important to support better coordination between the two budgets and ensure they both reflect budget allocations in line with HPSP priorities. The Committee is chaired by the Secretary and comprises members from both the Directorates and Line Ministry. It will be vital to ensure that the Budget Committee is supported with relevant financial information and technical assistance for carrying out this coordinating function.

4. **Development of systems for more reliable and timely financial reporting:** this includes; i.) A computerised accounting system (MACS) which has been installed on a pilot basis, with three Line Directors, to facilitate costing and generate data to support management decision-making, ii.) A budget consolidation system to assist Line Directors, and now the DGs offices to begin to mechanise the cumbersome budget preparation process. iii.) A fund disbursement model to facilitate the disbursement of allocations and funds, and iv.) A prototype budget modelling system to permit budget modelling around various ministry priorities and objectives.

PER and the Budget process

Past PERs undertaken by the Health Economics Unit have mainly concentrated on analyses of the MOHFW's expenditure trends and patterns of revenue and development budgets. They have mainly reported against aggregate trends in health spending, as well as against the three key financial indicators outlined in PIP, to monitor HPSP progress. An equity analysis of health spending was undertaken for the first time in last year's PER.

This section explores how the PER can be used to strengthen the budgetary process in support of HPSP. It develops a framework to guide future PERs. The last Annual Performance Review of HPSP made a number of recommendations for the PER (Aide Memoire, April 2000). The first relates to the timing of the PER. The APR team recommended the PER be prepared for the first half of the APR (in October/November). This ensures that it is available at the start of the budget and planning cycle to inform allocation decisions. Secondly, it was recommended that the PER provide analysis to map the revenue budget against the broad level three expenditure categories used in the development budget. This will provide the Budget Committee with revenue and development budgets in a common format to aid expenditure policy. Another key recommendation of the APR was the introduction of a Medium Term Perspective to Resource Planning and Prioritisation. This entails the preparation of revenue forecasts for both revenue and development budgets by source of funding, including both internal financing initiatives (such as user fees and insurance) and external financing initiatives (such as donor and tax revenue). A Medium Term Resource and Expenditure Framework (MTREF), it was argued, would provide a more realistic basis for making hard resource allocation choices in support of HPSP goals and priorities. It also helps overcome macro versus micro tensions between policy and local levels, by helping to ensure allocations are based upon strategic priorities.

Future PERs: strengthening the budgetary process for HPSP

1. Provide information and analysis to guide expenditure decisions for revenue and development budgets in line with HPSP policies and goals

This should include forecasts of likely resource availability and assessment of HPSP progress. Both should inform the development of a Medium Term Resource and Expenditure Framework (MTREF), including recommendations on how resource allocations can be re-directed to better meet HPSP objectives. The main client for such analysis is the Budget Committee. Committee involvement in development and approval of Terms of Reference for the PER will facilitate demand for PER analysis, as well as promote ownership of any recommendations.

i) *income side*

PERs should include rolling medium term revenue forecasts by source of funding (included for the first time in this PER). This will provide more realistic financial ceilings for undertaking budget preparation. Resource projections of tax revenue base should consider the macro-economic environment, such as growth and likely inflation. Estimates of internal revenue generation, through user fees and insurance, will give an idea of their likely contribution to sustainability goals. Areas where user fees are being piloted should consider fee revenue income when preparing financial bids.

ii) expenditure side

The overarching objective of public spending is to maximise social welfare, including impact on the poor. HPSP prioritises expenditures on the ESP, and aims to target these expenditures on women, children and the poor. In particular, it aims to reduce high burdens of maternal mortality and morbidity. ESP services are considered priorities since they (contribute?) the biggest burden of ill health, have some public good characteristics that make them unsuitable for provision by the private sector, and are most cost effective in terms of returns in health improvements relative to spending (PIP). Cost effectiveness however, is not based on any welfare criterion. To guide future allocations it would be important to:

- Assess relative spending on different ESP components: this requires mapping of the revenue budget according to ESP components. Since the bulk of the revenue budget is comprised of salaries, costs can be apportioned on the basis of time spent by health staff on different ESP services. Estimation of spending on ESP components under the development budget is much easier with the introduction of new cost centre based codes. However, there are still a number of apportionment problems to be resolved on the development budget side. For example, identification of the ESP spending in non-ESP service delivery operational plans. Another is the apportionment of joint salary costs across some ESP categories (such as child health and reproductive health). These need to be allocated on the basis of staff time spent on these activities.

- Attempt to link financial inputs for ESP services to measures of service output and ideally to measures of outcome in terms of health improvements. This will help guide what relative spending should be on different ESP components (and even sub-components, e.g. with Reproductive Health -how much on family planning versus maternal health?). However, since it is difficult to make causal linkages

between financial inputs and health outcomes, proxy measures will need to be developed to help guide resource allocations.

- Assess who is benefiting from HPSP spending and whether equity objectives of HPSP are being achieved. Ideally, public sector resources should be allocated (and used) on the basis of need. HPSP is largely based on the premise that primary services are mainly used by the poor whilst tertiary services benefit the rich. This is a fairly crude allocation factor. A benefit incidence analysis of ESP services should be undertaken to assess who is benefiting from public subsidies, in terms of gender, income and age. Are these in proportion to their needs? Gender equity should be a particular focus of PERs, since the reduction of maternal mortality is a key objective of HPSP. The geographic distribution of resources is another equity concern. Ideally, areas with greater vulnerability, including poorer health status indicators, should receive greater resources. The PER can help guide the re-allocation of resources on a geographic basis by analysing present allocations relative to need.

- Assess whether available resources are being used efficiently. In particular whether there is an optimal input-mix, especially of salary and non-salary items, for different ESP components. Typically in most developing countries there is crowding out of non-salary items by salary items. Unit cost estimation can help identify such inefficiencies in ESP delivery. One of the main reasons for this imbalance is poor recurrent cost planning of development expenditures.

Sources of information for PERs include routine information systems (Management and Financial Information Systems), secondary sources (budget documents, operational plans, other studies), and small sample surveys.

2. Include analysis of institutional aspects of the budgetary process

To improve public expenditure allocations, it is important to identify institutional weaknesses that impede optimal allocations in government budgetary systems. This PER makes a start with the description of the budgetary process and identification of key constraints. Institutional aspects should be interpreted in the widest sense to include the policy environment (which determines which allocations are appropriate), budgetary structures and processes, as well as the incentives/disincentives that drive fiscal discipline and optimal allocations. PERs can help identify institutional mechanisms that would facilitate more rational allocative decisions.

3. Use PER to facilitate wider participation in the budgetary process

Since the PER provides expenditure information in a fairly accessible form, it can be used to discuss budget priorities with lower level managers as well as other stakeholders, especially primary stakeholders. Primary stakeholder involvement will help ensure a match between beneficiary preferences and budgetary priorities. In addition, lower level managers are usually in a better position than senior policy makers to judge local needs.

4. Promote greater transparency and accountability in budgeting

Since the PER presents financial information in a more meaningful manner (i.e. related to specific programme objectives, services and outputs), it automatically promotes greater transparency and accountability in the budget. The PER is a powerful tool for generating awareness of, and demand for, better financial information from civil society broadly, and especially from stakeholder committees. Such dis-aggregated financial information will assist stakeholder committees to monitor local health expenditures. Future PERs can attempt to generate more detailed thana level expenditures to further aid monitoring by local committees.

All PERs will not contain all aspects of analysis outlined above. PERs will regularly report against a number of key monitoring indicators. In addition, each PER should include a selection of the themes and concerns outlined above. Since a government unit undertakes the PER, it already provides a major advantage in making the exercise an integral part of the public expenditure planning and budgeting system.

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