

Do essential service packages benefit the poor? Preliminary evidence from Bangladesh

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In 1998 Bangladesh began a sector wide approach (SWAp) to the extension of health care to vulnerable groups in the country. The central feature of this approach is the funding of an essential service package (ESP) emphasizing maternal care, certain communicable diseases and child health.

This study examines the way in which public sector expenditures are distributed by comparing the actual beneficiaries of spending with the target groups identified by the sector strategy. It finds that while the ESP is helping to target resources at priority services, considerable barriers to access by vulnerable groups persist.

The study suggests a number of issues that need to be addressed to improve the performance of the programme. First, improved targeting requires greater emphasis on the process of access to key services. Secondly, improving the efficiency of service provision at primary level is a key element to increasing access, since individual primary providers are often not ready to provide the standard of care required by the ESP approach to services. Finally, the system of financial control and management needs to be modified in order to make allocations more responsive to the priorities determined by the SWAp.

Given the widespread adoption of the ESP approach to health care, the paper also suggests a wider research agenda that examines its impact in other countries and evaluates this worldwide experiment in health service prioritization.

Key words: equity, essential health services, public expenditures, Bangladesh

Introduction

Since 1998 the Government of Bangladesh has implemented a sector wide approach (SWAp) in the health sector, called the Health and Population Sector Programme (HPSP). The objective is to focus both government and donor effort on the most important health problems facing the country in a co-ordinated and rational way. The core strategy of this approach is an essential service package (ESP) that attempts to target effective services to the most vulnerable – the poor, women and young children. The ESP concentrates on services that could have most impact on the vulnerable, delivered through facilities most used by these groups. The approach thus combines characteristic targeting with a supply led approach in order to improve the cost-effectiveness of spending. The crucial question is whether the resources allocated actually reach the vulnerable groups in the form of services prescribed by the sector programme.

Based on an ongoing series of economic and social studies this paper attempts to examine the current and potential impact of the ESP. The paper begins with some brief background details on essential service packages. It then describes the general approach to the ESP and national funding patterns. The third section examines how far funding can and does benefit the most vulnerable, given the organizational and system constraints of the sector. The final section looks at the

issues that must be addressed if the approach is to fulfil its potential in addressing the needs of the most vulnerable.

Essential service packages

Since the much publicized World Development Report of 1993, the concept of a package of essential services, based on services that have been shown to be cost-effective, has been adopted in principle or in practice by a large number of countries (World Bank 1993; Bobadilla and Cowley 1995). These range from middle-income countries such as Uruguay and Turkey to low-income countries such as Indonesia and Uganda. Often donors, such as the World Bank, have encouraged or promoted their adoption.

Although receiving greater attention during the 1990s, the package concept is not new and goes back to the idea that comprehensive primary care, as proposed at Alma Ata in 1978, is too expensive for most countries, and that a selective approach is inevitable (as articulated, for example, by Walsh and Warren 1980). The approach is criticized for not placing sufficient emphasis on the idea that primary care tends to be opportunistic, and that diagnostic and treatment strategies must necessarily take into account a range of diseases and procedures, some of which are inside the package and some outside. The finding that effective management of childhood disease is best and most cheaply accomplished using an

Table 1. Key indicators for Bangladesh and region

	Bangladesh	South Asia
Population	125 million	1305 million
Urbanization	20%	27%
GNP per capita	US\$350	US\$430
Illiteracy (% population over 15)	47	49
Infant mortality (per 1000 live births)	66	77
Maternal mortality (per 1000 births)	4.3	0.6 (Sri Lanka) to 5.4 (Nepal)
Life expectancy	61 years	62 years
Total fertility rate (births per women)	3.3	3.4

Source: World Bank (1997).

integrated approach is a good illustration. In the case of childhood disease, this is recognized by package proponents through the inclusion of the Integrated Management of Child Health (IMCH).¹

Much of the literature on essential packages concentrates on design and initial implementation (for example, see Bobadilla et al. 1994; Bobadilla and Cowley 1995). Other articles have dealt with the methodology tool for calculating economic benefit, the DALY, and problems revealed (for example, Barker and Green 1996; Paalman et al. 1998; Anand et al. 1999; Williams 1999).

Relatively little attention has been given to the evaluation and impact of the approach. Some practical considerations were addressed by Bobadilla and Cowley (1995) and also in practical briefings on DALYs and essential packages (DFID Health Systems Resource Centre 1999). Mostly these are in the form of what could go wrong rather than what actually happened. It is a little surprising that so little evaluation exists, given that the introduction of ESPs might be seen as the largest experiment in the use of evidence-based clinical practice and cost-effectiveness analysis in priority setting within the health sector. As Jayasinghe et al. (1998) point out in arguing why the ESP is not appropriate in Sri Lanka, OECD countries have generally failed (or have not even started) to pursue the package approach long enough to permit fundamental evaluation of the consequences.

The purpose of this article is not to re-examine the debate between those advocating a comprehensive versus selective approach, important though these questions remain. Rather it seeks to examine (at an early stage) the implementation of a package-based approach in Bangladesh. In doing so it is hoped to draw attention to some of the strategic and management problems faced in implementing a selective package approach, working within the context of a well-established, although far from perfect, public health system.

The sector wide approach and essential service package

Bangladesh has a comprehensive network of health facilities serving much of the population. The country is divided into

64 districts (zilas) in each of which there is a hospital with between 50 and 200 beds. In turn these districts are divided into sub-districts (upazilas), each with a Health Complex (31 beds), and into unions, most of which have a Health and Family Welfare Centre. Below union level the system has to depend heavily on community workers, who dispense family planning supplies and provide health advice. Controversially this door-step approach is being phased out in favour of services delivered through newly built community clinics serving a population of around 6000. The country is served by medical colleges (650 beds) serving district groups, and referral facilities at national level. All facilities at upazila and below are regarded as 'primary level'.

Prior to the implementation of the HPSP, health and population funding and delivery were separated. Around two-thirds of funding was allocated to health and the remainder to family planning (Kawaine et al. 1998). Donor funding accounted for more than 60% of funding for population activities but only around a quarter of health funding. Donor funding was spread across more than 100 projects and there was criticism that activities were often duplicated. While around 50% of health funding has historically been allocated to primary care (upazila and below), this proportion has not changed over the last 5 years despite greater emphasis given to it in project documents. Reviews of public expenditure indicated that those making use of inpatient level facilities, particularly at district and tertiary levels, were predominantly male, urban and relatively wealthy. In contrast those making use of primary level facilities were more likely to be poor and rural (Kawaine et al. 1998).

The central objective of the health sector SWAp (HPSP) is to improve the health status of the most vulnerable – defined as women, children and the poor. Maternal mortality, which at 4.3 per 1000 live births is one of the highest in the world, has been given special emphasis in the programme (see Tables 1 and 2 for details on maternal and infant mortality in Bangladesh and South Asia).

A central strategy of the HPSP is to finance an ESP delivered at sub-district level and below. The package includes basic services established as cost-effective in other countries. These are (GOB 1998):

Table 2. Infant mortality in South Asia by income quintile

	India (US\$450)	Bangladesh (US\$370)	Pakistan (US\$470)
Poorest	109.2	96.3	88.7
Second	106.3	98.7	108.7
Middle	89.7	97.0	109.3
Fourth	65.6	88.7	95.7
Richest	44.0	56.6	62.5
Total	86.3	89.6	94.0
Ratio (poor : rich)	2.48	1.70	1.42

Country per capita income in 1999 in brackets.

Figures refer to period 1990–94, hence the higher total IMR than reported in Table 1.

Source: Demographic and Health Surveys compiled by the World Bank, <http://www.worldbank.org/poverty/health/data>.

- (1) reproductive health care – including safe motherhood (essential obstetric care, antenatal and post-natal care), family planning, other reproductive services including sexually transmitted diseases;
- (2) child health care – including acute respiratory infections, diarrhoeal diseases, vaccine preventable disease and adolescent care implemented through an integrated management of sick child approach;
- (3) communicable disease control – including tuberculosis, leprosy, malaria, filarial, kala-azar and emerging diseases;
- (4) limited curative care – concentrating on first aid for trauma, medical and surgical emergencies, asthma, skin diseases, eye, dental and infectious ear diseases;
- (5) ‘behaviour change communication’ is being implemented as a way of influencing health behaviours and health-care-seeking practices across all of the ESP components.

Earlier studies indicated that while the rich tend to utilize urban, particularly district, hospital services more than the poor, this is reversed at the sub-district level in rural areas. The programme concentrates public resources on services and facilities utilized more by the poor in areas in which more of the poor live. HPSP is not operating in urban areas partly because rural areas are seen as more impoverished and partly because health is the responsibility of the city corporations and municipalities and not the health ministry.

From the viewpoint of efficiency, concentrating resources on services known (or thought to be known) to be cost-effective was a way of improving the use of resources. Most of the evidence is from outside Bangladesh, although some studies have been done in-country based on operational research. One study, for example, looked at the costs of delivering child health services through an IMCH approach rather than the conventional approach (Khan et al. 2000). The study assumed effectiveness as suggested by international patterns but developed locally based cost estimates of the differences in approaches. Other research has tested out the introduction of context-specific service delivery such as the transformation from home to facility based reproductive health services.

Detailed monitoring indicators (around 40) have been established to monitor the sector programme, in particular the

ESP. These indicators have been subject to considerable debate. From a financial viewpoint the indicators are primarily national input indicators. They require, for example, spending on the ESP to account for at least 65% of total funding for the health sector. Other indicators examine both process and outcome, including reductions in maternal mortality. An important qualification, however, is that all indicators are measured for the population as a whole rather than for specific low-income groups. Table 2 indicates that there is substantial difference in infant mortality between the top quintile and bottom three quintiles. Yet as Gwatkin and others have observed, it may sometimes be easier to improve aggregate health indicators by improving the health of the middle-income groups where education tends to be more effective (Gwatkin 2000).

Who benefits from ESP spending?

National level trends

The 5-year sector programme is just reaching the end of its third year. Reforms in the financial management information system mean that it is now possible to track much of the development spending² by ESP activity down to sub-district level. The revenue budget, which is largely staff and supplies, is still only reported by line items and level of facility. Information from a recent sample survey of upazila facilities (Ferdousi 2001), however, permits even this budget to be divided up into the main ESP sub-components (see Figure 1).

Bangladesh spends about US\$11 per capita on health care. Of this just under US\$3 is spent by the public sector. Evidence suggests that in the second year of the sector programme between 60 and 70% of public spending was allocated to the ESP (the higher figure includes an apportionment of super-overhead costs to ESP and non-ESP services) (HEU and MAU 2001). Comparison with pre-SWAp years is hampered by differences in definitions of primary or essential services used. Prior to HPSP just under 50% of health spending was allocated to the primary levels. Including spending on population activities, the bulk of which are delivered through primary level facilities, the figure rises to around 58% of total public sector funding (Kawne et al. 1998). It appears,

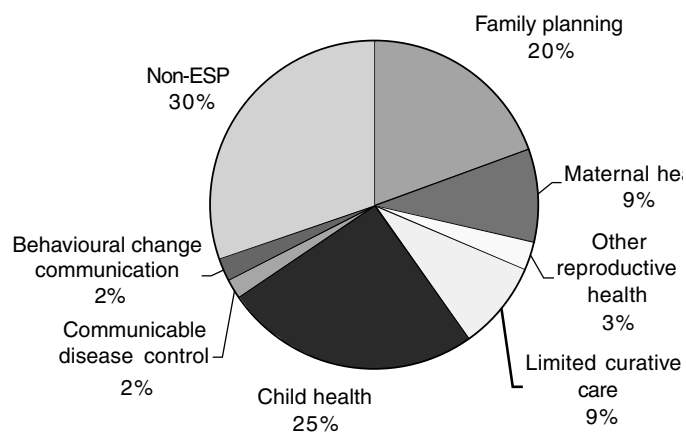


Figure 1. Spending by ESP component and non-ESP, 1999/2000 (Source: HEU/MAU 2001)

therefore, that funding for primary care facilities may have stabilized or risen slightly during the HPSP years. There is no evidence that the SWAp itself has had an impact on the total level of funding devoted to ESP services. The difference is, perhaps, one of emphasis, with greater weight given to the funding of particular services rather than primary care more generally.

Under the SWAp a significant part of donor and government funding is pooled and used according to new procurement methods (based on World Bank guidelines). Unfamiliarity with these methods has delayed much procurement and meant that over the first 2 years spending was around 12% below the planned budget. ESP services have been affected in different ways. Family planning supplies, which continue to be financed largely through bilateral donor and direct government sources, have largely been untouched. Other services have fallen well short of budget. Spending on maternal care, perhaps the central component of the ESP, was only 40% of what was planned in the initial HPSP planning documents. It is important to note that, while neither the SWAp nor the introduction of the ESP has yet led to a significant increase in funding flows, the reporting of expenditure by service type has ensured that much greater attention is given to whether funding flows are matching stated policy objectives.

Regional variations

The national figures suggest a substantial resource flow into services that should benefit the poor. Yet this conceals substantial variation across the country. The Bangladeshi health system is extremely centralized. District (zila) and sub-district (upazila) allocations are determined by norms that relate to the number of beds (for food and drugs) and staff in post (for salaries). In almost every sub-district there is a 31-bed hospital/health complex. The size is invariant to the size of the population. This inpatient capacity determines funding for both inpatient and outpatient services. The consequence is that there is enormous variation in per capita spending across the country. It is further noticeable that this

allocation is not clearly related to other measures of population need. Indeed the opposite appears to be the case.

A simple correlation between the human development index (HDI)³ for all districts and per capita public health care spending indicates a positive relation (Figure 2). The reason for this relationship is not immediately apparent. Some areas appear to be systematically disadvantaged as a result of the size of the capacity that was established in geographic areas. The political pressure that leads to the building of a health complex is reflected in future recurrent allocations for staff and medicines.

Group beneficiaries

The next stage of the analysis is to investigate the extent to which different groups derive benefit from ESP-level public spending. In the absence of up-to-date household survey data an exit survey (sample 1100 patients) was conducted in two divisions (Begum et al. 2001).

Combining the exit survey data with information on ESP costs, described earlier, public spending could be allocated between difference categories of patients for services delivered at the sub-district level. The results are adjusted for cost of ESP service by allocating the spending to each ESP category and then apportioning spending by income group according to service use. This produces a classic Benefits Incidence Analysis (BIA) for sub-district services (Table 3).

The results indicate that for both men and women public sector allocations favour the poorest quintiles – it appears that the poor are accessing sub-district government services more than the rich. This result only holds for the sub-district level. Above upazila level the consensus of other studies is that public expenditure favours the rich relative to the poor (Yazbeck 1999; Sen 2001).

Most statistics on use, including the official Management Information System (MIS), suggest that women use services more than men (Directorate General Health Services).

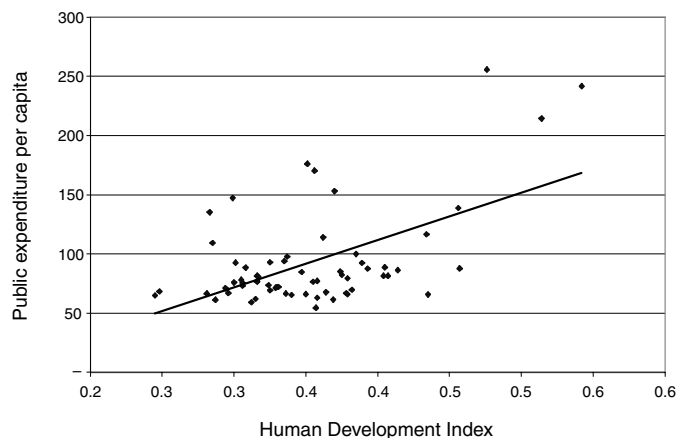


Figure 2. Per capita public spending allocations and Human Development Index (Source: Ensor et al. 2001b)

Table 3. Spending at upazila and below per capita by income group and sex, 1999–2000 (Taka)

	Spending per capita/% of spending on group					
	Male		Female		Female (not RH)	
	Taka	%	Taka	%	Taka	%
Quintile 1 (Q1)	92.95	34.90	187.36	27.55	81.54	35.51
Quintile 2 (Q2)	57.53	21.60	106.29	15.63	34.42	14.99
Quintile 3 (Q3)	67.32	25.28	206.87	30.41	72.13	31.41
Quintile 4 (Q4)	17.82	6.69	50.69	7.45	16.82	7.33
Quintile 5 (Q5)	30.72	11.53	128.97	18.96	24.73	10.77
Bangladesh	66.58	100.00	170.05	100.00	57.41	100.00

Quintiles are based on household survey data taken from the Household Expenditure Survey adjusted to 1999/2000 values (BBS 1999). Q1, <2068; Q2, 2068–2814; Q3, 2814–4615; Q4, 4615–8495; Q5, >8495.

95% confidence intervals constructed for men and women indicate that Q1 and Q3 both have distributions above that which would be expected if benefits were equal across groups, Q4 and Q5 are both below. Only the distribution for Q3 shows no significant pattern.

Source: Begum et al. (2001).

Statistics on inpatients suggest that women account for 53% more inpatient and outpatient consultations. Interestingly men account for more inpatient days, reflecting, inter alia, the shorter lengths of stays associated with delivery care. The BIA indicates that women appear to benefit from spending more than men (ratio women : men 2.55, 95% confidence interval ± 0.11). Yet these figures are biased by the figures for reproductive health services that are used more by women but impact on men and women more or less equally (certainly true for family planning which account for the majority of reproductive health funding). The picture changes when reproductive health services are excluded so that spending is seen to benefit men more than women at all income levels (ratio women : men 0.86 ± 0.18). Male use appears greater for children – child health under 5 years – and care for communicable diseases (ratio boys: girls 1.28 ± 0.16).

Process of care

The results do adjust for case-mix through the separate allocation of spending on each type of ESP service. However, in common with most studies undertaken in other countries, it assumes that the benefits accruing to any one individual for a particular ESP service are equivalent. It assumes, for example, that benefits to a poor woman are equivalent to those for a rich man for a particular service. Yet evidence suggests this is not the case. The exit survey found that individuals paid significant amounts, mainly for drugs (57%), but also to individual staff and for diagnostic tests. These were deducted from the gross subsidy to provide a measure of net benefit. The result is that the very clear spending preference for the poor decreases when account is taken of patient payments, which were found to be at least as high for the poor as they were for the rich (see Figure 3). Although a statistically significant positive benefit advantage to the poorest relative to the richest quintile remains, it is much diminished. In relative terms, the impact on the poor is even higher, with the cost of a visit for the richest accounting for around 3% of

per capita monthly income while for the poorest group it represents nearly 17%.

A further finding was that on average more is spent on men/boys than on women/girls for treatment. The interpretation of this finding is complicated. It could mean that households give males preference in the use of resources to pay for care. Equally, or in addition, it could mean that female patients are more likely to be exempted from payment. This finding deserves further investigation.

Another measure of the care process is the waiting time for treatment. Here again there appears to be a marked difference in length of waiting by income group. For the poor more than 35% wait longer than 30 minutes. For the rich the figure is only around 20%.⁴

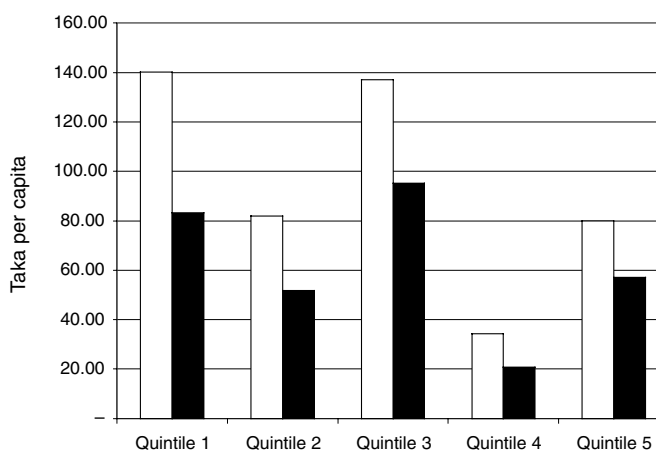


Figure 3. Gross and net benefits from public ESP spending by income group; white bars = gross benefits, black bars = net benefits

Table 4. Current and normative upazila utilization per capita

		Visits per capita (current)	Visits per capita (desired)	% increase
Family planning	Eligible couples (assumes all aged 15–44 are eligible)	1.46	1.80	23.0
Maternal health	Pregnant women	2.25	5.00	122.3
Child health	Children under 10 (focused on the under fives)	1.37	1.54	12.4
Limited curative care and control of communicable diseases	Adults and children	0.24	0.50	109.1
Total	Population	0.92	1.28	40.0

Source: Ensor et al. (2001a).

Two findings were common to all patients – rich or poor, male or female. Patients reported in more than 85% of cases that they were not told what was wrong with them. Secondly, more than 90% of patients were prescribed medicines as a consequence of their visit. Further scrutiny of the data revealed that prescriptions were strongly influenced by the availability of medicines in stock. Medicines such as anti-histamines, analgesics and antacids were handed out to most patients regardless of medical indication. These findings are similar to those found in other surveys (Gunyon 1994; Kawaine et al. 1996) and suggest that little has changed since the introduction of the ESP. Stocks of medicines may be more plentiful but they are not being used any more rationally.

Efficiency of service delivery

The available information suggests there is considerable variation in both the geographic allocation of funding and the productivity of resource use. A recent study of the costs of the ESP found that the unit costs of service varied 10-fold across 20 upazilas (Ensor et al. 2001a). More than 85% of this variation could be attributed to variance in the number of patients treated at the facility. This suggests that it is differences in demand factors, such as distance, information and perceived quality, rather than resource availability that account for much of the variation in unit costs.

Survey results suggest that the actual pattern of services provided falls some way from the population need as judged on the basis of expected demographic use. Estimates for the level of utilization required to provide ESP services were obtained. Visits per capita are based on the survey of government facilities. Desired visits are based on norms for the required number of visits for treating diseases treated by the essential package and the epidemiology of an average district. The results suggest that overall utilization per capita would have to rise by 40% (Table 4). For individual ESP components the rise would have to be larger still. A 122% increase in maternal health care would be required in order to provide antenatal care and delivery by a trained attendant. The corresponding cost would have to rise still further since delivery care is one of the most expensive ESP sub-components.

The wide range in facility efficiency suggests that a further focus is required on the efficiency of services, not only in delivering care once a patient is within a facility, but also in attracting the most vulnerable by minimizing the transaction costs of accessing services. Attempts to contract out services have so far been limited to the fringes of HPSP in the form of national nutrition and leprosy initiatives. Such developments also bear transaction costs of their own. A recent survey found that contracting and management costs of an NGO umbrella organization financed by USAID amounted to at least 20% of the cost of services (Hay 2001). Given that the public sector delivers much of the organized ESP health care, a further concentration on public sector efficiency could help to reduce the critical demand barriers to health service use.

Discussion

The ESP is designed to improve population health status through a targeting approach based on:

- facilities used more by the poor;
- effective services for diseases endured proportionately more by the poor;
- rural areas where population health is lowest.

The approach is largely supply led. An assumption is that by allocating more funding to the services included under the ESP, resources would be channelled to the most vulnerable. The key question is whether this broad-based targeting approach is sufficient to ensure effective services for the poor. The answer is ambivalent.

The evidence suggests that the programme has been successful in expanding funding for primary care (ESP) services and allocating these resources to the facilities used by the (rural) poor. At the national level the implementation of policy is quite clear-cut. Interim procurement problems aside, the objective of channelling funding into ESP sub-components appears to be functioning quite well. Further down the system the evidence is less clear.

First, allocation patterns suggest that resources do not generally favour the most under-developed areas. This is largely

the product of a resource allocation system that has remained unchanged despite the move to a sector wide approach. Secondly, the evidence suggests that the process of care does not always favour the most vulnerable groups. The poor are penalized by unofficial fees and longer waiting times. Non-reproductive service use favours men over women. Finally, there is evidence that wide variation in productivity and a failure to match available resources to the needs of the area mean that the pattern of ESP use is still some way from what is desired.

A number of factors appear to account for the difference in national patterns (inputs) compared with local use of resources (outputs).

1 Centralized command and control

Although HPSP conceptualization is a radical change from the project based planning of the past, structural changes have not developed to the same extent. Funding for the ESP is still allocated through the traditional line-budgeting system – staff and medical supplies. Funding levels are closely linked to inpatient capacity despite the ambulatory nature of much of the ESP. There are proposals to decentralize much of the planning function over services. Until this decentralization incorporates a degree of financial autonomy and flexibility over line budgets, it is not clear that this local level planning can have a significant impact.

2 Geographic allocation

Input-based allocation has also led to a geographic pattern of distribution that does not bear any clear relationship to health need or any wider differences in economic development. Some preliminary work has been carried out to examine a new basis for allocations according to size of population, demographic structure and proxy measures of health need such as standardized adult or infant mortality (Ensor et al. 2001b). This work suggests that, based on realistic economic projections, reallocating growth money would be enough to bring divisions into line with need-based targets within 5–10 years. However, clear political will is required to de-link the allocation system from the capacity norms used across most sectors.

3 Incentives and contracting

There is also evidence to suggest that resources intended for ESP are often not used appropriately. Surveys suggest that staff are often not found in post and are instead undertaking private practice. One recent study, for example, suggested that usable but unused time of health staff accounts for around 20% of total spending on services (Ferdousi 2001). Supplies are also used inappropriately or pilfered to be sold outside the health facilities.

There are two important issues here. The first concerns the extent to which resources allocated for one purpose can easily be used for another. This is less a problem with services such as family planning and vaccines where the supplies at least only have one use. It is much more of an issue with more

sophisticated ESP services. An antibiotic, for example, allocated for one illness, often has many other applications. Sometimes it may be sold off to the highest bidder. This makes it difficult to ensure that inputs are used for desired activities.

The second issue is the incentives that are in place to encourage staff to utilize resources in accordance with the planned priorities. The proliferation of dual practice and widespread evidence that staff take unofficial payments to supplement their salary suggests that individual incentives may be out of alignment with organizational objectives (see Nahar and Costello 1998; Killingsworth et al. 1999). The delivery of the essential package does not require that staff do no private practice or take no unofficial payments. It does, however, need staff to devote sufficient time and to utilize medical supplies in order to deliver the basic package service at a reasonable level of quality. The problems of leakage caused by poor incentives and flexibility in resource use make it very difficult to ensure that a selective approach to service delivered, offered by the ESP, is delivered in practice.

The package approach to essential services suggests a world of insurer-purchasers where activities and outputs can be well specified and appropriate incentives are in place to ensure that activities are carried out. Yet in Bangladesh, and indeed most other countries where the ESP approach is being promulgated, systems do not work in this way.

One response to this is to argue that they should – that contracting and purchasing are natural tools for implementing a package approach to primary and essential secondary services. Acceptance of this would lead to the development of public and public-private contracting mechanisms with explicit targets and contestable markets. Given that non-government providers deliver around 75% of first contact care, an approach that incorporates these providers into the ESP delivery system appears justifiable (Sen 2001).

Services could, for example, be contracted-out to NGO or private providers. This is occurring in city areas where health care is the responsibility of local government. It is more difficult in rural areas where a substantial public primary-care structure is already in place. A related approach is to 'contractise' the provision of public services so that staff in a facility are obligated to provide the minimum ESP services in return for their salary. While attractive it raises the question of whether the approach is feasible and offers benefits over the existing system. Surveys have generally found that the experience of contracting is mixed and is vitally dependent upon the level of management expertise development by the state purchaser (Mills 1998). This is particularly the case with primary care contracting where the output is difficult to measure. While it is relatively easy to specify and monitor services such as vaccinations and family planning services, it is harder for curative care where presenting symptoms may have a variety of possible causes, and various diagnostic and curative strategies are required. Even in developed countries the literature suggests that the measurement of primary care outputs is notoriously difficult (for a UK example, see Giuffrida and Gravelle 1998).

4 Demand for essential services

The development of the ESP in Bangladesh is primarily a supply led approach. Behavioural change communication (BCC) is integrated into the ESP delivery. However, much of the strategy is still embedded within the traditional change in contraceptive use and uptake of immunizations that have dominated information change over the last 20 years. A more radical and wide-reaching approach is now required that attempts to communicate wider messages about quality use of health services – particularly the appropriate use of drugs and knowledge of the referral chain. Evidence continues to indicate that wrong use of services is often a product of ignorance about the range of care available. One anthropological study, for example, suggested that lack of information is often a cause of the inability to access good emergency obstetric care (Blanchett 1999).

Use of facilities is primarily based on location. Most facilities, even the majority of medical colleges (not Dhaka Medical College Hospital), are utilized by people who live within 5 miles of the facility (Ensor et al. 2001b). According to the CIET baseline service delivery survey, used to monitor HPSP, location remains one of the most important reasons for accessing services (CIETcanada 2000). The same survey found that transport costs were the second most important cost element of service delivery incurred by patients (first was spending on medicines). Projections for the costs of expanding ESP services do not generally take into account these user barriers to service use. Neither does the budgeting system readily permit the introduction, for example, of a transport fund that would allow facilities to subsidize the transport costs of the poorest patients.

A further demand issue concerns the intra-household allocation of resources. In common with findings in other countries, there is some evidence that boys and men are given preference in health spending (Quisumbing and Maluccio 1999). Where charges, either official or unofficial, are in place women and girls may lose out. While reproductive health utilization may mask this effect, the BIA study shows that use of non-reproductive health services is biased towards male use. This is an important demand side issue that has, in the past, been partly addressed through the doorstep delivery of family planning and other primary services. It will be important to develop strategies for addressing this male preference, particularly in the poorest households.

5 Monitoring indicators

The monitoring of the sector programme is mostly through specific input-based financial indicators and outcomes and broad-based process/output indicators. The financial indicators are clearly limited to the resource inputs while the outcomes, while vitally important, are lagged indicators that are influenced by many other factors. At the same time the broad-based measures of use provide information on general utilization by income groups but do not focus sufficiently on use of particular services by lowest income groups. Broad-based findings that people are more or less satisfied with

treatment compared with a few years previously have limited value in identifying specific care-seeking barriers.

While it is clearly not possible to measure all services, a developing idea is monitoring the access to, and process of, care for identified tracer or representative services. Obstetric care has already been marked out as a vital tracer of success of the reproductive health component. Access to treatment for tuberculosis by the poor is similarly seen as a good tracer for the success of the communicable disease component. While the MIS will need to develop further to provide routine information on these services, it is likely that the existing MIS combined with regular surveys could provide adequate information for monitoring impact. The Government is aware of the weaknesses in the poverty sensitivity of indicators and is currently addressing this through the development of a health poverty strategy (key issues are described in Ensor and Sen 2001).

6 ESP and catastrophic care

As a final point, there is evidence in Bangladesh that it is the large, unexpected, catastrophic medical care costs that are often responsible for pushing households into poverty (Nabi et al. 1999). Such costs are generally not covered by the ESP approach. A recent survey of two rural areas revealed considerable willingness to pay for insurance (Howlader et al. 2001). The same study also found a large proportion of households reporting sickness that had travelled to India for treatment.

It is therefore apparent that while more resources for ESP may increase the use of effective primary services, it has very little impact on household exposure to financial risk through illness. Financial projections suggest that while ESP is not yet available to all the population, economic growth will mean that within 5 or 6 years services will have expanded sufficiently to provide a residual of resources that can be used to fund non-ESP services. There then appears to be a central choice between expanding funding for general hospital care – through conventional funding for district hospitals and medical colleges – or targeting the residual on the poor through some kind of subsidized insurance arrangement. Increasingly, NGOs supporting micro-credit programmes find that members demand health cover. Often cover is not affordable by the majority of the poor. One possibility is that the government might finance subsidized community insurance purchased through NGOs in order to protect against the financial risk of illness.

Conclusion

Evidence from a range of recent studies suggests that the ESP approach has been successful in diverting more resources into primary levels of care, in focusing attention on resource flows into vital essential services such as maternal care and in shifting attention from hospitals to primary services most used by the lower income groups. Yet evidence also suggests that organizational and institutional rigidities inhibit local resource flows and service uses that match these national trends.

The evaluation of impact is partial for two reasons. First, the sector programme has only been half implemented and many of the benefits accrue during the second half or even later. Secondly, the measures of impact are insufficient to accurately capture the effects on different groups. The classic BIA, for example, fails to take account either of process of care or the effectiveness of services. Further work will be required to investigate the care-seeking process in order to reveal whether the SWAp approach and, more specifically, the essential package are having the desired impact.

This partial evaluation also appears to have revealed a gap in the literature and possibly in health systems research more generally. There appears to be a dearth of evaluation evidence on the impacts of the widespread adoption of the essential service package across a range of countries. Given the considerable investment in this approach over the years such an evidence gap demands to be filled.

Endnotes

¹ Integrated Management of Child Health – the main idea being that children presenting with symptoms that suggest one illness are also screened for a range of other common illnesses.

² Budgets are separated into development and revenue. Historically development budgets included items that were funded through projects, often with foreign assistance. In principle, once the projects are integrated into regular activities, they should be moved to the revenue budget, wholly financed by government where staff have guaranteed employment and pension entitlements. In practice this has not always happened. As a result, funding for much regular activity, including a substantial portion of the staff costs of the family planning programme, are still financed through the development budget, which represents around half of total Ministry of Health spending. This is changing and there is a commitment from government to transfer staff to the revenue budget.

³ Based on the index developed by the United Nations Development Program, which combines literacy, life expectancy, infant mortality and Gross Domestic Product per capita into a single index of development.

⁴ Significant difference at 1% level.

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