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Letter to the Editor

Paying Out of Pocket for Healthcare in Bangladesh - A Burden on Poor?

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Dear Editor-in-Chief

Out-of-pocket (OOP) expenditures for healthcare continue to be the most significant means of healthcare issue in the developing world and constitute a large share of their living financial plan (1, 2). The healthcare expenditures are largely unpredictable and usually have a negative impact on the poor households, while large expenditures have catastrophic impacts on household welfare. A sudden serious feature of the illness deceits in the critical susceptibility of the poor to an unexpected and unforeseen healthcare related vulnerabilities, increased indebtedness due to income loss, and even employment. Thus, the illness and its related caring expenditures and consequent impacts can severely disrupt living standards (3). A household that has the misfortune to succumb to illness and whose spending pattern is disrupted suffers a further welfare loss (2). The magnitude of this welfare loss will depend upon the living standards of that particular household. A well-off household can finance medical expenses from savings, or by reducing on luxury stuffs of consumption. However, a less well-off household is bound to cut back on daily necessities and could be placed into further shortage for living budgets (1). Impulsive healthcare expenditures can expose households to a considerable financial risk, while many forego such expenses thereby raising the level and extent of morbidity.

Out-of-pocket healthcare expenditures of households in Bangladesh comprise 64.3% share of the total health expenditure and collectively spent approximately Taka 103.46 billion (US$1.49 billion) in yearly on health (4). High OOP expenditure in purchasing pharmaceuticals is the most distinctive feature in Bangladesh. Nearly 62% of the healthcare expenditure is on purchasing drugs and medical consultations (3). The high proportion of expenditure on drug reflects a high level of self-treatment and self-medication and in terms of share of household medical expenditure is diagnostic and imaging, which is about 10.6% (3). Households also spend a significant portion of its income on transportation is about 6.2% related to healthcare services and facilities (i.e. ambulance/car rental). It is observed that a household, on an average, spends 7.5% of its total income for and the poorest 20% spent approximately 13.5% of their income for purchasing health care (3). Thus, the intensity of catastrophic payments for various threshold levels reveals that approximately 29.2% of the households spend more than 5% of

their total resources for health care. Hence, the OOP expenditures for health care services have been sufficiently costly in Bangladesh. The OOP healthcare expenditure sufficiently expensive as 25.5% of the population in Bangladesh is below poverty line (5). Healthcare expenditures add another 4.2% population yearly (5.8 million people) to the extreme poverty. In absolute terms, the poverty impact of OOP expenditures for health care is substantially worse where the rates of poverty are higher and OOP health care expenditures have the most devastating impact and causes considerable financial risk.

If this burden can be relieved by pointing and provisioning of public healthcare system, this would substantially mitigate the effects on poor households and poverty. Further, normalized gap measures suggest that additional healthcare expenditures incurred by poor households not only raise the poverty prevalence, but also increase the poverty intensity over time (1, 2). This strongly provides the evidence that low health facilities and status of the population is a major factor for the persistence of poverty and it can be relieved by proper targeting and provisioning of public healthcare. How to reduce the OOP expenditures and decrease the share of household living standards is a fundamental question (6, 7). Therefore, it is a significant subject to identify the linkage between health, healthcare provision and poverty in Bangladesh. Recently, one basis, which is used for assessing the performance of health systems, is through the determination of the extent to which households are protected from unforeseen OOP expenditures and poverty induced effects of expenditures for such health care. Appropriate attention has hardly been given in Bangladesh to recognize the linkage between health, healthcare provision and poverty, which could be the basis for the public investment policies on the condition of health and living standard. It is evident that the poor are worse protected from healthcare burdens in Bangladesh. Therefore, the national policies should emphasize the poverty reduction strategies through improved healthcare status of the individuals. This also calls for investment in the health sector as a continuing process, especially in the rural areas, and then the outcomes contribute to sustainable development.

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