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RESEARCH ARTICLE

Towards Achieving Universal Health Coverage in Bangladesh.

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ABSTRACT

Bangladesh developed a Health Care Financing Strategy (HCFS) 2012-32 in 2012 by sketching a road map with a view to providing financial risk protection, promoting efficiency and equity, and strengthening health systems to achieve universal health coverage (UHC). The main objective of the paper is to study the progress of the strategy and to observe how it provides a framework to gradually bring all citizens in Bangladesh under three different social health protection schemes - targeting three segments of population: people below the poverty line, formal sector employees, and non-poor informal sector workers. Employing a qualitative method, the study adopted thematic analysis to present the data collected from FGD informants who have been chosen following non-probability purposive sampling. The study reveals that the strategy set targets for increasing resource generation, expanding the public share on health expenditure, and reducing out of pocket expenditure over the last 20 years of its adoption. Furthermore, the decision to design a Health Care Financing Strategy at that point in time in 2012 was relevant as there was a clear need for guiding principles and strategies for sustainable financing in the health sector to achieve universal health coverage greater successfully.

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1. Introduction

Bangladesh has made impressive strides in improving health indicators over the past few decades. Despite facing significant challenges, such as economic constraints and systemic issues, the country has achieved notable successes, particularly in reducing child mortality and making

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substantial progress in reducing maternal mortality. The success in achieving Millennium Development Goal 4 (MDG 4) on child mortality reflects a combination of effective health interventions, increased access to healthcare services, and improvements in nutrition and sanitation. Programs such as immunization campaigns, oral rehydration therapy, and maternal and child health services have played critical roles.

For Millennium Development Goal 5 (MDG 5) on maternal mortality, Bangladesh has made substantial progress, though challenges remain. The country has worked to improve maternal health through initiatives like increasing the number of skilled birth attendants, improving access to antenatal and postnatal care, and strengthening emergency obstetric care. Addressing health system bottlenecks, such as weak governance and limited financing, remains a challenge. However, the improvements in health outcomes are a testament to the resilience and effectiveness of health programs and policies implemented in the face of these obstacles. Continued efforts to strengthen the health system and address local needs will be crucial for sustaining and furthering these gains.

More recently, Bangladesh has been committed to achieving the Sustainable Development Goals and universal health coverage. The total health expenditure of Bangladesh in 2020 was 2.8% of gross domestic product, which is one of the lowest allocations in the world. At the same time, out-of-pocket expenditures took up 69% of total health expenditure, which is one of the highest proportions in the world. Annually, about 4% of households are pushed into impoverishment due to high out of-pocket expenditures on health (Islam, Akhter, and Islam 2018). Considering these circumstances, Bangladesh's Health Care Financing Strategy 2012–2032, established by the Health Economics Unit of the Ministry of Health and Family Welfare (MOHFW), did set a target of reducing out-of-pocket expenditures on health to 32% of total health expenditure by 2032 and identified several health financing reforms to move the country towards universal health coverage. (Health Economics Unit, Health Services Division, Ministry of Health, and Family Welfare; 2012)

Health financing is a core function of a health system that helps it progress towards universal health coverage by improving effective service coverage and financial protection. Millions of people cannot access health services due to the high expenses. Many others receive poor quality of services even when they pay out-of-pocket. Carefully designed and

implemented health financing policies can help address these issues (Shahinul 2020). The health sector of Bangladesh has achieved significant progress in recent years. But still large numbers of households are being pushed into poverty, or those already impoverished are further burdened, both by ill-health and by excessive out-of-pocket (OOP) payments for health care. Out-of-pocket expenditures are still high i.e., 64% (2012) of total health expenditure (THE), whereas the government is spending around 26%. Bangladesh spends 3.4 % of its GDP on health and less than 1% of the population are covered by an insurance scheme (Begum and Hamid 2021).

The economically vulnerable population of the country is threatened with impoverishment, and they are unable to cope up with catastrophic illnesses, unfortunately, the percentage of that population is rather too high. Furthermore, due to demographic and epidemiological transition of the country non-communicable diseases are also becoming a major burden as an addendum to the common infectious diseases. Total Health Expenditure level itself is also quite low. These calls for appropriate actions that will focus on deepening and broadening the resource base for healthcare in the country. This strategy was designed in 2012 to address these challenges and move towards the long-term objective of universal health coverage. As a commitment to the UHC, the govt. has formulated the Health Care Financing Strategy 2012-2032 aligning with the 3rd Health Population and Nutrition Sector Development Program (HNPSDP) 2011-2016 and the National Health Policy 2011. It provides a framework for mobilizing resources in order to achieve UHC in a stepwise manner and puts emphasis on extending financial protection to all segments of population (S. M. ahmed and kuhel F. Islam 2016).

With a view to Expanding Social Protection for Health Towards Universal Coverage, The Health Care Financing Strategy 2012-2032 started its journey while attempting to attain sustainable, equitable, effective, and efficient health care financing and also ensuring equal access to quality health services to the whole populations of the country. The policy was adopted in 2012 for the next 20 years, half of the time being already passed. The ambitious goal of HCFS 2012-2032 appears inconsistent with the country's overall low Total Expenditure on Health (THE). Bangladesh's low THE partly results from a small and declining allocation on health in the government's budget. HCFS 2012-2032 proposed a

contributory Social Health Insurance (SHI) for the formal sectors, a government subsidized regime for the BPL population, the Shasthyo Suraksha Karmasuchi (SSK), and Community-Based Health Insurance (CBHI) schemes for the large informal sectors populations as a complementary health financing option. The government subsidized program for the people living below poverty line started in 2016 in three Upazilas of Tangail district, later it was expanded in eight others Upazilas in 2018 as a pilot program. Now it has been expanded in six more districts of Bangladesh including Dhaka North & South City Corporation. A contributory social health scheme for the formal sector, has made no progress yet moving that Community Based Health Insurance (CBHI) is not a feasible solution for Bangladesh. Weak leadership and governance, as well as the assignment of implementation duties of Health Protection Scheme to the Health Economics Unit, MOH&FW, are impediments for the successful execution of HCFS. Purchaser- provider mechanism, need and demand side financing, purchasing health services from private entities are being hindered due to lack of comprehensive implementation plan of HCFS 2012-2032.

2. Objectives of the Study

The main objective of this study is to review the health care financing strategy focusing on the factors that are facilitating, or impeding the successful implementation of health care financing strategy and recommend some refinements and possible updates.

3. Methodology of the study

3.1 Study Design: The study aims to gather qualitative insights into health system dynamics, policy implementation, and other relevant issues within Health Economics Unit (HEU), Health Services Division under Ministry of Health and Family Welfare (MOH&FW). Non-random purposive sampling is employed to select informants who have relevant knowledge and experience related to the study's focus. A total of 10 informants are selected from Health Economics Unit (HEU), Ministry of Health & Family Welfare, University professional, public health expert and from Developments partners. The choice of 10 informants has been based on

their expertise and role in their respective organizations, ensuring a diverse range of perspectives**.**

3.2 Interview Guide: A thorough review of existing literature were conducted to identify gaps, and to prepare the interview guide. The interview guide includes a set of open-ended questions and prompts tailored to the research objectives. It was ensured that the guide addresses key topics relevant to the study, such as health policy, implementation challenges, and system dynamics. Face-to-face interviews were carried out with these informants. It has been ensured that the interviews are conducted in a comfortable setting to facilitate open and honest responses.

3.3 Thematic Analysis: The study identified and categorized key themes and patterns that emerge from both the KIIs and FGDs. Afterwards, it compared and contrasted findings from individual interviews and group discussions were compared to draw comprehensive conclusions.

4. Reviewing Relevant Literature

The Government of Bangladesh (GOB) prepared the country's first Health Care Financing Strategy (HCFS, 2012-32) in 2012 which outlined a pathway to achieve Universal Health Coverage (UHC) in Bangladesh over the next twenty years. The country is also on its way to be deemed as a developing country in 2026 from being a Least Developed Country (LDC). However, implementation of HCFS is challenging and progresses have been very slow. Over the years, out of pocket (OOP) health expenditure has increased while government share in the Total Health Expenditure (THE) is on a declining trend. In this context, it is an important and timely initiative to review the health care financing mechanisms proposed in the HCFS and the supporting actions to achieve SDG target of universal health coverage by 2030.

Achieving UHC requires significant efforts from governments to allocate additional public financing and ensure coverage for the poor and non-poor informal workers. UHC is about equity, that links healthcare to the needs of people rather than their ability to pay (Ahmed and Islam 2016). The specific strategies and approaches employed by different countries may vary, but the goal is to provide equitable access to quality health services for all without causing financial hardship. Since the inception of Bangladesh in 1971, Bangladesh did not have any health policy for 03

decades (three) and the health-related directions and targets as well as the health developments programs were guided by a five-year plan during that period. On the way to health trajectory the following relevant policies have been reviewed.

Table 1: Reviewed Policies

Sl	Name of the Policy	Year	Co-coordinating agencies	Paradigm Shift
01	First Five-Year Plan	1973-1978	MOHFW	Creation of rural health infrastructure for providing integrated health services at Thana Health Centre (THC) and Rural Health Centre (RHC).
02	Second Five-Year Plan	1980-1985	MOHFW	Primary Health Care (PHC) was made the focus of health care activities, with a view to ensuring a minimum level of healthcare to everyone.
03	Third Five Year Plan	1985-1990	MOHFW	Added a new dimension of health services by emphasizing Maternal and Child Health (MCH) as a means of population control.
04	Fifth Five Year Plan	1997-2002	MOHFW	Was introduced for the first time a sector-wide approach (SWAp) to health sector programming.
05	Health and Population Sector Programming (HPSP)	1998-2003	MOHFW, DGHS, DGFP, DGDA, NIPORT, and PWD	Transition from project-based approach towards sector –wide approach. Constructions of large number of Community Clinics and Essential service Packages ESP).
06	Health Policy	2000	MOHFW	Basic health services was made accessible to all particularly the poor.
07	Health Nutrition and Population Sector Program (HNPSP)- 2nd SWAp.	2003-2011	MOHFW, DGHS, DGFP, DGDA, NIPORT, and PWD	Adopting demand-side financing options (DSF) to stimulate demand for especially by the poor group, (Voucher scheme for the pregnant women).
08	Bangladesh National Health Policy	2011	DGHS and HSD of MOHFW	Providing universal access to excellent quality healthcare services at a reasonable cost for all citizens of Bangladesh irrespective of age, gender, and socio-economic status.
09	Health Nutrition and Population Sector Program (HNPSP)- 3rd SWAp.	2011-2016	MOHFW, DGHS, DGFP, DGDA, NIPORT, and PWD	Improve access to and utilization of essential health, population, and nutrition services, particularly by the poor.
10	Health Nutrition and Population Sector Program (HNPSP)- 4th SWAp.	2017-2023	MOHFW, DGHS, DGFP, DGDA, NIPORT, and PWD	The overall objective was "to ensure that all citizens of Bangladesh may enjoy health and well-being by expanding access to quality and equitable healthcare in a healthy and safe living environment".

(Source: Reviewing the Health Strategy, 1973-2023)

To review the health care financing strategy, the scenario of other countries has also been studied for the purpose of comparing and to find out a holistic approach on the way to its successful implementation. Different countries employ different financing strategies for UHC.

Some developing countries scenarios have been presented (based on secondary data), that describe their health financing strategies to seek universal health coverage.

Brazil significantly shifted its health policy in 1988 of the Unified Health System (UHS), by providing free health care to all citizens, eventually increasing coverage and improving health outcomes. In 1988, half of Brazil's population had no health coverage. Two decades after establishing its Unified Health System (Sistema Unico de Saúde), more than 75% of the country's estimated 190 million people started relying exclusively on it for their health care coverage (Jurberg and Humphreys 2010). Health care coverage in Chile is provided primarily either by the state-funded National Health Fund - Fondo Nacional de Salud, mostly known as FONASA, or by the private coverage schemes, Las Institutions de Salud Provisional (ISAPRE). FONASA which covers around 78% of the population, ISAPRES cover around 17-18% of the population, while a further 3-4% is covered under an Armed Forces insurance scheme(OECD 2019).

Law 100 of 1993 set up the legal framework of the new Colombian health care system and adopted the "structured pluralism" model (Londoño and Frenk, 1997). The reform unified the social security, public, and private sub-systems under the General System of Social Security in Health (known by its Spanish acronym, SGSSS).(Escobar et al. 2009)

Ethiopia has set out a hybrid system that combines Social Health Insurance (SHI) for the formal sector with Community Based Health Insurance (CBHI) for the poor and non-poor informal. The ministry has also developed 20 years plan of visioning Ethiopia towards the path of universal health coverage (2015 – 2035)(Bayked et al. 2023).

One of the most crucial elements of Rwanda's success has been the emphasis on community-based health care, which has allowed the decentralization of services and the development of a health workforce that is more receptive to public needs(Uwishema 2023). Thailand has implemented an incremental approach to achieve UHC, expanding health protections through public health insurance scheme which significantly

reduced out-of-pocket expenditure and improved access to healthcare. By 2002, the entire population was covered by three public health insurance schemes - civil servants and their dependents by the Civil Servant Medical Benefit Scheme (CSMBS), private sector employees by the Social Health Insurance Scheme (SHI) and the rest of the population by the Universal Coverage Scheme (UCS) (Haines et al. 2019). Overall, different countries have implemented different approach in the way to universal health coverage; Bangladesh can also opt for similar policies to become successful in UHC.

5. Understanding the Health Care Financing Strategy.

The Health Care Financing Strategy 2012-2032 is a plan for expanding social protection for health towards universal coverage. The HCFS provides a framework for developing and advancing health financing in Bangladesh. The challenges posed by health financing in Bangladesh are many and can be summarized under three broad categories. These are: (i) inadequate health financing; (ii) inequity in health financing and utilization; and (iii) inefficient use of existing resources. The Strategy is designed to address these challenges and presents a compelling case for an increase in public resources dedicated to health while outlining an actionable mechanism to capture private spending and channel it efficiently in prepayment and pooling arrangements.

The HCFS 2012-2032 formulated a health financing strategy with the aim of achieving UHC. It considered three separate mechanisms for three distinct population groups: Government financed coverage for the BPL population, CBHI for the non-poor informal and contributory SHI for the formally employed.

To begin with, this strategy proposes to cover the poverty-stricken people as well as the formal sectors, including government, private and NGO employees, and progressively extending the coverage to the remaining segments of the population by 2032.

The framework and its direction are aimed at:

(i) increasing the level of funding for healthcare,
(ii) ensuring an equitable distribution of the health financing burden
(iii) improving access to essential health services
(iv) reducing the impoverishments due to catastrophic health care expenditures

(v) Improving the quality and efficiency of service delivery.

6. Objective of the Health Care Financing Strategy 2012-2032

To cope with the challenges and to increase financial protection for the entire population and decrease out-of-pocket payments at point of service, the following three strategic objectives were proposed.

i. Generate more resources for effective health services.
ii. improve equity and increase health care access, especially for the poor and vulnerable.
iii. Enhance efficiency in resource allocation and utilization.

7. Strategic interventions and supportive actions

To achieve the strategic objectives, the HCFS proposes three different strategic interventions along with supportive actions; these are.

Table 2*:* Strategic Intervention and Supportive actions of HCFS-2012-2032.

Sl	Strategic Intervention	Supportive Actions
01	Design & implement Social Health Protection Scheme	I. Determine institutional arrangements for Social Health Protection Scheme II. Design and implement Health Equity Fund/National Health Security Office III. Implement SSK for BPL IV. Design social health protection scheme for above BPL (formal and informal)
02	Strengthen financing and provision of public health care services.	I. Generate more resources for effective health services. II. Scale up/reinforce Result Based Financing (MHVS) III. Retain user fees at point of collection

03	Strengthen national capacity.	I.	Support information exchange platform/knowledge hub/resources pool
		II.	Develop the capacity to design and manage the social health protection scheme.
		III.	Strengthen Financial Management and Accountability
		IV.	Improve monitoring and evaluation.
		V.	Introduce mechanisms to support the production of additional key staff (nurses, paramedics, and medical technicians)

(Source: HCFS, 2012-2032)

8. Goals of the Health Care Financing Strategy 2012-2032

It is mentioned that the goal of the Health Care Financing Strategy is to strengthen financial protection and extend health services and population coverage especially to the poor and the vulnerable segments of the populations with the long-term aim to achieve universal coverage.

The goals of the strategy are to

i. Provide everyone with access to health services (including prevention, promotion, treatment, and rehabilitation) of satisfactory quality to be effective, and
ii. Ensure that the use of these services does not expose its beneficiaries to financial hardship.

9. Findings of Primary Data.

Though the goal of Health Care Financing Strategy was to strengthen financial protection and extend services and population coverage especially to the poor and vulnerable segments of the population, with the long-term aim to achieve universal coverage. Based on desk review and findings from the KIIs, IDIs, FGDs there are some gaps in the way to proper implementation of Health Care Financing strategy. The key findings and recommendations from primary data are summarized as follows.

- The HCFS proposed a pre-payment health protection scheme for the whole population of Bangladesh. However, the respondents reported that there is no comprehensive action plan to implement it. Most the respondents claimed that the plan of the strategy seemed very much optimistic to implement for country like Bangladesh with limited

implementation skill and capacity. To make the plan implementable they suggested to revise the plan considering the country context.

- The strategy designed a three-tier health protection scheme: SSK for BPL, CBHI for informal non-poor populations, and contributory scheme for formal sector. Some of the respondents think that such different benefit packages will institutionalize inequity. Therefore, they opined that the strategy will be unsuitable to implement in some extent. To ensure equity, a unique benefit package is suggested by the respondents where the beneficiary will pay their contribution as per their financial capacity and all of them will serve under same benefit package.
- Respondents noted that many non-regulated NGOs and private healthcare providers operate in the country. However, they pointed out that there are no guidelines outlining the processes or criteria for purchasing health services from these private entities.
- HCFS intended to separate the purchaser from the provider of services, so that the provider can focus on effective management of their facilities. Most of the respondents welcomed the idea. Simultaneously, they also criticized that the strategy did not provide any instructions to develop separate institutional arrangements for purchaser-provider split.
- HCFS was designed to create Health Equity Fund under an autonomous body to receive public, private and development partner's fund and in addition to financing the social Health Protection Scheme. The respondents mentioned that without creating Health Equity Fund, Shasthyo Shuroksha Karmasuchi (SSK) has been started as piloting. For successful implementation of the strategy, they suggest creating the proposed health equity fund under an autonomous body.
- To attain equity and efficiency HCFS proposed Needs and Performance based allocation. Respondents suggested to create provision of flexibility in the PFM Rules which is currently rigid.
- The HCFS was developed by the Health Economic Unit (HEU), Health Services Division, MOF&FW. As a part of the HCFS, they also piloted SSK in Tangail district. However, the respondents opined that the HEU is not an implementing agency rather it's a policy advocacy unit of the government. If it was implemented by a dedicated entity, the coordination gap among the different govt. entities would be low. Most of them suggested that the responsibility of implementing the strategy should be handed over to a dedicated executive entity rather than to a policy advocacy unit.

- The respondent reported that there is no autonomous body that is exclusively responsible for successful execution of the country's first Health Care Strategy 2012-2032. For successful implementation of the strategy, they suggested providing responsibility to an exclusive autonomous body.
- Designing the social health protection scheme and population coverage mechanism is not appropriate for different population segments which was reported by some of the FGD participants.
- The respondents also opined that the insufficient public financing for health is inconsistent with the country's expressed desire to achieve UHC.
- For successful implementation of the HCFS, the respondents suggested enhancing the supervision, monitoring, and regulatory enforcement.
- Respondents also suggested distributing adequate HR, medicine, and equipment and the distribution must be equitable for the proper implementation of the strategy.
- Some of the IDI respondents quoted that there is no digital claim management system for existing government subsidized program named SSK. They claim that if there was a digital claim management system, the outcome of the program would be more beneficial.
- The respondents argued that the private and NGO operated health care providers should be properly regulated for the effective implementation of the strategy.
- Some of the KII respondents mentioned that a large amount of public money remains unutilized due to the lack of sufficient skill of the healthcare managers regarding public financial management rules every year. They suggested providing training to health facility manager for increasing the budget utilization.
- Respondents also reported that there is mistrust about the social insurance system & it is difficult to introduce Community Based Health Insurance CBHI) for large informal section due to the lack of trust among people. (Source: The Thematic Analysis, 2023)

10. Health related sustainable developments goals.

Since the inception, Bangladesh has many noteworthy achievements in health sector. Several standout such as the improvement of life expectancy at birth to 72 years, the reduction in under five mortalities from 251 to 31 per 1000 live births, the reduction in the total fertility rate from 6.6 births per woman to 2.0, the expansion of childhood immunization to 86 percent

and the elimination of polio and the decline in the percentage of deaths from diarrhea among children from 25 percent in 1970 to 2 percent in 2000 and since.(Perry 2023)

For attaining universal health coverage Goals-3 of SDG: Ensure healthy lives and promote well-being for all at all ages. All SDG-3 indicators plus other selected health-related indicators will also be ensured with proper interventions.

Table 5: Health-related Sustainable Development Goals (SDGs) and indicators.

Goals	Targets
SDG-3: Good Health and Well-being	Target 3.1: To reduce maternal ratio. Target 3.2: To end preventable deaths of new-borns and children under 5 years of age Target 3.3: To end of epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases. Target 3.4: To reduce mortality from non-communicable diseases. Target 3.7: To ensure universal access to sexual and reproductive health-care services. Target 3.8: To achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality, and affordable essential medicines and vaccines.
SDG 2: Zero Hunger (While not directly a health goal, it has implications for nutrition and health).	Target 2.2: To end all forms of malnutrition, including achieving, by 2025 the internationally agreed targets on stunting and wasting in children under 5 years of age.
SDG 6: Clean Water and Sanitation	Target 6.1: To achieve universal and equitable access to safe and affordable drinking water for all. Target 6.2: To achieve access to adequate and equitable sanitation and hygiene for all and end open defection, paying special attention to the needs of women and girls.
SDG 12: Responsible Consumption and Production (Indirectly related to health through environmental factors)	Target 12.4: By 2020, the environmentally sound management of chemicals and all waste throughout their life cycle, in accordance with agreed international framework, and significantly reduce their release to air, water and soil to minimize their adverse impact on human health and environment.
SDG 13: Climate Action (Climate change can have significant health impacts)	Target 13.1: To strengthen resilience and adaptive capacity to climate-related hazard and natural disaster in all countries.

(Source: Reviewing the SDG of Health Strategy)**.**

11. Conclusion

The Health Care Financing Strategy (HCFS) in Bangladesh was introduced ten years ago and it aimed to provide healthcare coverage for different population segments. The strategy included three schemes: SSK for the BPL (below the poverty line) population, CBHI for the nonpoor informal sector, and SHI for the formal sector. However, to date, only the SSK scheme has been implemented in the form of three pilot tests, with plans to scale it up to the entire country. The implementation of the SHI scheme for the formal sector has been delayed and has been subjected to debate.

Bangladesh has a high level of labor informality, with 94.7% of the population engaged in informal employment. This poses challenges for health financing reform, as in international contexts, it has been noticed that financing systems reliant on contributions from the nonpoor informal sectors face difficulties in achieving UHC. The HCFS in Bangladesh recognized this and opted for a social protection scheme based on CBHI instead. However, the feasibility of CBHI as a policy option has not been empirically proven, and only a few countries have attempted to implement it on a national scale. One major obstacle to achieving UHC in Bangladesh is the limited public financing available for healthcare. The country has low fiscal capacity, with the government collecting only about 7 percent of GDP through taxes. Additionally, the government allocates a small share of its budget to the health sector (2.5 percent), compared to other countries in the region. Strengthening fiscal capacity may take time, but increasing the allocation to the health sector in the shortly is crucial.

Expanding the SSK scheme to cover the nonpoor informal sector is a possible option, but it would require substantial additional public financing. This would be a challenging task for a government with limited fiscal capacity. A complementary option is to establish an SHI system for the formal sector, as attempted by Ethiopia and other countries. Defining coherent health benefits packages within the available financing is essential to ensure the financial feasibility and sustainability of the SHI scheme. Yet, to promote equity in access to health care, the government of Bangladesh must be mindful of the importance of defining and delivering a national minimum health benefits package to all citizens irrespective of income, location or other personal or family attributes.

As per the Constitution of Bangladesh, the government needs to ensure health care services to all its citizens as a fundamental right of the citizens. Bangladesh is also committed to achieving Universal Health Coverage (UHC) by 2030. The traditional input-based supply-side interventions currently practiced in Bangladesh have numerous limitations (e.g., inadequate budgetary allocation, low and inefficient utilization of budget, accountability and transparency, high out-of-pocket payment etc.) to achieve UHC. Thus, output-based demand-side interventions (e.g., strategic purchasing, social health protection, social health insurance etc.) appear to be necessary. Finally, countries that have made significant progress toward UHC are the ones that have benefitted from significant commitment and leadership from the highest levels of government and thus, created an effective agency responsible for health reform implementation. Bangladesh policymakers must reach a consensus on the way forward with UHC and once they do, they must set up the institutional mechanisms that will enable implementation.

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Declaration of Interests

I, the author of this research manuscript, declare that I have no financial interest. I have provided written consent to publish the paper in this journal. All findings and recommendations are derived from primary and secondary sources.

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