Journal of Business and Development Studies (ISSN: 2790-0703 & E-ISSN:3006-2195)
Volume: 02, Issue: 02, 2024, Web: www.isu.ac.bd/journal
RESEARCH ARTICLE

Health Care Financing Strategy 2012-2032: A Tool Towards Achieving Universal Health Coverage in Bangladesh

Md. Sirazul Islam[a]
[a] A Professional Civil Servent and Policy Analyst, People's Republic of Bangladesh

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 review 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 since it has been implemented 20 years ago. 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 UHC greater succesfully.

ARTICLE HISTORY
Received: 12 May 2024
1st Revision: 25 June 2024
2nd Revision: 05 July 2024
3rd Revision: 24 August 2024
Accepted: 01 September 2024
Published:

KEYWORDS: Health Care, Universal Health coverage, Bangladesh, MoHFA

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

Corresponding Author: Md. Sirajul Islam, A Professional Civil Servent and Policy Anylist, People's Republic of Bangladesh**,** email: sirajreza29@gmail.com

notable successes, particularly in reducing child mortality and making 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 2012–2032,6 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 (Ministry of Health, and Female Welfare; Health Economics Unit, Health Services Division 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 chigh 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. Thus, the paper is designed to assess the implementation status of the country's first Health Care Financing Strategy 2012-2032.

2. Objectives of the Study

The main objective of this study is to review the HCFS 2012-32 focusing on the factors that are facilitating, or impeding the successful implementation of health care financing strategy and recommend a policy option for its refinements and possible updates.

The specific objectives are (i) to assess progress of the implementation of the HCFS 2012-2032, (ii) to identify causes for any delays in implementation, and then, and (iii) to propose refinements and reformations.

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 the Ministry of Local Government, Rural Development, and Cooperatives (MOHFW). 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 MOHFW. The choice of 10 informants has been based on their expertise and role in the ministry, 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 HCFS, the scenario of other countries has also been studiedfor the purpose of comparing and to find out a holistic approach on the way to its successful implementation of it. 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 Único de Saúde), more than 75% of the country's estimated 190 mil- lion 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 Instituciones de Salud Previsional (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 2012-2032

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 resources 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: Reviewing the Health Strategy, 2012-2032)

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

The goal of the national health financing strategy was 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 role of health financing was 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.

Ten years ago, Bangladesh released its Health Care Financing Strategy 2012-2032 for the next 20 years with some expected outcomes. The expected outcomes of HCFS 2012-2032 are as follows.

Table 3: Outcomes of Health Care Financing Strategy.

Sl	Outcomes of the policy (HCFS 2012-2020)	Description
1	Reduce household out-of pocket payments (OOPs)	Payments paid directly by patients to healthcare providers at the time of receiving health services without recourse to reimbursement. HCFS intended to reduce OOPs from 67% (2012) to 32% in 2032 with its short- and medium-term targets.
2	Increase Health Financing	HCFS intended to increase the health budget as national budget from 5% (2012) to 15% in 2032 (with its short and mid-term targets that is 10 % in 2016 and 12% in 2021).
3	Capacity development of the healthcare providers for efficient utilization of health budget.	For proper implementation of health budget HCFS was intended capacity building of the healthcare providers.
4	Reduce catastrophic	HCFS was intended to reduce catastrophic

	health expenditure.	healthcare expenditures due to household out-of-pocket payments.
5	Introduce Social Health Protection Scheme for whole population of Bangladesh.	To provide a comprehensive impatient care a non-contributory health protection scheme for the people living below the poverty line (BPL), Community Based Health Insurance (CBHI) for the large informal sector and Contributory Health Protection Scheme for the formal sector (public, private and NGOs).

(Source: Reviewing the Health Strategy, 1973-2020)

9. Major Findings from KIIs, and FGDs.

Table 4: Findings from KIIs, IDIs and FGDs.

Thematic Findings	Description of the Findings	Recommendations	Respon-dents
Optimistic plan with limited implementation capacity	Several interviewed stakeholders stated that the HCFS was optimistic, especially in the context of supplying side barriers to the provision of quality care, a large informal sector, which challenges the feasibility SHI; and limited MOHFW capacity to design and implement the three financing schemes set forth in the HCFS.	Increasing of Demand side financing and resource pooling from different sources, aiming to form health equity fund.	R5, R2
A design partially sound, partially unsuitable	The strategy provided sound policy directions to set up a government financed scheme (SSK) to cover the BPL population. Respondents expressed their concern about creating a two-tiered health system, where formal sector workers can finance with their contributions a relatively generous benefits package while the informal sector and the poor	Introducing of unique social health insurance for BPL, informal and formal sector with unified benefit package.	R1, R4

	have access to a narrower benefits package mostly financed by government. Such a design in Bangladesh could institutionalize inequality.		
Weak leadership and governance Limited public financing for health	Bangladesh has a pluralistic health system where multiple entities engage in health service provision: the MOHFW, the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC), private for profit, and private non-profit (non-governmental organizations, NGOs) operate health facilities. Strong leadership and governance is required to coordinate, monitor, and regulate this complex and diverse health system, but the private sector remains largely unregulated, while service quality and costs vary widely across different types of service providers.	Institutional strengthening and strong regulatory framework.	R8, R7
Inefficient and inequitable allocation of government resources	MOHFW's budget allocation is centralized and unresponsive to the local needs and demands because it is based on the number of health staff and beds. This input-based budget allocation mechanism also led to inequity, with large differences in the availability of government health financing among districts.	Introduce strategic purchasing and increase efficiency in resource allocation and utilization.	R9, R10
Complicated and rigid financial management	Public providers are overburdened by the excessive demands of the existing PFM rules, thus restricting their ability	Reforms in PFM rules and initiating purchaser-	R1, R2

rules	to deliver timely and quality health care. In the respondent's view, these PFM barriers could be overcome through a purchaser-provider split.	provider split.	
Limited public financing for health.	Bangladesh's government collected a relatively small amount of revenue as a share of gross domestic product (GDP), thus limiting its ability to finance the social sectors, including health.	Increase financial allocation in health sector and expand the fiscal space.	R8, R9
A weak supply side system.	Insufficient and inappropriate supply of medicine and supplies in public facilities are major reasons of high OOP. In the absence of structured referral system, sale of drugs without prescriptions, unregulated private sector, and aggressive marketing of the pharmaceutical industries lead to high OOP for drugs and tests. The absence of referral system also creates unnecessary pressure on secondary and tertiary care, leading to the inefficiency of the use of the resources.	Increase supply side readiness (increase supply of medicines at public facilities) and establishing a referral system in health care system.	R2, R3

(Source: Outcomes of Thematic Analysis, 2024)

10. Factors impeding the successful implementations of HCFS 2012-2032

Though the goal of HCFS 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 or factors that are impeding in the way

to proper implementation of Health Care Financing strategy. The gaps/ impeding factors are summarized as follows.

- The HCFS proposed a pre-payment health protection scheme for the whole population of Bangladesh but there is no comprehensive action plan to implement it. It is an optimistic plan with limited implementation capacity.
- The strategy designed a 3 tier of health protection scheme SSK for BPL, CBHI for informal non-poor populations and contributory scheme for formal sector such different benefit package which institutionalizes inequity, so the strategy to be partially unsuitable.
- There is a large non-regulated NGOs and private healthcare providers but there is no guideline how and who will purchase health services from private entities.
- HCFS intended to separate the purchaser from the provider of services, so that provider can focus on effective management of their facilities but there is no separate institutional arrangement 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, prior doing this Shasthyo Shuroksha Karmasuchi (SSK) has been started as piloting without developing any mechanism.
- To attain equity and efficiency HCFS proposed Needs and Performance based allocation but it does not consider the rigid PFM Rules.
- The HCFS was developed and piloted by Health Economic Unit, Health Services Division, MOF&FW but HEU is not an implementing agency it's a policy advocating unit & there exists a co-ordination gap among the govt. entities that implies weak leadership and governance.
- There is no autonomous body that is exclusively responsible for successful execution of the country's first Health Care Strategy 2012-2032.
- Designing the social health protection scheme and population coverage mechanism is not appropriate for different population segments.

- Insufficient public financing for health is inconsistent with the country's expressed desire to achieve UHC.
- Weak supervision, monitoring, and regulatory enforcement.
- Inadequate and inequitable distribution of HR, Medicines, and equipment.
- Another important impeding factor is that there is no digital claim management system of existing government subsidized program named SSK.
- Large number of existing/operational non-regulated private health care providers and NGOs.
- Inefficiency of health care managers regarding utilizations of resources: Every year a large amount of public money remains unutilized due to the lack of knowledge of the healthcare managers regarding public financial management rules.
- There is an existing mistrust about 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.

11. Proposed Refinements and Updating of HCFS 2012-2032.

From the findings of KIIs, IDIs, FGDs and based on the secondary data analysis, the following refinements and updates are recommended for the proper implementation of HCFS.

i. **Increase allocation for health sector:** MOHFW needs to prepare an investment case with clear evidence of value for money for investing in health, and the possible pathway for increasing efficiency of resources used in the health sector. MOHFW needs to negotiate with Ministry of finance for channeling adequate resources in line with the targeted stipulated in 8th Five-year plan.

ii. **Developing purchasers-provider split:** To improve the efficiency, quality, and accountability of healthcare services, the responsibility of purchasing healthcare services and responsibility for providing those services should be separated.

iii. **Improve efficiency of resource use:** The health system is still not equipped for rolling out a nation-wide social health insurance

scheme. In this context, strengthening the existing general tax-revenue based system is important.

iv. **Supply-side readiness:** It is crucial to ensure regular supply of medicines at public facilities including those for chronic conditions to reduce OOPs. It is also important to fill the vacant posts and design incentives for retention of health personnel in rural and remote areas and ensure appropriate input and skill mix.

v. **Demand-side financing**: A gradual move towards demand-side financing from the current supply-side financing with appropriate skill and system in place is recommended.

vi. **Regulating and strategic purchasing from private sector:** A proper regulatory mechanism should be in place for empanelment, accreditation, and licensing of private providers. Involving private sector for providing services in SSK or through public-private partnership (PPP) needs careful consideration. The MOHFW should be allowed to contact with the best quality health care providers both in public and private sector. It will help in selective contracting and improve efficiency.

vii. **Benefit Package:** The benefit packages for different health care financing mechanisms proposed in the HCFS in Bangladesh could be same or it may vary. As per HCFS a larger benefit package is reserved for the civil servants followed by other contributory health insurance schemes and then the relatively smaller benefit package is for the non-contributory health insurance schemes. The SSK should include the outpatient services as well.

viii. **Redesigning of Social Health Protection Scheme:** HCFS proposed three different social health protection schemes for three segments of population. SSK for BPL, CBHI for non-formal poor population and Contributory scheme for formal sector population. These different types of schemes and benefit package will create inequity in healthcare services. Equity is a fundamental principle of UHC. Achieving equity means that health services and resources are distributed based on people's needs rather than their ability to pay. So, to ensure equity in healthcare services a unique health protection schemes and a unique benefit package is required.

ix. **Designing an effective actions plan:** The HCFS intended to reduce the OOPs, which leads to catastrophic consequence and

impoverishment specially for the poor and the vulnerable ones, but there is no effective action plan how it will be implemented. For the successful implementation of HCFS an effective actions plan is urgent.

x. **Leadership and Governance:** Coordination is required with different implementing units within MOHFW, including Planning Wing, DGHS, DGFP, DGNM and DGDA. Hence, HCFS needs to outline possible ways of effective coordination using the existing coordination mechanism. Greater leadership from HEU is required for policy advocacy and monitoring of implementation of the HCFS.

12. How Proposed Refinements and Updates will address the SDGs.

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 diarrhoea among children from 25 percent in 1970 to 2 percent in 2000 and since.(Perry 2023)

The proposed refinements and updates will play an important role in ensuring the Sustainable Development Goals-3: Ensure healthy lives and promote well-being for all at all ages. All SDG-3 indicators plus other selected health-related indicators will also ensure the intervention of the proposed refinements and updating.

Table 5: Refinements and updating linked to SDGs.

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)

13. 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 consensus on the way forward with UHC and once they do, they must set up the institutional mechanisms that will enable implementation.

References

Ahmed, Sayem et al. 2022. "Assessing the Incidence of Catastrophic Health Expenditure and Impoverishment from Out-of-Pocket Payments and Their Determinants in Bangladesh: Evidence from the Nationwide Household Income and Expenditure Survey 2016." *International Health* 14(1): 84–96.

Bayked, Ewunetie Mekashaw et al. 2023. "The Impact of Community-Based Health Insurance on Universal Health Coverage in Ethiopia: A Systematic Review and Meta-Analysis." *Global Health Action* 16(1). https://doi.org/10.1080/16549716.2023.2189764.

Begum, Afroza, and Syed Abdul Hamid. 2021. "Impoverishment Impact of Out-of-Pocket Payments for Healthcare in Rural Bangladesh: Do the Regions Facing Different Climate Change Risks Matter?" *PLOS ONE* 16(6): e0252706. https://doi.org/10.1371/journal.pone.0252706.

Escobar, María-Luisa, Ursula Giedion, Antonio Giuffrida, and Amanda

L Glassman. 2009. “Colombia: After a Decade of Health System Reform Background and Context.” *From Few to Many*: 1–13.

Haines et al, 2019 et al. 2019. “The Kingdom of Thailanda Health System Review.” *Journal of Chemical Information and Modeling* 53(9): 1689–99.

Health Economics Unit, Health Services Division, Ministry of Health and Family Welfare. 2012. “Expanding Social Protection for Health: Towards Universal Coverage.” (September).

Health Economics Unit, Health Services Division, MOHFW. 2022. “Bangladesh National Health Accounts 1997-2020.” *European University Institute* (2): 2–5. https://eur-lex.europa.eu/legal-content/PT/TXT/PDF/?uri=CELEX:32016R0679&from=PT%0Ahttp://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52012PC0011:pt:NOT.

Institute of Health Economics, Dhaka university. 2023. “National Health Security Office (NHSO) in Bangladesh: Design and Structural Aspect Based on Learning from Success Countries.” (1): 1–14.

Islam, Md Ashadul, Shamima Akhter, and Mursaleena Islam. 2018. “Health Financing in Bangladesh: Why Changes in Public Financial Management Rules Will Be Important.” *Health Systems and Reform* 4(2): 65–68.

Islam, Syed Masud ahmed and kuhel Faizul. 2016. “Bangladesh Path to UHC: The Health Care Financing Strategy 2012-2032.” *Health watch* 6(August): 128.

Jurberg, Claudia, and Gary Humphreys. 2010. “Brazil’s March towards Universal Coverage.” *Bulletin of the World Health Organization* 88(9): 646–47.

OECD. 2019. “OECD Reviews of Public Health: Chile. A Helthier Tomorrow. Assessment and Recommendations.” *OECD Reviews of Public Health*: 1–28. https://www.oecd.org/health/health-systems/OECD-Reviews-of-Public-Health-Chile-Assessment-and-recommendations.pdf.

Perry, Henry B. 2023. “‘ 50 Years of Bangladesh : Advances in Health ’ Charting a Path to Reach Health for All in Bangladesh.” (May).

Shahinul, Alam Professior Dr. 2020. -*Global Healthcare Financing Policy and Practice in Bangladesh.*

Sheikh, Nurnabi et al. 2022. "Disease-Specific Distress Healthcare Financing and Catastrophic out-of-Pocket Expenditure for Hospitalization in Bangladesh." *International Journal for Equity in Health* 21(1): 1–16.

Uwishema, Olivier. 2023. "Rwanda's Health-Care Transformation: A Case Study for War-Torn Countries." *The Lancet* 401(10382): 1076–77. http://dx.doi.org/10.1016/S0140-6736(23)00452-X.

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.

To cite this article: Islam, M.S. (2024). Health Care Financing Strategy 2012-2032: A tool towards achieving universal health coverage in Bangladesh. *Journal of Business and Development Studies,* Vol: 02, Issue: 02, page: 1:22, ISUCRDP, Dhaka