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Review Article

Marginalized Population
Scopes and Opportunities for Universal Health Coverage in Bangladesh
Marginalized Population - Universal Health Coverage - SDGs

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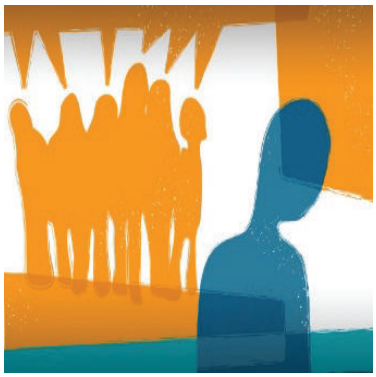

Abstract

Achieving universal health coverage (UHC) is central to the health-for-all agenda and the Sustainable Development Goal (SDG) 3.8. Bangladesh has made significant progress in health outcomes, yet large segments of marginalized populations remain left behind. To review the current status of health provision and financing for marginalized populations in Bangladesh, identify major barriers and enablers, and highlight opportunities and policy options to accelerate progress toward UHC. Narrative review of published literature, policy papers, and programme reports (2010–2025) focusing on marginalized populations and UHC in Bangladesh, emphasizing service coverage, financial protection, and equity. Marginalized groups-defined by poverty, geography, ethnicity, gender, disability, or informal employment- face disproportionate barriers to essential services and financial protection. Out-of-pocket (OOP) health spending remains high (~11% of household budgets), pushing many families into poverty. Although the Government of Bangladesh has committed to achieving UHC by 2030, barriers such as under-financing, governance gaps, and inequitable access persist. Achieving UHC in Bangladesh requires an explicitly pro-equity approach targeting marginalized populations first. With sustained political commitment, innovative financing, and inclusive governance, Bangladesh can move closer to the SDG 3.8 target of leaving no one behind.

Keywords: *Universal health coverage, marginalized populations, equity, Bangladesh, SDGs, financial protection*

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INTRODUCTION

Universal health coverage (UHC) ensures that 'all people' can access quality health services without financial hardship, aligning with SDG 3.8[1]. Bangladesh has achieved notable gains in child and maternal health and infectious disease control, yet inequities remain profound[2].

Marginalized populations including urban slum dwellers, indigenous communities, people living in coastal chars, refugees, informal workers, and women in poverty often experience multidimensional exclusion[3]. This review explores the scope and opportunities for UHC among marginalized groups in Bangladesh, summarizing barriers, enablers, and strategic pathways to equitable coverage.

Current Status and Equity Gaps

1. Service Coverage Gaps: Bangladesh's UHC service coverage index was reported as 52/100 in 2021[4]. However, marginalized populations experience much lower effective coverage. Studies from coastal and remote areas reveal significant disparities in healthcare access between rich and poor households[5]. Urban slums also remain under-served, with reliance on informal and unregulated providers[3].

2. Financial Protection: Financial hardship is a defining constraint. Average household OOP health spending is about 11% of total expenditure, with catastrophic expenditure affecting up to one-quarter of households[6]. Poorer groups are disproportionately impacted, often foregoing care or resorting to high-interest loans.

3. Geographic and Social Exclusion: Residents of hard-to-reach areas such as chars, hill tracts, border premises and remote islands face limited facility density, higher travel costs, and workforce shortages[7]. Ethnic minorities, refugees, farmers, laborers and people with disabilities face linguistic, cultural, or stigma-related barriers[3].

4. Policy and Programme Context: Bangladesh's Seventh Five-Year Plan, Health Care Financing Strategy 2012–2032, and the Social Security Strategy all incorporate UHC principles[8]. In 2023, the Government reaffirmed its UHC commitment with focus on equity and essential service packages[9]. Despite this, implementation remains fragmented due to weak governance, insufficient funds, and poor coordination between government, NGO, and private sectors[7].

Barriers to UHC for Marginalized Populations

1. Under-financing of the Health Sector: Public health expenditure (~0.7% of GDP) remains among the lowest globally[10]. This limits primary care expansion, infrastructure, and human resources in underserved areas.

2. Fragmented Governance and Weak Regulation: Multiple public–private actors operate without unified standards, hampering accountability[7].

3. Demand-Side Constraints: Sociocultural barriers, poor health literacy, and distrust of formal systems prevent care-seeking among marginalized groups[3].

4. Inadequate Targeting: Existing programmes often overlook informal workers, ethnic minorities, and slum populations[7].

5. Workforce and Quality Gaps: Rural and remote regions suffer from staff shortages, absenteeism, and poor service readiness[11].

6. Informal Economy: Over 85% of Bangladesh's labour force works informally, complicating contributory insurance schemes[7].

Opportunities and Enabling Pathways

1. Political Commitment- Bangladesh's renewed pledge to accelerate UHC by 2030 provides a strong foundation for inclusive reforms[9].

2. Phased, Pro-Equity Approach- The "progressive universalism" model advocates prioritizing the poorest first[8]. UHC roll out can begin with marginalized areas (slums, hill tracts, refugee camps), offering subsidized essential services before scaling nationally.

3. Innovative Financing and Insurance- Prepayment schemes such as- 'Shasthyo Surokhsha Karmasuchi (SSK)' target poor households through subsidized insurance[12]. Expanding these pilots and pooling funds from government, donors, and cross-subsidies can enhance financial protection.

4. Outreach and Technology- Community-based services, telemedicine, and mobile clinics have demonstrated success in coastal and hard-to-reach areas[5]. Expanding these models ensures equitable service delivery.

5. Public-Private Partnerships- Non-state providers account for over 60% of care utilization. Structured contracts, accreditation, and regulation can integrate these actors within UHC for marginalized populations[13].

6. Strengthened Data and Accountability- Equity-disaggregated data (by gender, income, ethnicity, and location) are vital to monitor progress. Transparent dashboards and citizen oversight can enhance accountability.

7. Workforce Redistribution and Incentives- Incentivizing deployment to remote areas, improving working conditions, and career progression for rural health workers will address persistent service gaps[11].

Planning to Implementation Framework for UHC among Marginalized Populations in Bangladesh

The following framework illustrates the sequential process from planning to impact, highlighting critical components for achieving Universal Health Coverage (UHC) among marginalized populations in Bangladesh. It aligns with the Sustainable Development Goals (SDGs), particularly SDG 3.8, focusing on equity, inclusiveness, and system strengthening.

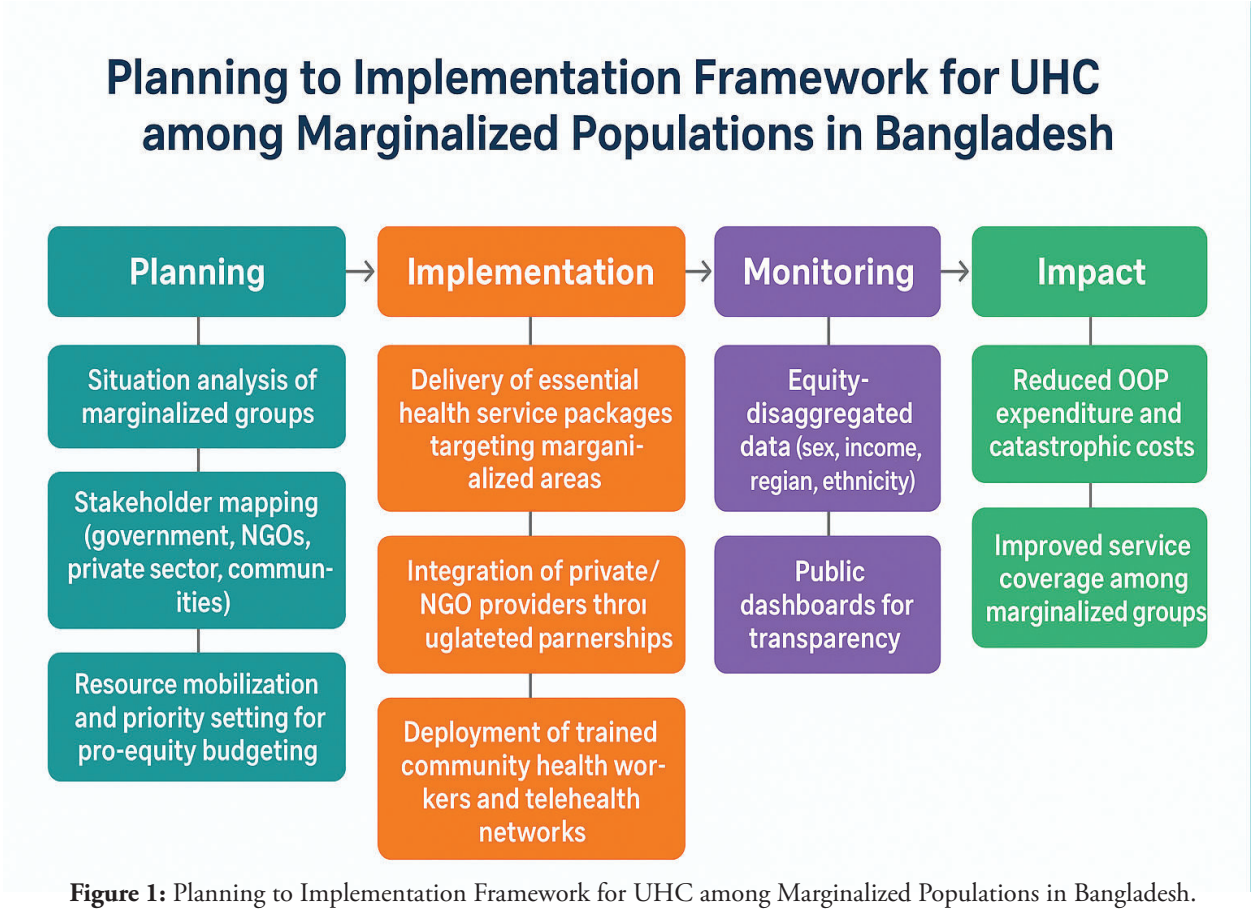

Figure 1: Planning to Implementation Framework for UHC among Marginalized Populations in Bangladesh.

DISCUSSION

Bangladesh stands at a crossroads between progress and exclusion. UHC advancement without explicit equity targeting risks deepening disparities. Marginalized groups face a dual disadvantage- limited access and severe financial vulnerability. Global evidence supports a 'pro-poor, phased implementation model' in which the poorest populations receive subsidized essential packages first, supported by strong primary care and pooled financing[14]. Governance reforms are equally crucial: decentralizing decision-making, regulating private providers, and ensuring quality through performance monitoring[7]. Without substantial increases in domestic public spending and efficient resource use, Bangladesh may fall short of SDG 3.8. An integrated multisectoral approach linking health with education, housing, and social protection can amplify UHC outcomes.

CONCLUSION

Marginalized populations are at the heart of Bangladesh's UHC challenge. Achieving equitable UHC requires strategic investments, inclusive planning, and governance reforms that empower communities. With targeted interventions, Bangladesh can turn its strong policy intent into practical, equitable outcomes by 2030.

Policy Recommendations

Increase public health spending- to at least 2% of GDP with earmarked funds for marginalized areas. Adopt a pro-equity, phased UHC roll out- prioritizing slums, coastal and hilly regions, and vulnerable groups. Expand prepayment and pooling mechanisms- with targeted subsidies. Strengthen primary care delivery- via community health workers, telemedicine, and outreach services. Engage private and NGO sectors- through regulation, quality assurance, and contracts targeting marginalized communities. Ensure dis-aggregated monitoring and accountability- frameworks for UHC equity indicators. Link UHC with social protection programmes- to address non-medical determinants of exclusion.

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