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Revitalizing Bangladesh's Health Care Financing Strategy: Implications from the Health Care Financing Strategy 2012-2032

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Introduction:

Bangladesh's Health Care Financing Strategy (HCFS) 2012-2032 represents one of the most comprehensive long-term financing blueprints in South Asia. It articulates a clear pathway toward universal health coverage (UHC) through increased public spending, pooled financing mechanisms, an autonomous strategic purchaser[1], and reduction of out-of-pocket (OOP) payments to approximately one-third of total health expenditure by 2032. More than a decade since its adoption, the strategy remains conceptually sound, but implementation has progressed far slower than anticipated. Persistently high OOP payments dominated by medicines and diagnostic expenses continue to expose millions of households to catastrophic and impoverishing health expenditures[2,3]. These trends raise critical concerns about whether Bangladesh can realistically achieve its UHC aspirations without renewed policy urgency, stronger financing reforms, and institutional redesign.

Experiences from Southeast Asia provide valuable insights for recalibrating Bangladesh's financing trajectory. Singapore's system, often cited as a model for sustainable UHC in middle- to high-income Asian contexts, is built on layered financing: Medisave (a mandatory medical savings scheme), MediShield Life (social health insurance for catastrophic care), and heavily progressive government subsidies[4,5]. This structure combines strong public stewardship, explicit coverage design, and compulsory contributions, achieving high levels of financial protection even in a system with notable reliance on private provision. Meanwhile, Malaysia demonstrates the effectiveness of a tax-funded public health system complemented by a regulated private sector. Despite political contestation around introducing full social health insurance, Malaysia's publicly financed network has maintained comparatively low OOP expenditure and broad service access[6,7]. These contrasting systems share core features essential for UHC: assured public financing, effective pooling, and institutionalized strategic purchasing. Their divergent political economies underscore that there is no singular UHC model, but all successful pathways hinge on predictable revenues, equity-oriented subsidies, and regulated provider incentives.

When evaluated against these regional benchmarks, Bangladesh's financing gaps become more apparent. First, low public financing continues to constrain progress. Public health expenditure in Bangladesh has remained well below regional peers for decades, while OOP payments account for more than two-thirds of total health expenditure[3,8]. As medicine purchase is the largest component of OOP spending, limited financing of essential medicines remains a structural weakness. Second, risk pooling remains minimal. The HCFS envisioned a National Health Security Office and a unified purchasing entity, yet these institutional commitments have not materialized at scale[1,2]. Without robust pooling and a purchaser–provider split, resource allocation remains fragmented and dominated by supply-side budgeting. Third, coverage of informal sector workers remains a structural barrier. Evidence from regional systematic reviews demonstrates that voluntary insurance schemes consistently fail to achieve meaningful pooling, particularly in countries with large informal labor markets similar to Bangladesh's[9,10]. Countries that successfully expanded UHC Thailand, Malaysia, and Singapore did so using either compulsory contributions or tax-funded universal entitlements, not voluntary enrolment.

Policy directions for Bangladesh must therefore reflect both the strengths of the HCFS and the realities of regional evidence. The first priority is substantial increases in public financing, ideally through earmarked revenues such as sin taxes or a dedicated health security levy. Such mechanisms have proven politically viable in Southeast Asian settings and provide predictable fiscal space for UHC expansion. Second, Bangladesh should legally establish an autonomous National Health Purchasing Agency capable of pooling funds and contracting providers based on quality, equity, and efficiency. Strategic purchasing central to the HCFS cannot be realized without such an institution. Third, Bangladesh requires a dual financing architecture: mandatory contributions for formal sector employees, and a tax-financed coverage floor for the poor and informal sector. This hybrid model mirrors features of Malaysia's publicly financed system and Singapore's progressive subsidy structure, while aligning with Bangladesh's labor market composition. Fourth, immediate increases in public spending for essential medicines, diagnostics, and primary care are likely to yield the fastest reductions in OOP expenditure. Finally, transparent monitoring frameworks with annual benchmarks for OOP reduction

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and pooling expansion are essential to revive momentum toward HCFS objectives[11,12].

Although the HCFS 2012–2032 remains an ambitious and well-designed roadmap, its potential will remain unrealized without decisive political commitment and institutional reform. Evidence from Singapore and Malaysia confirms that UHC is not only a matter of increasing financing but of structuring it through nationally coherent, equitable, and enforceable mechanisms. Bangladesh now stands at a critical juncture. With eight years remaining in the strategy period, there is still an opportunity to re-align the financing system with HCFS goals, if reforms are accelerated, institutions strengthened, and financing made more predictable and equitable. A renewed commitment to strategic purchasing, inclusive financing and robust public investment would allow Bangladesh to translate the HCFS vision into measurable gains in financial protection and population health.

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