Universal health care in Bangladesh—promises and perils

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Valid and reliable indicators against which progress towards global targets of 80% coverage of health services and 100% financial protection from catastrophic and impoverishing health-care costs can be assessed are crucial to achievement of universal health coverage (UHC). An even more ambitious project is to predict whether UHC targets will be met by 2030, and equitable gains achieved. In *The Lancet Global Health*, Md Shafiur Rahman and colleagues used Bayesian regression modelling techniques to take on this challenge for Bangladesh.[1] Their work is premised on many assumptions, which need to be acknowledged, but serves to warn against complacency.

Bangladesh is a country that has seen remarkable health improvements since gaining independence in 1971, and has evolved from being a "basket case",[2] to an exemplar of "good health at low cost".[3] Although initially cautious about rallying around the goal of UHC, its 2012–22 Health Care Financing Strategy provides an initial roadmap that recognises the complexities of universal coverage in a largely informal economy with a pluralistic health system and limited fiscal space.[4]

Situating their modelling exercise in this context, Rahman and colleagues extracted available UHC indicators from 17 nationally representative (in terms of epidemiology and health systems) surveys from Bangladesh. They projected that the goal of 80% coverage would be not be achieved for eight of 13 prevention indicators by 2030 under *ceteris paribus* conditions (with wide socioeconomic inequality in four of these indicators).[1] The next 15 years, however, are likely to be characterised by rapid socioeconomic, climatic, and geopolitical forces of disruption and innovation that challenge *ceteris paribus* assumptions. For example, the forces of urbanisation and growing numbers of urban poor who reply primarily on the private sector for care might be a massive oversight in the assessment of both service coverage and financial protection.[5] That said, predictive modelling of this nature, with the caveats clearly spelled out, can serve as a wakeup call to policy makers in Bangladesh who might otherwise be complacent.

So, what do Rahman and colleagues' predictions mean for Bangladesh? A first observation is that simple, preventive interventions were more likely to hit the UHC 2030 target of 80% coverage, whereas coverage of complex ones, such as institutional delivery by a skilled attendant, were marked by lower coverage and high inequalities. It follows that issues of access to, and quality of, complex and comprehensive interventions need increased policy attention. With respect to the projected failure to reach the target of 100% financial protection, a lot needs to be done, especially in view of the latest Bangladesh National Health Accounts 1997–2015, which show an increase in the proportion of total expenditure accounted for by out-of-pocket payments from 63% in 2012, to 67% in 2015—pushing 4–5 million people per year into poverty.[6,7]

If these projections are correct, the path towards UHC is far from guaranteed, and simply staying the course will not suffice. Awareness and consensus-building at the policy and practitioner level, on the scope, contents, and priorities for UHC reforms, especially with respect to the role of government, are laudable initial efforts.[8] However, serious omissions include the absence of meaningful engagement of the rapidly growing private sector and the role of other sectors for health such as urban development, transportation, and water, sanitation, and hygiene. Furthermore, attention to the systems ingredients for better supply of services, including performance measures, health workforce development, and procurement of supplies, is sorely lacking. With respect to financing, increased efforts need to be focused on the design, implementation, and scale-up of pre-payment and pooling of resources for health that will provide the opportunity for rational allocation decisions (ie, best buys) and greater efficiency, transparency, and accountability in resource use by managing the provider–purchaser split. Importantly, neither a fully government-financed nor a fully employer-financed UHC model is realistic. Rather, Bangladesh should look to similar contexts of high informality and low government financing to develop its own path forward. Implementation and operations research will also provide relevant evidence for policy makers.

To avoid these less-than-ideal projections for UHC, much more than reforms to the supply side of the health system are required. In the 21st century information age, people's aspirations for their health and access to high-quality services are rapidly increasing. Public demand for health should be coupled with enlightened

leadership that acts on irrefutable evidence that better health accelerates inclusive growth, and acknowledges the health sector as a growing source of employment. Mobilisation of this demand for UHC could amplify Bangladesh's intrinsic character of resourcefulness and resilience, and propel progress towards UHC, and a healthier society and economy.

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