Barriers in the Path to Achieve Universal Health Care in Bangladesh

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Universal health coverage (UHC) is the one of the essential targets of the Sustainable Development Goals. It will be achieved by financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all by the year 2030[1]. According to the World Health Organization (WHO), UHC offers an effective health system by which all people have quality health services according to their needs and affordable to them.[2]

Bangladesh is a country that has seen remarkable health improvements since gaining independence in 1971, and has evolved from being a "basket case",[3] to an exemplar of "good health at low cost".[4] The Bangladeshi Constitution commits to address inequalities in access to health in rural areas, and the country joined the global community in committing to achieve UHC by 2030 under the SDGs.[5]

Barriers towards Achieving UHC in Bangladesh

There are several Barriers for Bangladesh to achieve UHC by 2030. According to Joarder *et al.*(2019)[6] these barriers can be felt at three levels. The three levels are (1) larger policy-level barriers, often beyond the juris diction of health sector alone, (2) implementation barriers in health sector, and (3) demand side barriers.

1. Larger Policy-Level Barriers (Health Sector and Beyond)

Public financial management has been designed such that only health sector finance is very difficult to alter separately. Ministry of Finance needs to change all its mechanisms and rules of procedures for all other ministries, if it wants to do something for one particular ministry. Bangladesh has traditionally been practicing supply-side budgeting, who's changing is complicated, has crosscutting ramifications, and, therefore, demands much broader or revolutionary commitment for whole system change.

2. Implementation Barriers in Health Sector

Poor human resource management in Bangladesh, including shortages, deficient training, low motivation, retention issues, skill-mix imbalance, and quality service provision is staggering. Recruitment mechanisms by Bangladesh Civil Service (BCS) are also criticized for taking too long to deploy physicians into vacant posts in time. Political interference is

often adding insult to injury, as recruitment, retention, and disciplinary measures become difficult for managers to exercise.

3. Demand-Side Barriers

There is a pervasive sociocultural barrier against insurance. Several key informants mentioned there is overall deficiency of trust in the society, due to historical and sociocultural reasons. Due to the pervasive lack of societal trust, coupled with lack of historical precedence to insurance mechanisms, it is difficult to convince people to give their money to a pooled fund. Another historically established perception among the people is that the government is solely responsible for health and that must be free of cost. People are not receptive to the idea of paying for government health care, be it in the form of prepayment or other wise. Lack of information on the available services is another demand-side barrier to UHC. Communities also lack awareness regarding their own entitlements

Recommendations to overcome the barriers

Joarder et al.(2019) recommended several ways to overcome these. Their recommendations are

(1) Redesign the Public Financial Management.

Bangladesh must invest in addressing inequalities in access to health services and reducing reliance on OOP payments if it is to achieve UHC by 2030. Bangladesh's Heath Nutrition and Population Strategic Investment Plan 2016-2021 recognizes the importance of investing in a strong foundation for UHC through its commitment to delivering primary healthcare under the ESP as the first milestone on the road to universal coverage. However, in order to accommodate the flexibility in financing options, required for UHC, redesigning the traditional public financial management is recommended.

(2) Health Insurance and Health-Financing Reform.

The government should consider introducing a national single payer system and increase coverage gradually to different population segments; starting with the formal sector as they are more informed and more empowered to reclaim their right. Creation of a purchasing body and separation of providers from purchaser authority is needed. Innovative financing mechanisms, such as bringing corporate social responsibility (CSR) money, zakat money, and sin tax money into UHC should be considered.

(3) Improve Regulatory Framework and Mediatory Mechanisms.

It should be done with the aim of decreasing cost of medicines and healthcare. Policy makers need not only develop protocols, but also ensure compliance to these. Private sector should be regulated for better management, improved quality, and reduced cost. Regulation and its implementation should ensure that there is no overcharging, exploitation of any form, unnecessary procedures and tests, and irrational use of antibiotics.

(4) Intersectoral Collaboration.

Civil society needs to be consulted for optimization of UHC endeavor. There should be a civil society and government collaboration, where civil society will monitor national progress, keep a watch, engage in dialogues, and raise the voice from civil society time to time. This is needed so that the government, or whoever is working (on UHC), stays on right track. There needs to be an institutional body or a coordinating body, involving all relevant ministries or sectors and developing a common pathway towards UHC. NGOs should come forward to support the government with technical expertise they have. There should be a clear guideline regarding intersectoral collaboration.

(5) Political Commitment.
Political commitment and a better buy-in on UHC are indispensable. This may be achieved by going to the political parties before election and convincing them to include UHC in their manifesto. Suggestions to Address Implementation Barriers in Health Sector

(6) Health Systems Strengthening.
Comprehensive improvement in all health systems building blocks, such as financing, governance, and human resources, should be planned and operationalized.

(7) Improve Health Service Management. Health service management, including human resource management, inventory management, facility management, financial management, needs to be further improved. Vacant positions need to be filled.

(8) Improve Monitoring and Supervision.
In order to improve supervision, the managers should get more support from the government; e.g., they should get vehicles and communication cost, etc.8

(9) Involve ICT.
Government of Bangladesh has placed importance on the utilization of ICT in various sectors. Building on government's commitment, health sector decision makers also should use the ICT more to allow the hard-to reach population to reach the services quickly and improve supervision and monitoring.

(10) Improve Health Promotion and Disease Prevention.
In regard to the importance of SBCC in achieving UHC, a key informant from a multilateral organization remarked: "If we are able to provide good health promotion, prevention, and we are able to bring a change on the behavior of the people that could have a significant impact later on cost of the services so that we avoid expensive interventions.

(11) Deciding on and Adhering to Quality Criteria.
Strict criteria for quality of care should be set, and a directive should be passed that providers would receive payment only if they comply with an agreed treatment protocol and quality criteria. Functioning referral mechanism should be ensured, along with a defined referral protocol. These require improved capacity of service providers by training. The training should not be limited to technical aspect of care but rather should include training on responsiveness or patient-centered care and quality of care.

(12) Code of Conduct for Service Providers.
There should be code of conduct for service providers, like physicians and nurses. These need to be developed in consultation with relevant stakeholders, including professional bodies of the respective professional groups, i.e., Bangladesh Medical Association(BMA),Bangladesh Diploma Nurses Association (BDNA), etc.

(13) Improve Efficiency. To best utilize the existing resources, technical and allocated efficiency should be ensured.

(14) Special Attention to Hard-to-Reach Areas and Marginalized Populations. Special attention should be paid to hard to-reach areas and the marginalized population.

(15) Decentralization.
A policy reform for decentralization is needed.

(16) Patient/Client Education. We need to inform people about UHC in order to generate demand for it. We need to improve health literacy of general population, which is not possible only by the health sector. Health literacy should be enhanced through the general education as well. Common people

should know what services are available.

(17) Community Empowerment.
Communities should know what they are entitled to and how to get the responsible persons accountable for their work.

(18) Research. In order to improve our knowledge and understanding on UHC, particularly in the context of Bangladesh, further research is necessary.

(19) Advocacy. Based on research, policy best-practices, and multi sectorial experiences, advocacy for UHC should continue.[6]

Having identified the challenges and potential solutions, it is believed that Bangladesh will accomplish its mission successfully towards equity and UHC.

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