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OPINION — HEALTH FINANCING & SYSTEM RESILIENCE

Increasing public health investment must be a top priority

In its first months, a new government reveals its priorities — and in Bangladesh, health protection is economic protection.

MD SHAFAAT ALI CHOYON, MCIM, MBA, MPH, CHES®

A public health professional and former business strategist with more than 16 years of cross-sector experience.

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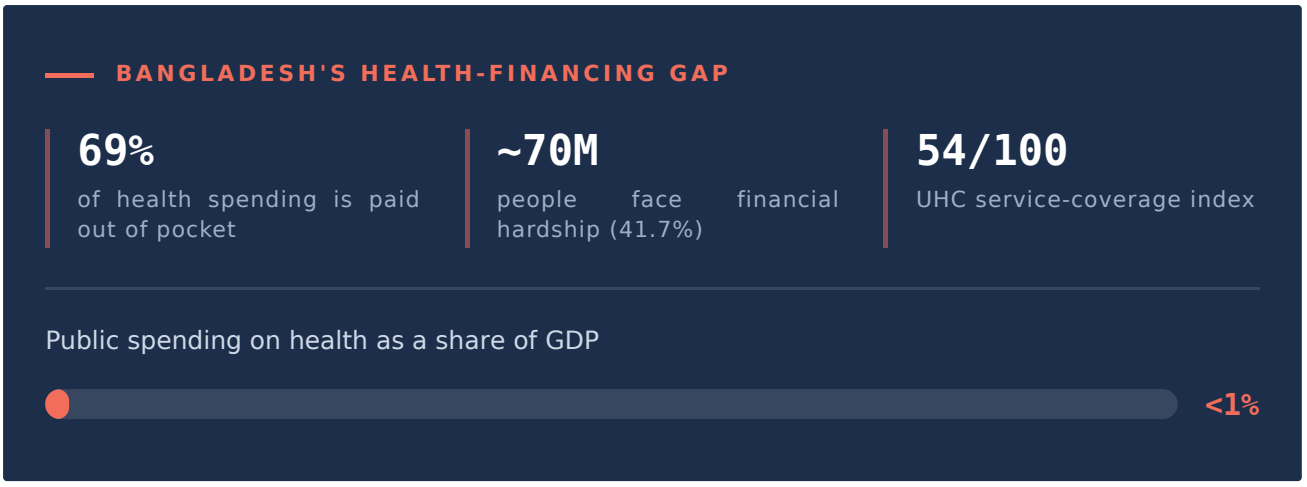
What a new government chooses to fund, plan for, or ignore in its first months reveals its level of priority or seriousness about its commitments to the people. In the health sector, Bangladesh's newly sworn-in administration faces that test against two closely linked threats that quietly undermine households nationwide: medical debt driven by high out-of-pocket health spending and climate- and disaster-related shocks, both of which expose the fragility of the health system. Health protection is also economic protection, and the new government must treat it as such.

Bangladesh's health financing model has a gaping structural flaw. According to the Bangladesh National Health Accounts 1997-2020, nearly 69 percent of total health expenditure is paid directly by households out of their own pockets, one of the highest shares in South Asia. Global evidence consistently shows that heavy reliance on out-of-pocket payments exposes families to catastrophic health expenditure and financial hardship.

A technical consultation hosted by the World Health Organization in Dhaka in November 2025, reviewing the draft Universal Health Coverage (UHC) Roadmap 2026-2035, reported that about 41.7 percent of the population, roughly 70 million people, had experienced financial hardship due to health costs. The same

consultation noted that Bangladesh's UHC service coverage index stands at just 54 out of 100, reflecting major gaps in access to essential services. When illness strikes, many families are forced to sell assets, borrow from informal lenders, or pull children out of school. A single, relatively prolonged hospitalisation can push a household from fragile stability into poverty.



This burden is not limited to rural areas. Urban informal workers like rickshaw pullers, day labourers, and small traders face the same exposure, often with higher living costs and no safety nets. In recent years, health sector allocations have hovered around five percent of the national budget, while public spending on health has remained below one percent of GDP, according to World Bank data. Research on health financing and universal coverage consistently shows that such low public investment constrains service coverage and leaves households to absorb risks individually, with long-term consequences for economic growth and inequality.

No serious observer would argue that Bangladesh can build universal health insurance overnight. But it is unacceptable when institutional inertia pushes even the prospect of phased implementation into the background. The draft UHC Roadmap 2026-2035, developed jointly by the Ministry of Health and Family Welfare and the World Health Organization, outlines a long-term strategy centred on population coverage, service coverage, and financial protection through pooled financing. The new government should adopt this roadmap as a binding policy commitment rather than leave it as another draft. An initial focus on low-income households, informal urban workers, and disaster-exposed communities linked to existing social protection programmes would stabilise household finances and protect labour productivity effectively.

> *Health protection is also economic protection, and the new government must treat it as such.*

The second half of this crisis receives far less attention. Bangladesh's disaster preparedness has rightly earned global recognition, particularly for cyclone early-warning systems that have saved countless lives. But these successes share a critical blind spot: health system continuity is

still treated as secondary. A WHO inception meeting held in Cox's Bazar in December 2025 on integrating noncommunicable disease and mental health care into emergency preparedness acknowledged that while Bangladesh has strong systems for infectious disease outbreaks and trauma response, preparedness for chronic disease care during disasters remains limited. Health facilities often lack contingency planning, medicine supply chains are vulnerable to disruption, and frontline responders are not equipped to manage chronic conditions during crises.

Urban seismic risk compounds these vulnerabilities. Experts warn that a 7.5-magnitude earthquake in Dhaka could generate more than 31 million tons of debris and severely disrupt critical services. Bangladesh's first-ever sub-national earthquake risk assessment has mapped hazards down to the upazila level and assessed exposure of buildings and critical infrastructure, including health facilities. Yet preparedness planning remains focused on building codes and search-and-rescue, with limited attention to whether hospitals and clinics could function after a major shock.

Community-level preparedness offers a practical and cost-effective solution. Bangladesh has more than 13,200 community clinics staffed by community health workers, widely recognised as the backbone of primary healthcare delivery. During COVID-19, these workers maintained essential services and community trust under extreme pressure. But their role in disaster response has never been formally embedded in preparedness planning. Integrating community health workers into disaster management structures would strengthen service continuity rather than forcing systems to improvise after failure.

Three priorities, therefore, should guide the first 18 to 24 months of the new government: adopt the UHC roadmap as a binding national commitment with clear phases and accountability; embed health system continuity into disaster planning, including backup power, medicine supply chains, and trained frontline workers; and reframe public health spending as economic stabilisation, setting a credible, time-bound target to raise public investment in health. Bangladesh's public healthcare has long suffered from poor planning and execution; it is time to make some progress in this regard.