



Policy Brief

Bridging Gaps in Bangladesh's Public Health System

*A Rapid Facility-Level Assessment of
Expenditure Efficiency*

July 2026



1 Introduction

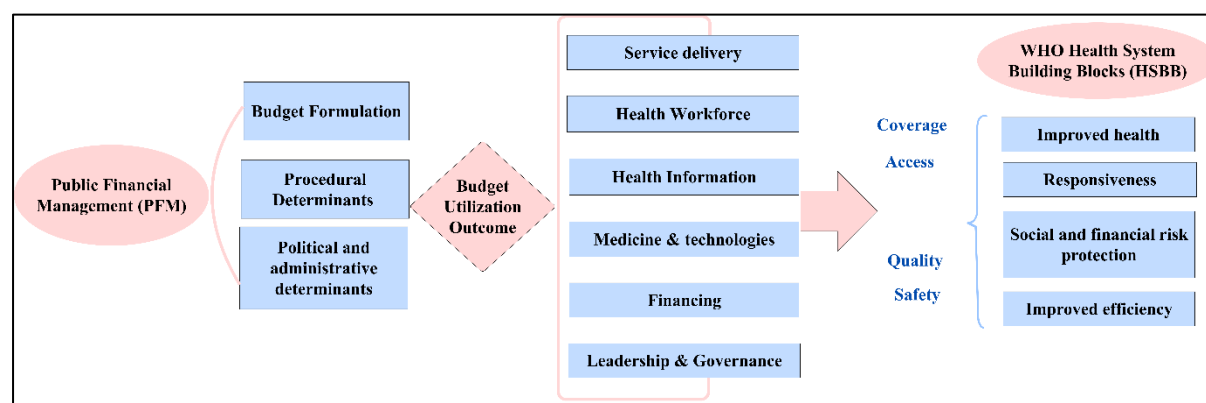
Context

Bangladesh is committed to achieving Universal Health Coverage (UHC) by 2030, as part of its constitutional obligation and international commitments under the Sustainable Development Goals (SDGs). Despite notable policy initiatives like the Health Care Financing Strategy 2012–32, the country continues to face high out-of-pocket health expenditures (68.5% in 2020), limited public health investment (0.67% of GDP), and declining external support. Although budget allocations for health have increased in national plans, persistent issues, including under-utilization of funds, inefficient procurement processes, and imbalanced investments - favoring new construction over maintenance of facilities and human resources development - undermine progress toward UHC.

Conceptual Framework

A governance-oriented conceptual framework integrating Public Financial Management (PFM) and the WHO Health System Building Blocks (HSBB) adopted to guide the analysis. The PFM framework enabled examination of the structural, procedural, and political determinants influencing budget formulation, fund flows, procurement processes, and overall budget execution. The HSBB framework was incorporated to assess how financing bottlenecks translate into system-level effects across service delivery, health workforce, medicines and supplies, health information, and leadership and governance. This integrated approach allowed us to link upstream governance and financing constraints with downstream facility performance, resource availability, and patient experience. Using this framework, quantitative and qualitative data triangulated to identify barriers to effective budget utilization and their implications for health system efficiency and progress toward UHC.

Figure 1
Public Financial Management and WHO Health System Building Blocks Integrated Framework



Study Objectives and Methodology

To evaluate existing knowledge on the current state of financial resources, infrastructure, medicine supply, health workforce, and data-driven practices in Bangladesh’s public health facilities, Health Economics Unit of MoHFW commissioned Power and Participation Research Centre (PPRC) through a competitive bidding process to undertake a facility-level diagnostic study. The objective of the study was to identify gaps and inefficiencies in facility level financial and operational management and service delivery to inform strategies for improving healthcare service delivery and ensuring its sustainability.

PPRC conducted a mixed-method, cross-sectional study, including a retrospective budget analysis, to assess the utilization of public health budgets in Bangladesh.

The quantitative component included document review and surveys. The survey covered 22 public health facilities across primary, secondary, and tertiary levels covering eight administrative divisions of Bangladesh.

Table 1
Selected public health facilities

Administrative Division	Tertiary Level	Secondary Level	Primary level	
			UHC	Union Health Sub Center
Barisal	Institute of Child and Mother Health, Matuail	Barisal District Hospital	Banaripara	
Chattogram		Bandarban District Hospital	Chandanaish	
Dhaka		Tangail General Hospital	Gopalpur	Nogda Shimla
Khulna	Kushtia Medical College Hospital	Bagerhat District Hospital	Sarankhola	South Khali
Mymensingh		Netrokona District Hospital	Kalmakanda	Shidli
Rajshahi		Chapai Nawabganj District Hospital	Paba	
Rangpur		Gaibandha General Hospital	Sundarganj	
Sylhet		Moulvibazar General Hospital	Sreemangal	Huglia
Sub-total	2	8	8	4
Total		22		

The document review included government budget and operational plan documents, health facility budgets, and procurement documents related to medical and surgical requisites. The surveys included assessments of facility functionality and knowledge, attitudes, and practices (KAP) of training for staff and its utilization, budgeting process, and public procurement.

The qualitative component included key informant interviews (KIIs) and in-depth interviews (IDIs). We conducted a total of 32 interviews, including 20 KIIs with frontline implementers (health facility managers), contractors who supplied medical and surgical requisites (e.g., medicines, reagents, and diet), national policymakers, academics, and researchers, and 12 IDIs with outdoor and indoor patients to understand their experiences in accessing healthcare services.

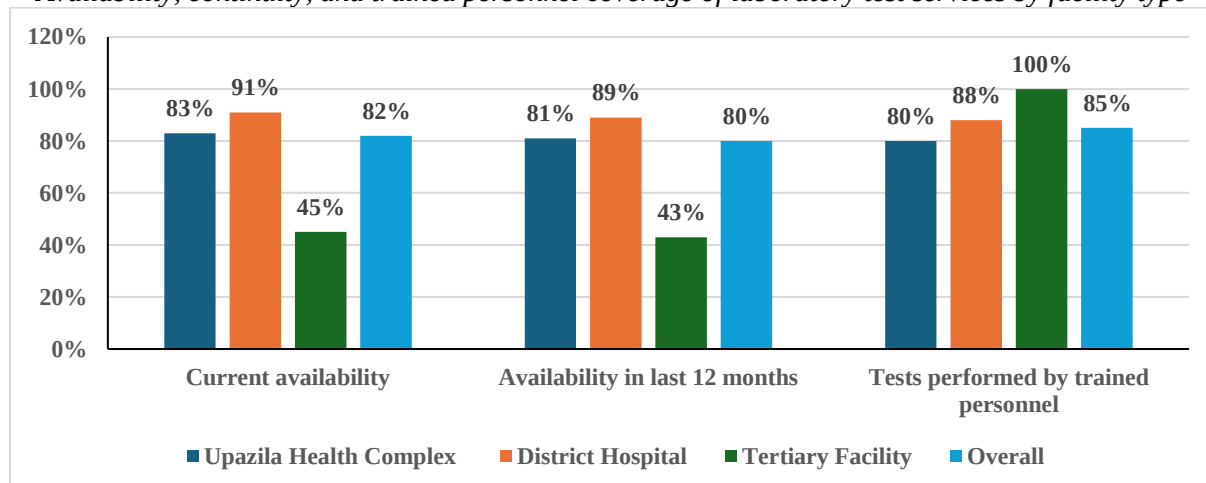
Findings of the quantitative and qualitative analyses were compiled to address the specific objectives of the study to increase the validity and credibility of the research findings.

2 Findings Highlights

Diagnostic Services and MSR

Diagnostic services are widely available across health facilities; however, their effective utilization is constrained by significant operational inefficiencies. Laboratory service availability and continuity remain high (81–91%) at primary and secondary levels, supported by trained personnel (80–88%). It is mentioned that the availability and continuity of diagnostic services in tertiary facilities range between 43% and 45%.

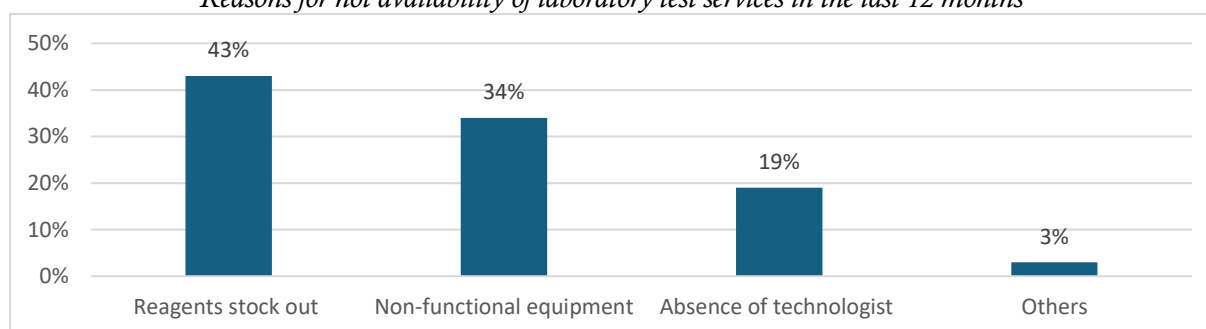
Availability, continuity, and trained personnel coverage of laboratory test services by facility type



Data source: Functionality Survey

Service disruptions are primarily driven by reagent stock-outs (43%), non-functional equipment (34%), and shortages of trained technologists (19%). Despite relatively high nominal availability of imaging services (up to 85% at secondary level), sustained availability remains low (17–33%), with 36–60% of services underutilized, largely due to non-functional equipment (79%) and shortages of consumables (14%) and personnel (7%).

Figure 3
Reasons for not availability of laboratory test services in the last 12 months



Data source: Functionality Survey

Availability of medical and surgical requisites (MSR) is generally adequate for routine services, with high availability of items such as gauze and cotton (90.9%), syringes (86.4%), and gloves (81.8%). However, critical gaps persist in emergency and lifesaving supplies, including tourniquets (63.6% not available), bag-valve-mask resuscitators (54.6% not available), and umbilical cord clamps (40.9% not available).

Medicines

Essential medicine availability remains critically low across all facility levels, with only 22.7% availability at primary (UHC), 23.9% at secondary, and 11.5% at tertiary facilities.

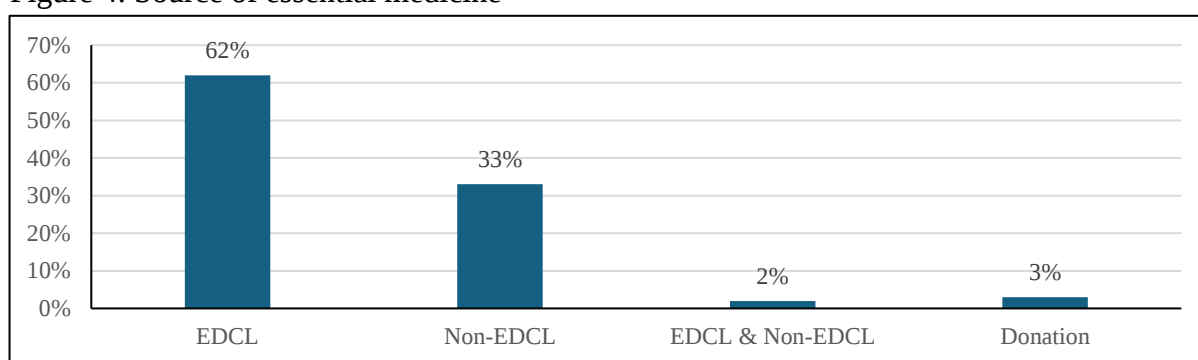
Table 2
Current and last 12 months stock of essential medicines by health system level (%)

Availability (%)	Primary level – UHC (%)	Secondary level (%)	Tertiary level (%)	Overall (%)
Current stock	22.7	23.9	11.5	22.0
Stock in last 12 months	19.98	23.03	10.53	20.28

Data source: Functionality Survey

On average, approximately 62% of medicines are supplied through EDCL, while 33% are sourced from non-EDCL suppliers. Persistent gaps in medicine availability are driven by production limitations and supply chain constraints.

Figure 4: Source of essential medicine

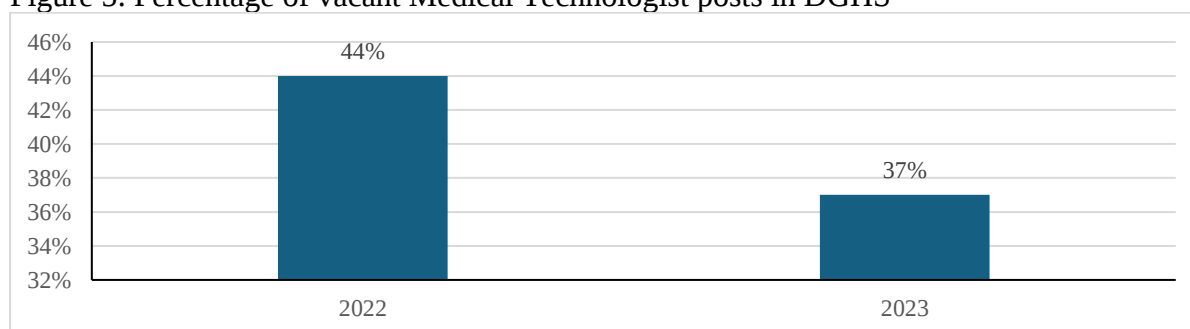


Data source: Functionality Survey

Human Resources

Human resource shortages further constrain service delivery, with approximately 6,406 sanctioned medical technologist posts but only 3,892 filled, indicating a vacancy rate of nearly 40%. Facility-level gaps are also substantial, with vacancies of 27% at primary, 12% at secondary, and 36% at tertiary facilities. This contributes to significant misalignment between available diagnostic equipment and qualified personnel, leading to underutilization of infrastructure. On the other hand, although procurement processes show high compliance with e-GP procedures (85%), rigid budget allocations - such as only 2% allocated for chemical reagents - combined with high but imbalanced expenditure patterns, limit flexibility and hinder service continuity.

Figure 5: Percentage of vacant Medical Technologist posts in DGHS



Data source: HRH Data Sheet 2022 and 2023

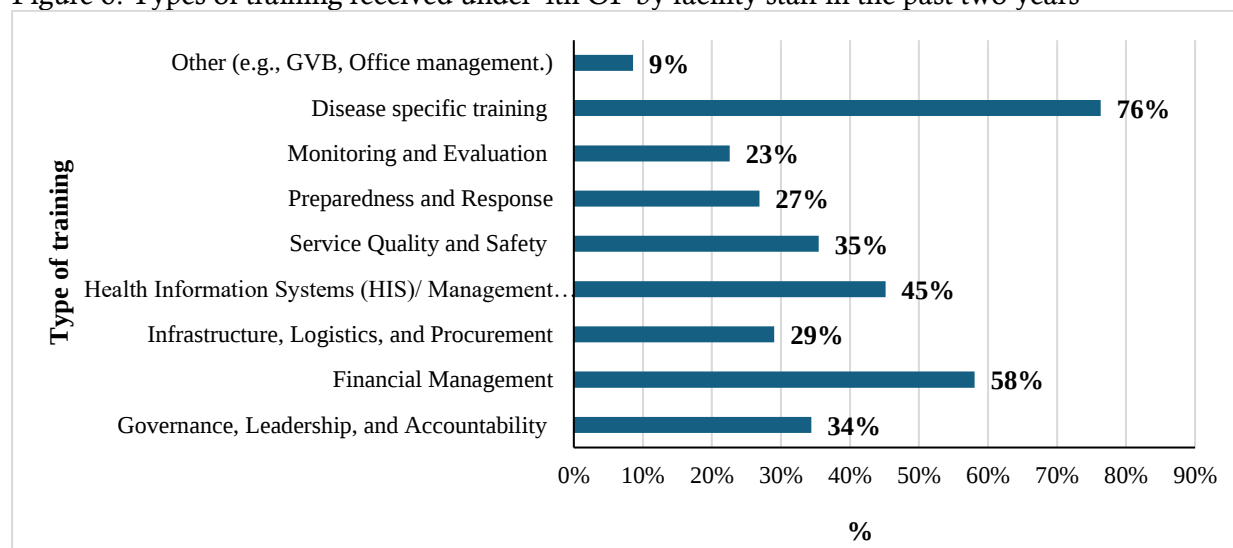
Training

Training coverage is high, with 84% of staff receiving at least one formal training course in the past two years; however, its effectiveness remains limited. While most training courses are aligned with service delivery (63% fully, 34% partially), improvements are mainly seen in service quality (83%)

and coverage (66%), with lower impact on patient satisfaction (39%), timeliness (39%), and staff motivation (23%).

Gaps in training relevance and systemic barriers - such as insufficient resources (59%), lack of time and management support (49%), and role misalignment (23%) - restrict the practical application of knowledge.

Figure 6: Types of training received under 4th OP by facility staff in the past two years



Data source: KAP Survey

A substantial gap exists in translating training into practical improvements in budget and procurement management. While most staff reported comprehensive or partial knowledge of revenue and development budget preparation (79%) and 68% were aware of mandatory steps under the Public Procurement Rules (PPR) 2008, only 28% demonstrated full understanding of the annual budget process. Documentation practices are inconsistent, as nearly 27% never maintain records in line with PPR requirements, undermining transparency and accountability. Critically, only 40% of participants reported using their training to initiate reforms or improvements at the facility level, indicating that knowledge acquisition does not automatically lead to actionable change. These findings reinforce that without structured monitoring, supportive institutional frameworks, and clear authority for applying training, capacity-building efforts fail to meaningfully enhance financial governance or operational efficiency.

This study identified several systemic factors contributing to gaps in the effectiveness of training and capacity-building initiatives. Frequent post-training staff transfers were found to undermine the retention and application of institutional knowledge, limiting the continuity of skills within facilities. In addition, inequitable access to training persists, with centrally located staff more likely to receive repeated training opportunities, while personnel in peripheral facilities remain underrepresented. This imbalance reinforces disparities in workforce capacity and constrains equitable improvements in service delivery and operational efficiency. Furthermore, the relevance of training content was often misaligned with participants' professional roles and responsibilities. Generic training approaches, lacking differentiation by staff category or function, reduced the practical applicability of acquired knowledge and weakened the overall impact of capacity-building investments. The absence of structured refresher mechanisms further limited the sustained application of skills, contributing to a decline in knowledge retention over time.

Investment

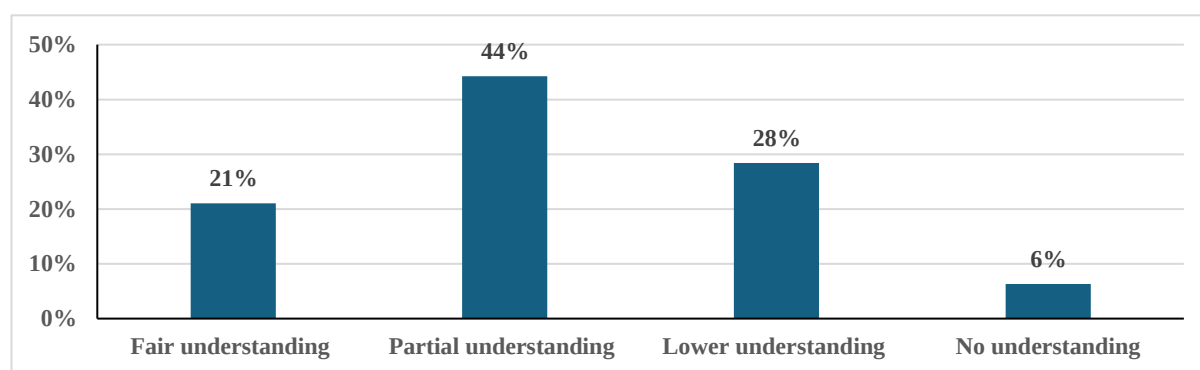
Historically, health sector investment in Bangladesh has prioritized new construction over repair and maintenance, with over 20% of development budgets allocated to infrastructure expansion. However, this approach has led to underutilized and non-functional facilities due to inadequate

staffing, poor maintenance, and delayed operationalization. Currently, there is no dedicated budget allocation for new construction (FY 2024–25), and the system relies entirely on maintaining existing infrastructure. Although repair and maintenance funds show high utilization (>93%), lower investment in primary-level facilities, along with weak planning, coordination, and oversight, has limited overall system efficiency.

Use of Data

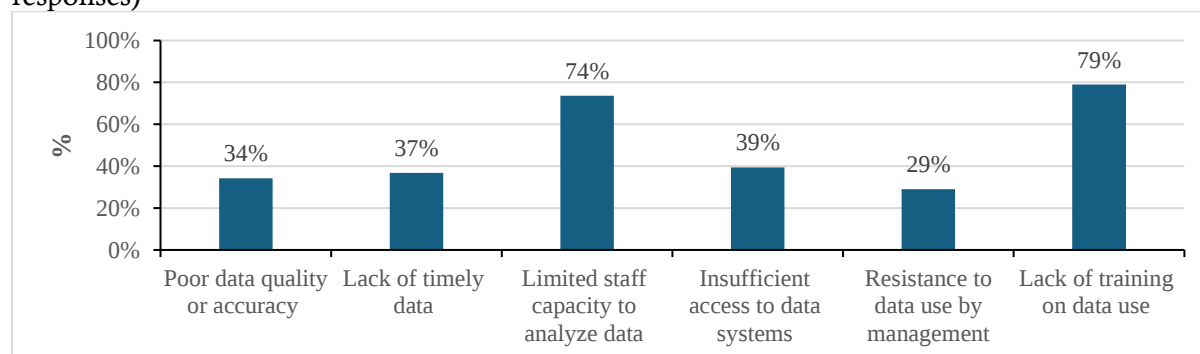
The use of data at operational and budgeting levels remains limited, with decisions often based on historical allocations and administrative practices rather than performance analysis. Although 58% of facilities report using data for decision-making, a significant 42% do not systematically apply it. Key barriers include inadequate training on data use, limited analytical capacity, and restricted access to functional data systems. The KAP survey also reinforced the reality of gaps in understanding in evidence-based policymaking.

Figure 7: Understating the use of evidence-based data in policy making, especially for facility budget formulation or preparation



Data source: KAP Survey

Figure 8: Reported barriers to using data for facility policy or operational decisions (multiple responses)



Data source: KAP Survey

Further qualitative exploration revealed persistent structural weaknesses in health information systems that constrain effective evidence-based planning and resource allocation. While Management Information System (MIS) indicators are routinely utilized at the national level to guide indicator-based budget allocation, these systems remain fragmented, partially paper-based, and insufficiently decentralized. Consequently, data-driven decision-making is relatively strong at the central level but diminishes considerably at district and upazila-level facilities, limiting local autonomy and responsiveness.

At the national level, policymakers described a standardized, indicator-driven allocation approach primarily based on MIS data, including outpatient attendance, inpatient and emergency caseloads, bed occupancy rates, and hospital service statistics. However, needs assessment continues to rely

heavily on existing MIS and financial platforms such as IBAS++, with limited incorporation of systematic facility-level documentation or service quality indicators. Facility managers emphasized that a more integrated and functional MIS could reduce reliance on subjective negotiations and enable more transparent, evidence-based planning. Despite this potential, access to financial management systems remains constrained. Participants reported that IBAS++ is not fully operational at the upazila level, necessitating continued dependence on higher administrative tiers and contributing to delays in budget execution, which were widely perceived as inefficient. In addition, significant gaps were identified in clinical documentation and continuity of care. The absence of digital prescription and medicine-dispensing systems limits the ability to link service delivery data with patient outcomes, medicine availability, and out-of-pocket expenditures.

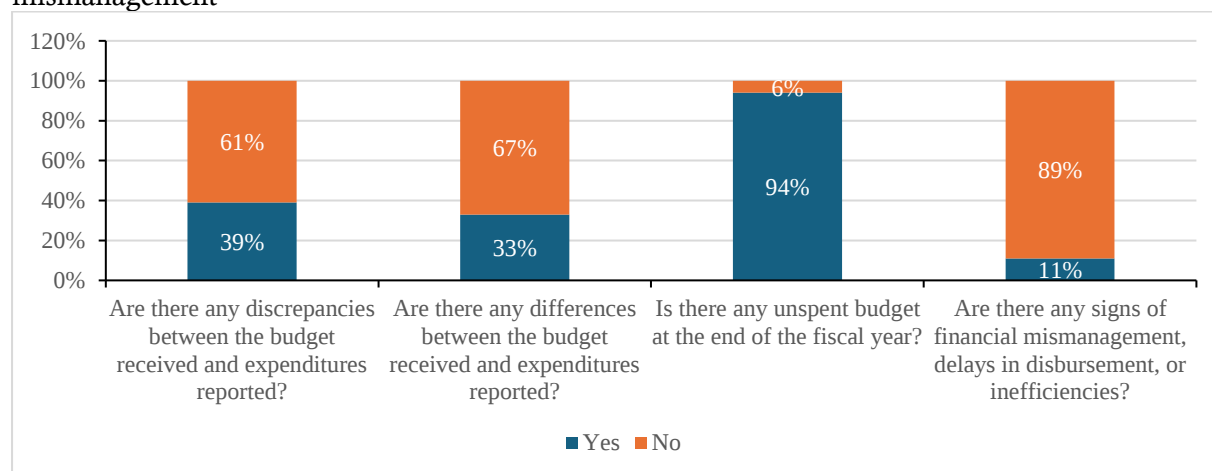
Budget Utilization

The FY2024-25 survey found average budget utilization of 85%, with secondary-level facilities showing the lowest execution (78%) and under-spending concentrated in discretionary operational categories. Budget underutilization reflected governance failures rather than funding shortages. Fragmented institutional roles, centralized control, and misalignment between budget authority and implementation constrained timely spending. Rigid line-item budgets, lengthy approval and procurement processes, and delayed fund releases further limited execution. Political and accountability pressures encourage risk-averse behavior, discouraging adaptive spending. Donor priorities and parallel implementation arrangements weakened alignment with national plans. Therefore, essential activities were delayed or scaled back despite available allocations, with uneven programmatic and geographic impacts.

The survey data indicates notable gaps between budget allocations and actual expenditures. While 39% of respondents reported discrepancies between the budget received and expenditures reported, a similar 33% observed differences between allocated budgets and reported spending, highlighting inconsistencies in budget tracking and reporting mechanisms. Strikingly, 94% of facilities reported unspent budget at the end of the fiscal year, suggesting underutilization of allocated resources despite overall availability.

However, perceptions of overt financial mismanagement or inefficiencies were low (11%), indicating that under-spending is less likely due to corruption and more likely attributable to structural, procedural, or operational barriers such as delayed disbursement, limited financial authority, or capacity constraints at the facility level.

Figure 9: Financial management practices: discrepancies, unspent budget, and signs of mismanagement



Source: KAP Survey

These findings point to the need for stronger monitoring and accountability mechanisms, more flexible and timely fund release processes, and enhanced capacity at lower-level facilities to absorb

allocated budgets effectively. Without addressing these systemic constraints, even adequate budget allocations may fail to translate into improved service delivery and infrastructure utilization.

3 Gaps and Inefficiencies

This study highlights a range of systemic, administrative, and contextual barriers affecting effective budget utilization in the health sector. These challenges operate across levels from facility managers to project directors and are shaped by procedural complexity, insufficient skills, political influence, and emergency uncertainties. In-depth interviews of cross-section of key informants identified the following key system gaps and inefficiencies:

Limited administrative capacity and training gap

Many facility managers, particularly clinicians promoted to administrative roles, lack formal training in budgeting, procurement, and financial management. As a result, increased delays and administrative errors are common, and reliance on clerical staff or contractors increases. Existing staff trained under operational plans often do not extend knowledge to new recruits, reducing overall execution capacity.

Lack of motivation and limited ownership over budget execution

Participants noted a lack of motivation and ownership among some facility managers regarding budget execution. For many, administrative and financial responsibilities are perceived as secondary to their clinical duties, leading to missed opportunities for timely expenditure. This mindset contributes to delayed decision-making and low budget absorption. In the absence of clear incentives or accountability mechanisms, budget execution remains deprioritized.

Fear of audit objections and compliance risks

Findings indicate that a pervasive fear of audit objections substantially constrains proactive financial decision-making at the facility level. Participants reported that even minor audit remarks are perceived as having severe personal and professional consequences, including potential delays in pension approval and negative implications for career progression. This heightened perception of risk encourages managers to adopt overly conservative spending behaviors, leading to delayed procurement processes and systematic under-utilization of allocated budgets.

Beyond fear of punitive outcomes, participants emphasized that limited understanding of financial rules and delegated authority further amplifies compliance risks. Many facility-level officials reported uncertainty regarding what types of expenditures are permissible under their delegated powers, increasing the likelihood of unintentional procedural errors. This uncertainty reinforces risk-averse behavior and discourages timely expenditure.

Low managerial capacity

Even when some discretionary authority exists, many facility managers hesitate to exercise it due to fear of audit queries and lack of managerial training.

Procedural complexity of public procurement rules (ppr/ppa)

Participants reported that Public Procurement Rules and the Public Procurement Act are perceived as rigid and difficult to implement at the facility level. Limited understanding of these procedures among key decision-makers often results in delayed purchasing processes and an increased risk of bill rejection. The complexity of procurement requirements was described as a major contributor to both delayed and incomplete procurement, with some activities remaining unfinished beyond the fiscal year.

External pressure, contractor influence, and political interference

Participants reported that procurement processes at district and upazila facilities are often disrupted by contractor pressure, intimidation, and politically motivated interference. These external influences compromise transparency, demotivate committed administrators, and create

an environment in which procurement decisions are stalled due to safety concerns and fear of retaliation. Consequently, such pressures hamper timely action and frequently delay or derail procurement activities.

Inaccurate budget preparation and weak understanding of budget logic

Participants reported that inaccurate budget preparation and limited understanding of budgeting principles contribute substantially to systematic under-utilization of funds. Facility budgets are often prepared based on sanctioned posts rather than existing staff, leading to miscalculations in salary and allowance requirements and resulting in large unspent amounts.

Complexity of budget codes and weak information systems

Participants indicated that the administrative complexity of budget codes, combined with weak information systems, significantly constrains expenditure at facility level. Understanding star-marked budget codes (double- or triple-star) is often challenging for accountants and managers, and ambiguities in approval procedures further impede spending. Inadequate data systems also limit the capacity for accurate estimating and evidence-based budgeting, contributing to under-utilization of allocated funds.

Approval dependencies and multilevel stakeholder bottlenecks

Facility managers also described bureaucratic reliance on multiple administrative layers for approval of even routine adjustments. Redistribution approval must come from the ministry-level budget-approving authority, which slows financial responsiveness. The system is further complicated by involvement of multiple stakeholders such as DGHS Finance, Audit, HED, PWD, and vendors. This fragmentation weakens facility-level control. As a result, hospital managers lack direct authority over essential expenditures related to maintenance and equipment repair.

Weak project management structure and frequent PD turnover

Participants reported that weak project management structures and frequent turnover of Project Directors (PDs) contribute to delays and underutilization of development budgets. PDs often lack essential expertise in areas such as engineering, human resources, equipment management, or auditing, which are critical for managing large-scale health projects. High turnover further disrupts continuity and institutional memory, leading to persistent delays and large unspent balances.

Unrealistic targets and fragmented implementation

Many development programs allocate budgets assuming rapid, full-scale implementation, but actual implementation is often slower due to unrealistic targets, staff shortages, or fragmented planning. As a result, allocated funds remain underutilized or unspent, reducing program impact and creating inefficiencies. Delays in coverage or program activities directly contribute to low budget absorption.

Inflexibility of MSR structure and percentage allocation rules

Participants highlighted that the current MSR budget structure is restrictive. Although all items fall under a single MSR code (105), the government prescribes fixed percentage allocations for sub-items such as medicines, reagents, gauze, bandages, and small equipment. However, these percentages do not reflect real needs. For example, reagents may require significantly higher allocations, while items like gauze or bandages require far less. As a result, facilities often cannot purchase essential items within the prescribed limits. This mismatch between mandated percentages and actual needs leads to chronic underfunding of essential consumables such as reagents. When facilities attempt to adjust within the system through re-distribution, they face significant delays. This delay reduces the facility's ability to respond to urgent service delivery needs. Participants emphasized that the percentage distribution for different MSR sub-items has not been revised in over a decade, despite major changes in service volume and real needs.

Time-consuming redistribution process

Participants indicated that when the prescribed percentage allocations do not align with operational requirements such as reagent shortages, facilities must submit requests for

redistribution to adjust allocations across sub-items. This process, however, is protracted, often taking several months, which generates procurement bottlenecks and can result in underutilization of allocated funds before the end of the fiscal year.

Reduced ability to match budget to actual need

Overall, these structural determinants centralized control, outdated expenditure rules, fragmented authority, and managerial insecurity significantly limit facilities' financial autonomy. Consequently, even when allocations appear adequate, facilities struggle to direct resources towards true service delivery needs.

Confusion arising from multiple codes for a single item

Participants reported significant challenges in procuring a single item due to its classification under multiple codes, such as furniture: MSR (small-scale items), Code 32 (repair and maintenance), and Code 41 (capital nature, large items). This overlapping coding structure creates confusion for managers in determining which allocation to use and often compels facilities to retain funds for furniture even when there is no immediate need, contributing to underutilization of budgets.

EDCL production constraints and restricted medicine procurement

Participants identified significant challenges related to the supply of medicines through the EDCL. Despite EDCL being the primary supplier of medicines to public facilities, participants reported frequent shortages and partial deliveries, limiting the ability of facilities to meet patient needs. In addition to supply constraints, procurement rules further restricted facilities from purchasing medicines independently using MSR funds when EDCL supplies were insufficient. These dual challenges, limited EDCL production capacity and regulatory restrictions on alternative procurement were reported to contribute directly to under-utilization of medicine budgets and gaps in service delivery.

Misinterpretation of overall budget utilization due to aggregation bias

Participants consistently emphasized that assessing budget utilization using overall averages obscures substantial variation between development and operating budgets. When these two components are aggregated, utilization appears low, despite relatively strong performance in operating expenditure. These findings indicate that aggregate utilization metrics fail to capture operational realities and risk misinforming higher-level budget decisions.

Salary buffering creates apparent under-expenditure

Participants mentioned that under-utilization of allocated resources should not be interpreted as a failure of execution but rather as a deliberate fiscal safeguard. Due to frequent fluctuations in staffing resulting from transfers and temporary appointments, managers maintain a reserve to ensure uninterrupted salary disbursements. Consequently, this serves as an additional reason for unspent budget allocations. One participant cited,

Lengthy multi-layered approval processes for development budget

Participants consistently reported that development budget execution is significantly slower than revenue expenditure due to complex, multi-stage approval procedures for large procurements. Several informants noted that files must pass through multiple institutional layers, resulting in prolonged delays. In some cases, projects reached the end of the fiscal year before receiving final approval, leading to under-utilization of allocated development funds.

Project directors as additional charge holders

The widespread practice of appointing PDs on an additional-charge basis was identified as a key institutional constraint. Participants reported that PDs frequently lack sufficient time and, in some cases, prior project management experience, which adversely affects project oversight and timely implementation. Senior officials holding multiple academic and administrative responsibilities were described as particularly constrained in fulfilling PD roles effectively.

Absence of a structured PD pool

Despite ongoing investments in project management training, participants highlighted the absence of a centralized registry or structured pool of trained PDs. As a result, trained personnel are not systematically tracked or strategically assigned to development projects, limiting the effective use of existing human resource capacity.

Human resource constraints

Participants mentioned that a significant factor affecting budget utilization is the high vacancy rate among field staff. More than 40% of posts remain vacant, limiting the operational capacity to implement activities and utilize allocated funds. Prolonged recruitment procedures and pending standardization of staffing rules were cited as contributing factors.

Timing of fund availability

Participants reported that delays in fund release at the start of the fiscal year contribute to under-utilization. Revised budgets are typically issued mid-year (November–December), and any inter-sectoral adjustments require additional approval time, shortening the effective period for expenditure.

Broader structural and macroeconomic determinants

Participants highlighted that broader structural and macroeconomic factors significantly affect budget execution at both facility and project levels. Regulatory restrictions, such as government circulars limiting land acquisition or capital expenditures, often halt previously approved spending, creating challenges for timely budget utilization.

Unspent Emergency fund

Preparedness budgets for disasters or outbreaks also frequently remain unspent when emergencies do not occur.

Addressing these interconnected gaps through a more integrated, systems-focused approach is essential to improve the efficiency, equity, and sustainability of health service delivery.

4 Recommendations

Short Term

<i>Recommendation 1</i>	Recruit and deploy adequately trained Medical Technologists – Laboratory to ensure effective utilization of existing medical equipment and uninterrupted service delivery.
<i>Rationale</i>	Although necessary machines are available, insufficient lab technologist limits their operation, resulting in underutilization of resources and reduced service delivery capacity. Adequate human resources are required to ensure that installed equipment is effectively used for patient care.
<i>Likely Impact</i>	This improves utilization of existing medical equipment, reduces resource wastage, enhances service availability, and ensures that patients receive timely and appropriate healthcare services
<i>Recommendation 2</i>	Mandate disaggregated budget performance analysis by economic codes and by operational versus development budgets in all financial assessment and reporting processes
<i>Rationale</i>	Disaggregated analysis enables identification of under-spending, implementation delays, and inefficient resource utilization, thereby improving the accuracy and transparency of financial assessment.
<i>Likely impact</i>	This strengthens financial monitoring and accountability, enables more targeted resource allocation, improves identification of budget implementation bottlenecks, and supports evidence-informed planning and decision-making.
<i>Recommendation 3</i>	Strengthen integrated data systems and real-time digital dashboards to support evidence-based budgeting and resource planning.

<i>Rationale</i>	Limited availability of integrated and real-time data on staffing, service utilization, medicine consumption, and equipment need reduces the accuracy of budget estimation and planning. Strengthened data systems can support more accurate and timely budgeting decisions.
<i>Likely impact</i>	This improves budgeting accuracy, strengthens resource allocation efficiency, reduces uncertainty in financial planning, and supports data-driven decision-making.
Recommendations 4	Simplify public procurement procedures introduction of emergency flexibility provisions to expedite purchasing processes.
<i>Rationale</i>	Complex procurement rules and limited procedural clarity contribute to delays, weak compliance, and underutilization of allocated funds. Lack of practical guidance and insufficient training further constrains effective implementation at the field level.
<i>Likely impact</i>	This improves procurement efficiency, reduces delays in purchasing, enhances compliance with procurement regulations, increases budget utilization, and ensures timely availability of essential goods and services.

Medium Term

Recommendation 1	Establish a dedicated health management cadre through a structured professional management track to reduce reliance on untrained staff.
<i>Rationale</i>	Weak managerial capacity in budgeting, procurement, human resources, and project implementation limits efficiency and consistency in health system operations.
<i>Likely Impact</i>	This strengthens administrative and financial management capacity, improves efficiency in procurement and enhances overall health system performance.
Recommendation 2	Decentralize financial authority and introduce greater flexibility in MSR coding and budget allocation procedures to enable facilities to adjust expenditures based on local operational needs.
<i>Rationale</i>	Centralized approval processes and rigid budget allocation formulas contribute to procedural delays and limited responsiveness to facility-level needs. Greater decentralization and flexibility facilitate timely financial transactions and context-specific budget utilization.
<i>Likely impact</i>	This improves fund utilization, reduces administrative delays, strengthens operational efficiency at the facility level, and supports timelier and need-based resource allocation.

Long Term

Recommendation 1	Strengthen medicine production and supply systems through modernizing EDCL with updated machinery, uninterrupted raw material supply and improve efficiency of CMSD to ensure medicine availability across health facilities as per need.
<i>Rationale</i>	Production limitations, supply chain disruptions, and uneven distribution contribute to medicine shortages and reduced service availability at healthcare facilities.
<i>Likely Impact</i>	This improves medicine availability, reduces stock-outs, strengthens supply chain efficiency, and enhances continuity of healthcare services.

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