

Inequity in Healthcare Utilisation and Public Subsidy Distribution Among Persons With Disabilities in Bangladesh

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INTRODUCTION

Bangladesh, a South Asian low- and middle-income country, is committed to achieving Universal Health Coverage (UHC) by 2032. However, progress so far remains slow. Across the three dimensions of UHC cube;

- 52.1% of foregone healthcare in Bangladesh is due to financial constraints¹.
- 41.0% of participants seek private healthcare facilities for treatment, creating high OOP².
- One in four people cannot access the healthcare they need on time¹.

While inequities in healthcare access are well-documented, the literature largely overlooks people with disabilities despite their high prevalence (5.7%)³.

METHODS

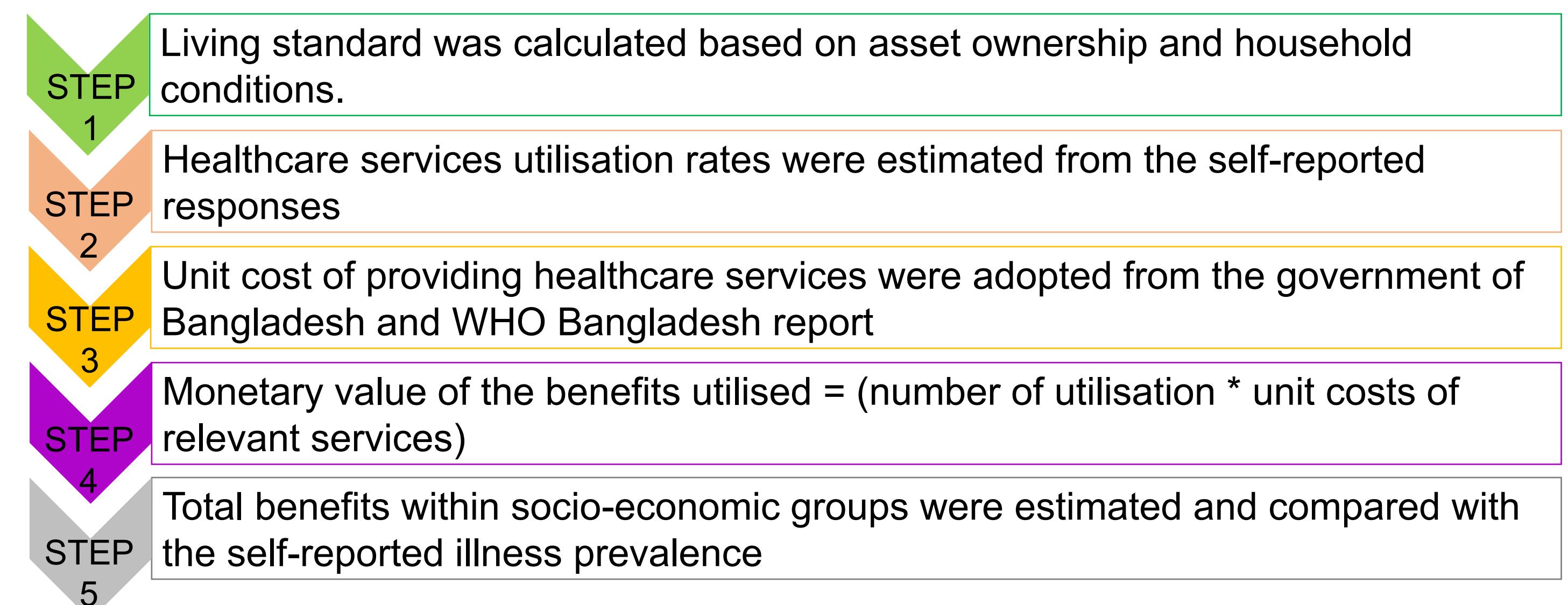
Study design	Cross-sectional study
Data source	Secondary data: Household Income and Expenditure Survey 2022
Sample size	60,576 individuals from 14,395 households
Living standards assessment	Based on an asset index using Principal Component Analysis
Healthcare provider	21 types grouped into three categories- 1. Public 2. Private and 3. Traditional and non-qualified
Disability identification	Washington Group's self-reported functional difficulty modules
Analysis methods	Benefit Incidence Analysis (BIA), Concentration Curve (CC), and Concentration Index (CI).

OBJECTIVE

This study aims to investigate the inequity in healthcare services utilisation and public subsidies utilisation among persons with disabilities in Bangladesh

Specific objectives are:

- To analyse patterns of healthcare service utilisation among persons with disabilities (PWDs) in Bangladesh.
- To identify the extent and nature of inequities in public healthcare service utilization among PWDs in Bangladesh.
- To evaluate the role of public subsidies in reducing inequities in healthcare utilisation among PWDs in Bangladesh.



RESULTS

- **Figure 1** illustrates that with increasing socio-economic status among participants, private healthcare facility utilisation rises, traditional or unqualified providers declines, public healthcare facilities utilisation remains relatively stable.
- **Figure 2** shows that among lower socio-economic groups, estimated public benefit utilisation was lower than the reported need, however, higher than the need among higher socio-economic groups, indicating pro-rich inequity in public subsidy distribution.
- In **Figure 3**, CCs for both the overall population and PWDs, lies below the equity line, indicating a pro-rich distribution of healthcare benefits utilisation. This confirms that public healthcare benefits are disproportionately concentrated among higher-asset groups within both population groups.

Fig 1: Facility utilisation rate over asset quintile for PWDs

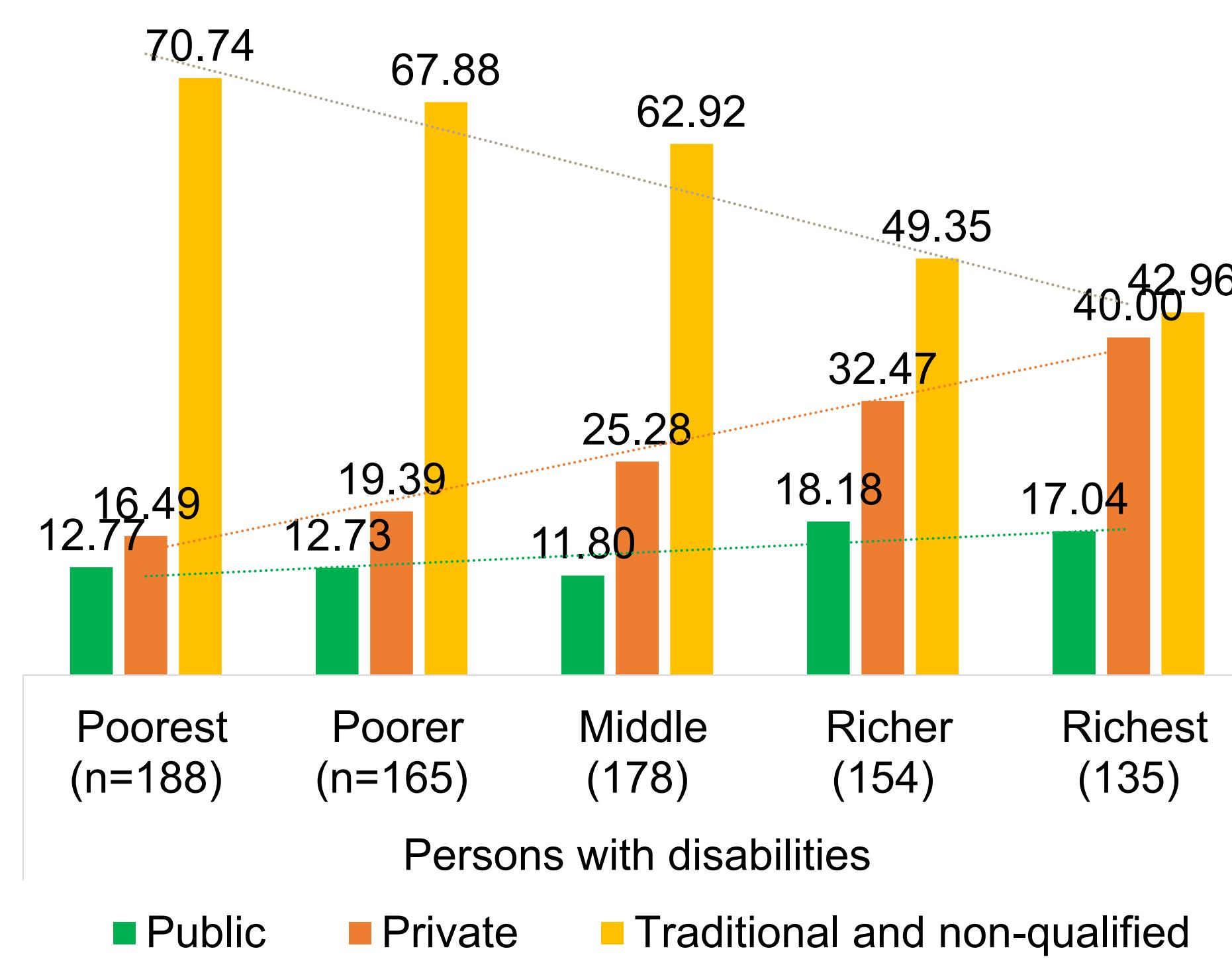


Fig 2: Comparison of % share of need and % share of benefit utilised by asset quintile and disability status

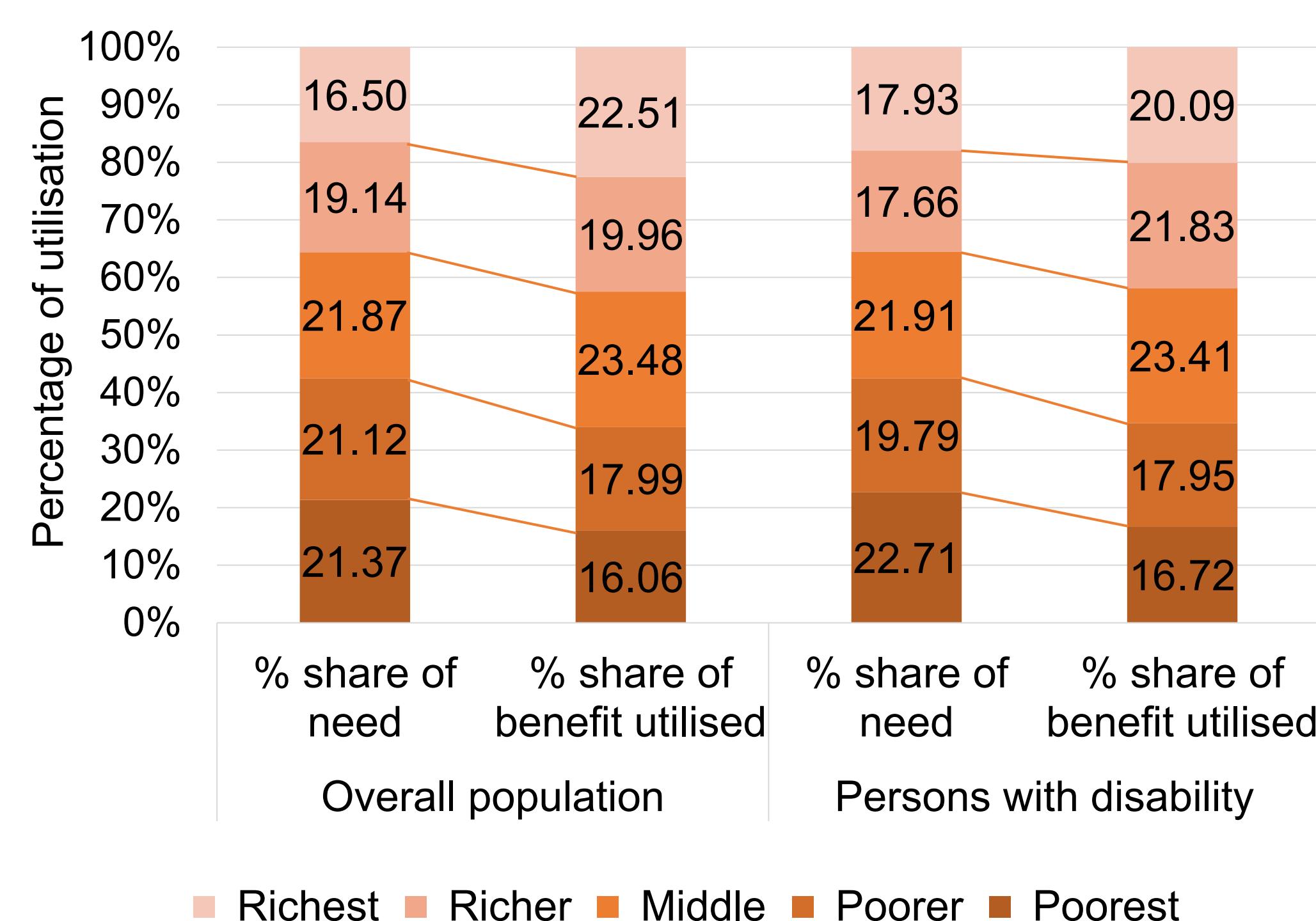
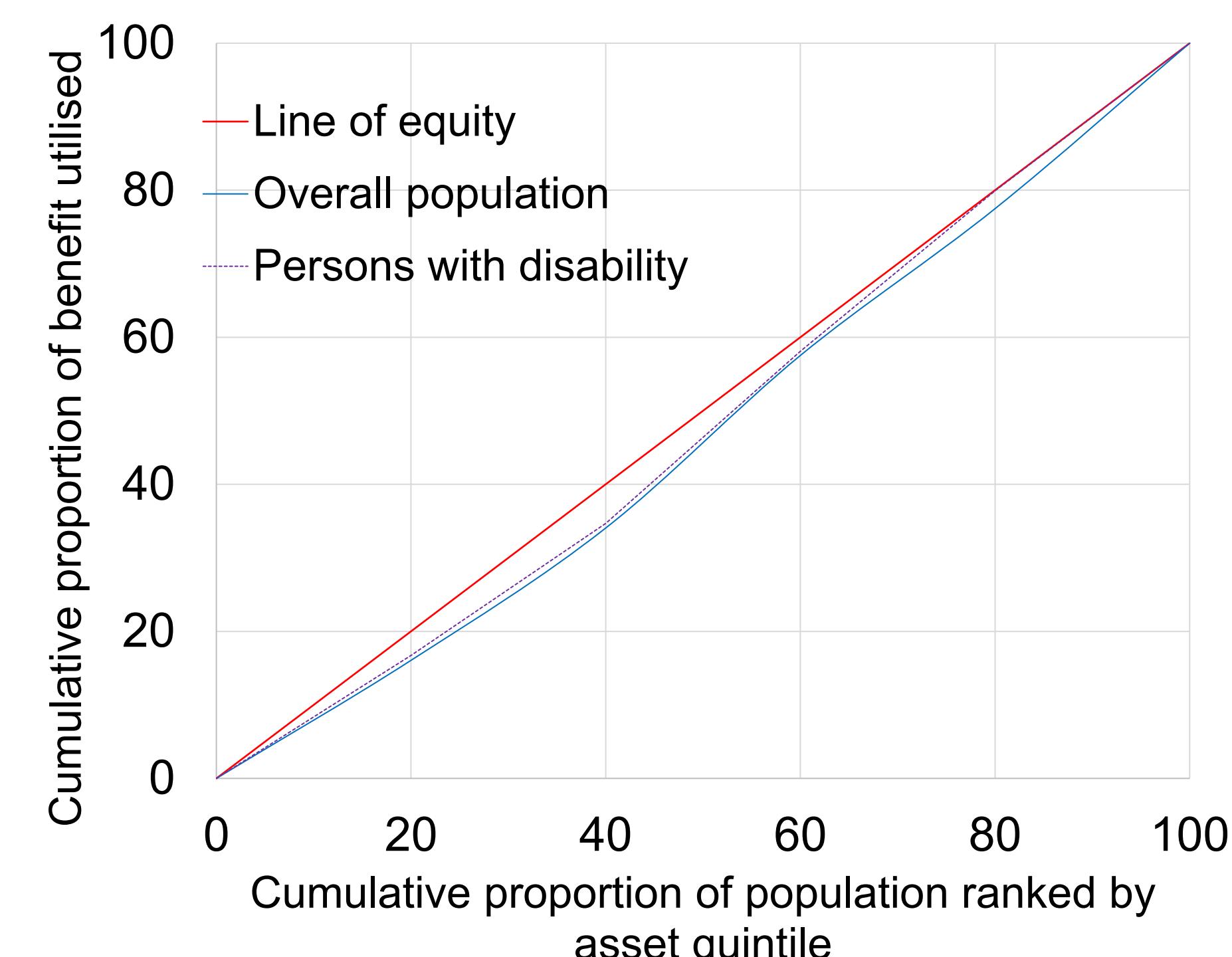


Fig 3: Concentration Curve of BIA



CONCLUSIONS

- **Enhance equity in public healthcare access:** Targeted interventions are needed to improve healthcare utilization among lower socio-economic groups and PWDs
- **Reform public subsidy distribution:** Current public healthcare benefits disproportionately favour higher-asset groups; policy reforms should prioritize equitable allocation of subsidies to reduce pro-rich bias.
- **Strengthen public and community-level services:** Expanding the reach and quality of public and community healthcare facilities can reduce reliance on private and unqualified providers, promoting equitable access.

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