Challenging inadequate and fragmented primary health care financing: findings from Bangladesh, Indonesia, Maldives, and Nepal

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Summary

Strengthening primary health care (PHC) is essential for achieving universal health coverage, with effective financing playing a critical role in its success. Despite the increasing emphasis on PHC investment, securing sustainable public financing remains a significant challenge in the countries of the South-East Asia (SEA) Region. This study provides an overview of PHC financing arrangements in Bangladesh, Indonesia, Maldives, and Nepal, highlighting key challenges in these four countries. Data sources included the document review (87 documents included across the four countries) and key informant interviews (21 in total). Findings highlight the diverse approaches to PHC financing across the four countries, bringing out common and country-specific challenges. Our findings suggest that while PHC has been receiving more attention in policy agendas, underlying PHC financing functions still face many challenges. Some constraints stem from the existing health financing models within these countries, indicating a need for targeted reforms.

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Keywords: Primary health care financing; Bangladesh; Indonesia; Maldives; Nepal; South-East Asia

Introduction

Primary health care (PHC) serves as a cornerstone of a resilient health system, as underscored by the COVID-19 pandemic. A robust PHC framework ensures universal access to essential health services and medicines while reducing overall health spending by prioritizing prevention and health promotion. Strengthening PHC financing and delivery could expand health care coverage, make health systems more resilient, and accelerate progress towards UHC.[1] Evidence from low- and middle-income countries (LMICs) shows that increased investment in PHC could enhance access to services, improve health outcomes, and reduce healthcare costs.[2–4]

Recognized as a global health priority since the 1978 Alma-Ata Declaration, PHC's importance was reaffirmed in the 2018 Astana Declaration. In the Seventy-sixth Session of the WHO Regional Committee for the South-East Asia (SEA) Region in 2023, member states of the WHO South-East Asia Region announced prioritizing PHC within their health budgets. The Delhi Declaration on Strengthening PHC as a Key Element Towards Achieving Universal Health Coverage (UHC) underscores this commitment, with its first action point emphasizing the optimal allocation of resources to PHC.

Securing adequate public funding for health remains a persistent challenge in the SEA region, impacting overall health services including PHC. Government health expenditure ranked second lowest among all WHO regions, averaging 3.12% of GDP in 2022, while share of out-of-pocket (OOP) expenditure ranked the highest, constituting 37.9% of health expenditure in 2022. Moreover, in the SEA region, PHC financing relies on various financial modalities, including general tax revenue, mandatory social insurance, and OOP. On top of this, political economic factors may shape financing for PHC. Many LMICs continue to prioritize public investment in hospitals, which are more visible and politically appealing, over PHC.[4] Although there is growing commitment and

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interest within broader political agendas at various levels, these financing arrangements remain inadequately understood across countries.

To address this gap, we conducted key informant (KI) interviews to analyze PHC financing arrangements and challenges in four SEA countries—Bangladesh, Indonesia, Maldives, and Nepal—complemented with the extracted data from a scoping review[5] (Appendix). Four countries were purposively selected based on their mixed health systems, substantial private sector involvement, and existing social or government-provided health insurance schemes. By examining the financing mechanisms in these contexts, this study aims to generate insights that can inform PHC financing strategies across other LMICs.

The operational definition for PHC used in this study refers to the community-level and first-level of health care or the first level of contact of individuals, families and communities, which includes and integrates healthcare services for health promotion, disease prevention, treatment and management, rehabilitation and palliative care, delivered at both individual and population levels. Thus, this study focuses on facility-based PHC services. We present our learnings on health financing functions and arrangements of PHC in Bangladesh, Indonesia, Maldives and Nepal below, followed by key challenges in PHC financing across these countries.

Health financing arrangements for primary health care

Table 1 depicts key financing data related to PHC for the four countries as sourced from the WHO Global Health Expenditure Database, with the missing data on PHC expenditure for Indonesia and Maldives. This reflects the limited data available on PHC expenditure at the country level. Nevertheless, it indicates that domestic private expenditure constituted the largest share of PHC in Bangladesh at 76%, while it constituted almost half (47%) in Nepal. The share of domestic general government health expenditure (GGHE-D) on PHC represented over one-third (38%) in Nepal. In contrast, the share of GGHE-D was considerably lower in Bangladesh at 18%.

A summary of the health financing arrangements for PHC in each country is given in Table 2. For revenue mobilization, OOP payment is a major source of financing for PHC services in Bangladesh,[6,7] while in Nepal, OOP payment is significant but also supplemented by government revenue to support public sector providers.[6,8] Maldives is a government-dominated health financing system, where PHC funding primarily comes from the government.[9,10] While health insurance contribution plays a significant role in financing of PHC facilities in Indonesia.[11] Regarding pooling of funds, all four countries have no specific pooling mechanism for PHC. The pooling structure follows that of general health financing. For resource allocation and purchasing, only Indonesia adopts capitation payment and performance-based payment for PHC facilities.[11] Line-item budget is commonly applied for public sector providers of the four countries.[12–14]

Challenges for financing of primary health care

The KIs, consultative meeting, and review identified four shared challenges: limited monitoring of PHC spending, inadequate budget allocation for PHC, fragmentation of funding, and low and poorly aligned incentives for frontline PHC providers. Low absorptive capacity and underspent budgets in Bangladesh and Indonesia, as well as rising costs of medicines in Bangladesh, Nepal, and Maldives, were also discussed. Sample quotations for each theme are elaborated in the Appendix.

PHC financing data	Bangladesh	Indonesia	Maldives	Nepal
Gross national income/GNI (current US$)–2023	454,873,454,273	1,335,866,354,418	5,819,886,404	41,385,089,423
Current Health Expenditure (in million current US$)–2022	10,348	35,535	603	2623
Primary Health Care (PHC) Expenditure as % Current Health Expenditure (CHE)	67% (2020)	No data	No data	67% (2021)
Domestic General Government Health Expenditure (GGHE-D) (in million current US$)–2022	671	18,393	471	830
Domestic General Government Expenditure on PHC as % GGHE-D	66% (2020)	No data	No data	76% (2021)
Domestic General Government Expenditure on PHC as % PHC	18% (2020)	No data	No data	38% (2021)
Domestic Private Health Expenditure (PVT-D) (in million current US$)–2022	7761	16,792	115	1522
Domestic Private Expenditure on PHC as % PVTD	67% (2020)	No data	No data	57% (2021)
Domestic Private Expenditure on PHC as % PHC	76% (2020)	No data	No data	47% (2021)
Household out-of-pocket payments (OOPS) (in million current US$)–2022	7505	11,713	106	1463
External Health Expenditure (EXT) (in million current US$)—2022	1916	350	17	271
External Health Expenditure on PHC as % EXT	83% (2020)	No data	No data	83% (2021)
External Health Expenditure on PHC as % PHC	7% (2020)	No data	No data	16% (2021)
PHC (government and donors) as % of GDP	No data	No data	No data	2% (2021)

Remark: External Health Expenditure (EXT) refers to external sources spent on health, including direct foreign transfers and foreign transfers distributed by the government. These external funds may be channeled through government schemes, non-governmental organizations, or other financing mechanisms. Source: WHO Global Health Expenditure Database.

Table 1: **Key PHC financing data for the four countries.**

Health financing functions	Bangladesh	Indonesia	Maldives	Nepal
Revenue mobilization	Mainly out-of-pocket payment (e.g., medicines, services), followed by government revenue and external funding.	Mainly insurance contributions, followed by government revenue (central and subnational), and external funding (donors).	Mainly government revenue for health financing, including PHC.	Out-of-pocket payment (e.g., medicines, cost-sharing, and informal payments), followed by government revenue and external funding.
Pooling	No specific pooling mechanism for PHC funding. Limited pooling for general health financing.	No specific pooling mechanism for PHC funding. The two main pools allocated to Puskesmas (public PHC facility) are the government budget (central and subnational) and BPJS-K.	No specific pooling mechanism for PHC funding. The pool structure follows the general health financing that is a single national pool under the MoF, with separate small pools from external funding and voluntary private health insurance.	No specific pooling mechanism for PHC funding. The PHC funding flows with the overall pooling structure, which are multiple pools at federal, provincial, and local government levels, with separate pool of external funding.
Resource allocation and purchasing	(Rural) The MoHFW allocates the budget to upazila health complexes and lower-level facilities based on line-item budget. (Urban) The MoLGRDC adopts a low-cost bidding system to contract private PHC providers.	The BPJS-K allocates the budget for Puskesmas through risk-adjusted capitation, fee-for-service, and performance-based payments. While the MoH allocates funds for Puskesmas through regional health offices, mostly public health activities and vertical programs, through a co-financing scheme with subnational governments. The subnational governments allocate budget for Puskesmas through line-item budget.	The MoF allocates health sector budgets to the MoH and the NPSA. The MoH allocates the operational budget to atoll hospitals. Then atoll hospitals allocate the budget to health centers based on line-item budget. The NPSA allocates budget to Aasandha scheme, which reimburses private clinics based on fee-for-service.	Central and provincial governments allocate conditional grants to local governments, then local governments allocate the budget to public PHC facilities based on line-item budget.

Remark: External funding refers to external sources in funding healthcare, including direct foreign transfers and foreign transfers distributed by government. MoHFW, Ministry of Health and Family Welfare; MoLGRDC, Ministry of Local Government; Rural Development, and Cooperatives; BPJS-K, BPJS Kesehatan (Social Health Insurance Agency for Health); MoF, Ministry of Finance; MoH, Ministry of Health; NPSA, National Social Protection Agency.

Table 2: **Health financing arrangements for primary health care in the four countries.**

Limited monitoring of PHC spending

Limited monitoring and reporting mechanisms following national budget transfers to local governments or PHC facilities hinder the tracking of PHC expenditures in these four countries. In Indonesia and Nepal, limited monitoring and reporting of expenditures by local governments were observed, while in Bangladesh, tracking the total budget allocated to PHC facilities remains challenging. Similarly, in the Maldives, national budgets are well-monitored at the central level but lack oversight at the atoll and island levels due to inadequate IT infrastructure.

Inadequate budget allocation for PHC

Inadequate budget allocation for PHC, particularly for preventive and promotive services, was highlighted as a concern across the four countries. In Nepal, insufficient budget allocations, as well as allocations calculated based on historical data, have constrained financial resources for the health sector and PHC services. In Indonesia, the BPJS-K allocates minimal funds for preventive services. In Bangladesh, budget allocation prioritizes secondary and tertiary-level health services, rather than PHC. In the Maldives, despite adequate overall healthcare funding, substantial investments are directed towards curative care and infrastructure, leaving preventive services underfunded, especially when such services are not included in the health benefits package. To address this, the government recently incorporated preventive care services, such as testing, screening, and medical check-ups, into their national health benefits package.

Fragmentation of funding for PHC

Fragmentation of PHC funding across multiple sources makes it difficult to track expenditures and to assess whether PHC is adequately financed. It also creates accountability challenges and increases administrative burdens on PHC facilities as different funding streams come with distinct target services and performance indicators. In Nepal, financial flows overlap across multiple programs for basic health care services, while Indonesia faces challenges from fragmented financing sources across central and subnational governments and the BPJS-K, resulting in duplicated funding for the same activities. Indonesia is undergoing a health transformation starting in 2023, and multiple funding flows are one of the issues this reform aims to address. The Maldives and Bangladesh also experience difficulty overseeing PHC spending due to having two separate pools allocated to PHC at the central level.

Low and poorly aligned incentives for frontline PHC providers

Insufficient financial and non-financial incentives, such as housing and professional development opportunities, hinder the recruitment and retention of frontline providers at PHC facilities, especially in rural or remote

areas in Bangladesh, Indonesia, and the Maldives. In Indonesia, community health workers' salaries vary across geographical areas based on village capacity. Staff shortages in these four countries result in high workloads, forcing frontline providers to multi-task without adequate compensation. To address this, the Maldives recently increased the salary of full-time community health workers to improve workforce retention.

Low absorptive capacity and underspent budget

In Bangladesh and Indonesia, public financial management issues were a recurring theme throughout the KIs. In Bangladesh, a lack of public PHC facility readiness and human resource constraints led to low local absorptive capacity and underspent budgets. In Indonesia, budget utilization restrictions and report requirements limit the ability of Puskesmas (public PHC facility) to pool funds from multiple sources, leading to underspending of budgets by the end of the financial year.

Rising costs of medicines

The cost of medicines poses a financial burden on households and governments. Despite free PHC services, limited scope of benefit packages, lack of facility readiness, and inadequate budget execution lead to medicine shortages in public PHC facilities in Bangladesh and Nepal, forcing households to make OOP payments. In contrast, the Maldives' fully subsidized healthcare system has resulted in high government expenditures on medicines.[9] This was attributed to medicines being reimbursed on a fee-for-service basis, along with the absence of a maximum price ceiling and the reliance on imported medicines. Additionally, unrestricted provider choice without a gatekeeping system has led to healthcare and medication overutilization.

Discussions

This study provides an overview of PHC financing arrangements in Bangladesh, Indonesia, Maldives, and Nepal. Results suggest that countries have taken a variety of approaches to finance PHC, encompassing different revenue-raising, pooling, and purchasing mechanisms. Despite these variations, several common challenges persist.

Inadequate government budget allocations for PHC, especially for disease prevention and health promotion services, was a common challenge across the four countries. These countries operate under general health financing structures where preventive care is less prioritized, aligning with findings on LMICs from the Lancet Global Health Commission on Financing PHC.[1] Limited public funding for PHC is closely linked to overall government revenue constraints and restricted allocations towards the health sector. Addressing this requires both broader public financing reforms and targeted health financing strategies to increase PHC's financial share.

Exploring supplementary or alternative funding sources to increase government revenue, such as sin taxes, could be a viable strategy, as has been implemented in the Philippines[15] and Botswana.[16] However, while such mechanisms may support general health financing, they are not necessarily earmarked to PHC. Other sources suggest that relying on local philanthropies or community-based financing may be questionable due to their unclear effectiveness and sustainability.[17,18]

Merely increasing PHC funding is insufficient without safeguarding budget allocations to PHC at the community level and ensuring resources reach the frontline providers.[1] In three of the four countries, line-item budgeting dominates, limiting the ability to accurately track allocation and spending for PHC. Provider payment mechanism can be used as a purchasing tool to enhance population-based resource allocation. Indonesia stands out as an exception, having recently implemented risk-adjusted capitation payment based on age group and gender and fee-for-service payments at Puskesmas. This allows for more targeted and equitable allocations to PHC facilities. Nepal is also planning to adopt the capitation payment scheme for PHC at the local level. For frontline providers, financial incentives remain weak in the four countries, as payment mechanisms predominantly rely on supply-side line-item budgets without performance-based incentives.

Payment mechanisms can influence the performance of PHC providers.[1] In three of the four countries, line-item budgeting dominates, which provides no incentive for improvements in service delivery or patient-centered care. This is supported by our findings in the Maldives, where their fee-for-service model for medicines and lack of gatekeeping leads to overutilization of services, rising medicine expenditures, potentially unnecessary care, and inefficiencies to the health system.[9] Co-payments may be considered as an option to curb spending and to minimize unnecessary utilization of health services. The exception is Indonesia, where performance-based payment complements capitation for Puskesmas.[11]

Payment reform towards performance-based payment systems can be implemented by creating a linkage between payment and performance of providers or quality of PHC services. For other countries to shift towards performance-based payments, it is imperative that the public financing mechanisms are reformed to increase financial autonomy of public providers, improve health information systems, and enhance data reporting for accountability. Provider payment reforms can also enable the public sector to consider engaging private PHC providers into their systems.

Additionally, it is important to address structural limitations. Existing PHC systems in some countries have limitations in absorbing increased funding due to infrastructure deficiencies, human resource shortages, and rigid public financial management rules.[19] This is supported by findings from Bangladesh, where the budget remained underspent due to slow financial disbursements and facility readiness, resulting in health programs not getting implemented. While in Indonesia, strict regulations on earmarked spending, combined with audit concerns, have made Puskesmas hesitant to fully utilize their budgets. This points out the need to increase investment in facilities and human resources as well as enhance financial autonomy and flexibility at PHC facilities.

Another point to consider is the persistent dichotomy between PHC investment and PHC operating costs. There is a need for significant structural investments such as building new facilities, purchasing new equipment, and increasing staff trainings in areas where public service infrastructure is still inadequate. At the same time, these structural investments require longer-term financing for PHC operations to ensure that all operational costs are covered. Both investments in new infrastructure and operational financing need to be well-coordinated and planned out to enable performance. Maldives has successfully invested in both areas, whereas the other three countries allocate a larger proportion of resources to operating costs. In Bangladesh, staff shortages and inadequate infrastructure result in low absorptive capacity and underspending of PHC operational budgets,[20] highlighting the importance of striking a balance between both investments and operational costs.

No dedicated pooling mechanism for PHC was found in the four countries. Instead, they rely on the pooling mechanisms used to support overall health services. Multiple fragmented pools as the source of funding for PHC were commonly observed as PHC facilities are financed through both general supply side financing plus program specific funding, such as domestic funding and external funding for disease-specific programs. This is especially evident in Indonesia and Nepal. The fragmentation of funding creates unclear accountability for PHC facilities on whom they should account and their priority settings. In addition, it creates difficulties in calculating and monitoring PHC spending. This could result in inefficiencies from overlaps in funded activities.[21] One possible solution is to implement a program-based budgeting, where a dedicated PHC budget consolidates multiples funding streams into an integrated budget allocation for PHC.

Comprehensive PHC expenditure data is crucial for monitoring and evaluation. However, these countries, particularly Maldives and Indonesia, cannot collect and report the data on PHC expenditures due to different levels of government transfers, fragmented funding flows, and inadequate information technology infrastructure. Furthermore, most countries still use line-item budgeting, preventing effective tracking of PHC expenditures. Prioritizing the enhancement of health information systems for PHC is essential to enable systematic recording and analysis of PHC expenditures, and to effectively monitor funding availability for PHC. Moreover, the absence of a standardized PHC definition limits cross-country comparisons and benchmarking.[22] This reflects a gap in the methodologies used to measure PHC expenditure.

To ensure the success of reforms in PHC financing, understanding the political economy is essential.[1] It requires a good understanding of key stakeholders involved in decision-making and implementation processes, the value and incentives that the reforms will bring to each actor in the system, and the underlying social and economic conditions that may shape their support for or resistance against the change. It is important to go beyond the national level and engage with stakeholders at all levels through a whole-government approach with a people-centered focus.

This study has some limitations. Due to time constraints, the number of KIs were small and limited to four to five per country, including representatives from Ministries of Health, academia, NGOs, and international development agencies. In some countries, NGO participation was absent, and supplementary documents related to NGOs on PHC were reviewed to address this gap. However, our methodology still aligns with qualitative research standards for elite interviewing, where smaller, purposively selected samples—though less accessible—are appropriate for achieving thematic saturation.[23] Second, this study focuses on facility-based financing, it does not cover the financing of community outreach services. Third, Indonesia and Maldives are currently undergoing PHC transformations, meaning that this study can capture only their situations as of 2023.

Future research should deepen the analysis of the four countries by incorporating other methods of data collection such as questionnaire and field observations and introducing an interdisciplinary perspective that includes socio-cultural and political economy factors to gain a more comprehensive understanding of primary health care financing issues. Financing of community outreach services is a component that should be explored further among these four countries.

Conclusion

Our study highlights the diverse approaches to PHC financing in Bangladesh, Indonesia, Maldives, and Nepal, particularly on resource mobilization, pooling, and allocation and purchasing. Despite variations in health financing structures and arrangements,

common challenges include inadequate budget allocations for PHC, fragmented funding flows, low and poorly aligned incentives for frontline providers, and limited tracking of PHC expenditures. Strengthening PHC financing requires targeted policy reforms, such as improving financial autonomy for public providers, shifting towards performance-based payment models, consolidating funding streams, and enhancing health information systems for better expenditure tracking. Additionally, the balance between infrastructure investments and operational funding must be carefully planned to optimize service delivery. Political economy considerations are also crucial for successful PHC financing reforms.

Contributors

AP is the overall in charge of this manuscript. AP and PH conceptualised the manuscript, with inputs from TT, and VdOC. AP developed the original first draft. AP, HM, and LTL collected the data. AP and HM analysed the data sets. HM, LTL, PH, TT, and VdOC provided feedback and edits for the manuscript. All authors contributed to the review of manuscript drafts and agreed on the final version of the submitted manuscript.

Declaration of interests

The authors declare no competing interests.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.lansea.2025.100613.

References

1 Hanson K, Brikci N, Erlangga D, et al. The lancet global health commission on financing primary health care: putting people at the centre. *Lancet Glob Health*. 2022;10(5):e715–e772.
2 Evans T, Chowdhury A, Evans D, et al. *Thailand's universal coverage scheme: achievements and challenges. An independent assessment of the first 10 years (2001-2010)*. Nonthaburi, Thailand: Health Insurance System Research Office; 2012.
3 Stenberg K, Hanssen O, Bertram M, et al. Guide posts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study. *Lancet Glob Health*. 2019;7(11):e1500–e1510.
4 Perry HB, Sachs JD. *The investment case for strengthening primary healthcare and community health worker programs in low- and lower-middle-income countries*. Oxford University Press; 2024.
5 Pholpark A, Mon H, Lim L, Hanvoravongchai P. *Financing of primary health care in South-East Asia Region: findings from systematic scoping review and key informant interviews*. Delhi: World Health Organization, South-East Asia Regional Office; 2023.
6 *Global health expenditure database*. World Health Organization; 2024. Available from: https://apps.who.int/nha/database.
7 Ministry of Health and Family Welfare. *Public expenditure review 1997-2020*. Bangladesh: Ministry of Health and Family Welfare; 2020.
8 Ministry of Health and Population. *Nepal national health accounts (2018/19 - 2019/20)*. Nepal: Ministry of Health and Population; 2023.
9 Ministry of Health Republic of Maldives. *Maldives: national health accounts (2015-2017)*. Maldives: Ministry of Health Republic of Maldives; 2019.
10 Moosa S, Ibrahim A, Shafeeq M. *PHC plus investment case: primary health care for universal health coverage*. Maldives: Ministry of Health Republic Maldives; 2022.
11 Sambodo NP, Bonfrer I, Sparrow R, Pradhan M, van Doorslaer E. Effects of performance-based capitation payment on the use of public primary health care services in Indonesia. *Soc Sci Med*. 2023;327:115921.
12 Ahmed S, Begum T, Smith O. *Diagnostic study of public financial management: to strengthen health financing and service delivery in Bangladesh*. Washington, D.C.: World Bank Group; 2019 [Contract No.: Health, Nutrition and Population (HNP) discussion paper].
13 World Health Organization Regional Office for South-East Asia. *Crisis or opportunity? health financing in times of uncertainty: country profiles from the SEA region*. New Delhi: World Health Organization; 2021.
14 Federal Ministry of Health and Population. *Health sector budget analysis: first five years of federalism*. Nepal: Federal Ministry of Health and Population; 2022.
15 Javadinasab H, Masoudi Asl I, Vosoogh-Moghaddam A, Najafi B. Comparing selected countries using sin tax policy in sustainable health financing: implications for developing countries. *Int J Health Plann Manage*. 2020;35(1):68–78.
16 Nabyonga-Orem J, Christmals CD, Addai KF, et al. The nature and contribution of innovative health financing mechanisms in the World Health Organization African region: a scoping review. *J Glob Health*. 2023;13:04153.
17 Yoshino N, Hendriyetty NS, Sioson EP. *Exploring community-based financing schemes to finance social protection*. Tokyo: Asian Development Bank Institute; 2020.
18 Jasonson E. *Philanthropy and innovative financing in Asia and the Middle East*. UK: Centre for Strategic Philanthropy, Cambridge Judge Business School; 2024.
19 Kumar AKS, Chen LC, Choudhury M, et al. Financing health care for all: challenges and opportunities. *Lancet*. 2011;377(9766):668–679.
20 Evans J, Alam MI. *Primary health care systems (PRIMASYS): comprehensive case study from Bangladesh*. Geneva: World Health Organization; 2017.
21 Mathauer I, Saksena P, Kutzin J. Pooling arrangements in health financing systems: a proposed classification. *Int J Equity Health*. 2019;18(1):198.
22 Nathalie Vande M, Ke X, Agnes S, Lisa F, Maria A, Hong W. Measuring primary healthcare expenditure in low-income and lower middle-income countries. *BMJ Glob Health*. 2019;4(1):e001497.
23 Green J, Thorogood N. *Qualitative methods for health research*. SAGE Publications; 2018.