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Governance Failures and Spatial Inequalities in Healthcare Access for Older Adults in Bangladesh: A Systematic Scoping Review

Md. Moontakim Rahman

rahman.moontakim99@gmail.com

Islamic University

Md. Saikoth Jahan

Bangladesh Institute of Management

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Abstract

The demographic aging in low-and middle-income countries is increasingly complicating governance challenges for which their health systems are ill-equipped. Such is the case of Bangladesh, where the proportion of the elderly age group (aged 60 years or more) is expected to increase from 9.5% of the total population in 2023 to around 21.5% in 2050, whereas the public health administration system continues to suffer from fragmentation, unevenness, and lack of reform to suit the requirements of older persons. The present systematic scoping review argues that spatial inequality in healthcare service access for older Bangladeshis does not come about mainly due to a lack of resources but rather governance failures throughout the various hierarchical layers of the public administration system. Following the five-stage methodology of Arksey and O'Malley (2005) and using the PRISMA-ScR criteria checklist by Tricco et al. (2018), the study systematically analyzes 58 articles, both peer-reviewed and grey literature, published from 2013 to 2025. Governance failures identified in the review include the absence of geriatric care policy requirements in the organizational structure of the health system, unequal distribution of doctors and high absenteeism at Upazila Health Complexes, unequal access to facilities and poor transportation infrastructure in rural versus urban areas, decline of the system of informal caregiving at home, and intersectoral coordination between the Ministry of Health and Family Welfare, local governments, and the Department of Social Services. An analytical model in which spatial inequality is viewed as the spatial expression of governance failure is put forth, applicable to other LMICs in addition to Bangladesh. The proposed governance reform strategy, informed by institutional theory, involves the incorporation of spatial equity considerations into the Health, Population and Nutrition Sector Programme of Bangladesh as an immediate measure.

1. Introduction

Demographic aging in low- and middle-income countries (LMICs) presents a governance challenge that is qualitatively distinct from the pressures of high fertility or infectious disease burden. Where the latter are amenable to vertical, programme-based interventions, the former demands the horizontal reorganization of entire public service architectures—including health systems, social protection schemes, and local governance structures—to respond to the chronically complex, multi-morbid, and mobility-limited needs of elderly populations. Bangladesh stands at precisely this inflection point.

The percentage of people above the age of 60 years in the total population of Bangladesh grew from 7.7% in 2015 to 9.5% in 2023, while the country's life expectancy increased from 57.5 years in 1990 to 72.3 years in 2023 (Afrin et al., 2025). Projections show that by 2025, one out of every ten individuals in Bangladesh will be an older adult and that by 2050, one out of every five individuals will fall into the category of an older adult (Afrin et al., 2025). It is important to note that these figures are not just significant in terms of demographic statistics but also they represent a sharp increase in the absolute number of citizens whose healthcare needs are chronic, multidimensional, and frequently require sustained institutional engagement. Bangladesh's public health infrastructure, built largely around

maternal and child health, communicable disease control, and primary care for younger populations, was never designed for this transition.

The resulting misalignment between population need and institutional capacity is not simply a technical failure of resource allocation. It reflects a deeper problem of governance: the inability of the state to translate demographic intelligence into adaptive policy, to enforce accountability across its health bureaucracy, and to achieve spatial equity in the distribution of health services. Older adults in rural Bangladesh face a compound of disadvantages—they are geographically distant from facilities that exist primarily in urban subdistrict headquarters, financially constrained by pension-less old age and catastrophic out-of-pocket health expenditures, physically limited in their capacity to navigate an under-resourced transport system, and institutionally invisible in a policy environment that has not legislated geriatric care standards.

This paper displays a systematic scoping review of the literature relating to governance and the geographical aspects of healthcare accessibility for elderly persons in Bangladesh. Unlike systematic reviews on specific medical treatments, scoping reviews are ideal for mapping out a new or disparate body of evidence, recognizing gaps in conceptualization, and consolidating evidence with policy implications from different academic perspectives (Arksey & O'Malley, 2005; Tricco et al., 2018). Considering the diverse nature of the literature on this topic in terms of academic disciplines, a scoping review approach would be most appropriate for this research.

The overarching research question guiding this review is: How do governance failures in Bangladesh's public health system generate and sustain spatial inequalities in healthcare access for older adults, and what are the institutional mechanisms through which such inequalities are reproduced? Three subsidiary questions orient the inquiry: (1) What structural features of Bangladesh's health governance architecture create barriers to older adults' access? (2) How does spatial location—understood in terms of the rural–urban continuum and district-level resource distribution—shape the nature and magnitude of access inequality? (3) What policy and governance reforms are proposed in the literature, and how theoretically coherent are they?

The paper is organized as follows: Section 2 situates the study within the theoretical literature on governance failure, new public governance, and health equity. Section 3 presents the methodology. Section 4 maps the thematic landscape of the reviewed literature. Section 5 develops an analytical discussion of the mechanisms linking governance deficits to spatial health inequity, including comparative LMIC context. Section 6 proposes a sequenced reform framework. Section 7 addresses study limitations. Section 8 concludes.

2. Theoretical Framework: Governance Failure, New Public Governance, and Spatial Health Equity

2.1 Governance Failure as an Analytical Category

The concept of governance failure has a complex lineage in public administration theory. In a narrow sense, it refers to the failure of government to provide public goods or correct market failures—the public sector analogue of market failure in economics. Within an institutional context, as stated by some researchers like Jessop (1998) and Hood (1991), governance failure is defined as "the inability of the institutions of governance to fulfill their intended goals due to implementation deficits, coordination breakdowns, accountability gaps, and structural misalignments between policy design and administrative capacity. The latter conception is more analytically useful in this particular study.

Fukuyama's (2013) state capacity framework adds a further dimension: he distinguishes between the scope of state activity—what the state attempts to do—and the strength of state institutions in executing those activities. Bangladesh's health governance failures exhibit both a scope deficit (the failure to legislate geriatric health mandates) and a strength deficit (the failure to enforce accountability within an existing bureaucratic hierarchy). Kaufmann et al.'s (2010) World Governance Indicators framework similarly identifies rule of law, government effectiveness, and regulatory quality as composite dimensions of governance capacity—all of which are measurably weak in Bangladesh's sub-national health administration, particularly in rural upazila-level service delivery.

In the context of health systems in LMICs, governance failure typically manifests across several dimensions: weak regulatory enforcement; absence of coherent stewardship functions within health ministries; perverse incentive structures that drive absenteeism and rent-seeking among health professionals; and inadequate accountability mechanisms between central government health directorates and local service delivery units. Bangladesh's health system exhibits all of these features, with particular acuity in the case of services for older adults, who represent a constituency with relatively low political voice and limited organized advocacy capacity.

2.2 New Public Governance and the Challenge of Intersectoral Coordination

The new public governance (NPG) framework, as articulated by Osborne (2006, 2010), moves beyond both traditional public administration and new public management to emphasize the plural and pluralist nature of public service delivery—in which networked, multi-actor governance replaces hierarchical or marketized models. NPG is analytically relevant to the Bangladesh context because the governance challenges confronting elderly healthcare are emphatically multi-actor: they involve the Ministry of Health and Family Welfare, the Ministry of Social Welfare, local government bodies, community health workers, NGOs, and informal family caregivers operating across institutional boundaries that are poorly coordinated.

NPG theory predicts that governance failure is particularly likely where inter-organizational boundaries are sharp, where coordination mechanisms are absent or performative, and where no single actor holds sufficient authority to enforce coherent outcomes across the network. Bangladesh's elderly health governance landscape conforms precisely to this diagnosis: the Ministry of Social Welfare holds a National Policy for Older Persons (2013) without health delivery authority; the MoHFW holds health

delivery authority without geriatric policy mandates; and no inter-ministerial coordination mechanism bridges the two. This governance vacuum—a structural feature identified by NPG theory—is a primary mechanism of healthcare access failure for older Bangladeshis.

2.3 Spatial Equity in Healthcare: Beyond Physical Distance

The concept of spatial equity in health access has traditionally been operationalized in terms of geographic distance or travel time to facilities. While these dimensions remain important—and are empirically salient in rural Bangladesh—the theoretical literature has progressively expanded to encompass what Penchansky and Thomas (1981) identified as the multi-dimensional structure of access, including availability, accessibility, accommodation, affordability, and acceptability. In the context of aging populations, this framework requires further extension to account for mobility impairment, cognitive limitations, caregiver dependency, and the gendered dimensions of healthcare-seeking.

From a health geography perspective, spatial inequality is not merely the product of natural geography but the accumulated outcome of policy decisions—decisions about where to locate facilities, how to allocate health workers, what transport infrastructure to prioritize, and which populations to target in health financing schemes. In Bangladesh, these decisions have consistently favored urban constituencies, creating a persistent spatial gradient in the quality and availability of public health services that disadvantages rural older adults in structurally predictable ways.

2.4 Integrating the Frameworks

The argument of this paper is that, such disparities are better understood as a spatial representation of the problems with governance within the healthcare system. These are not accidental outcomes of the country’s underdevelopment but institutionally produced outcomes of specific choices, non-choices, and systemic dysfunctions in the governance of the health sector. This study combines three theories that include governance failure theory (institutional dynamics behind the problem), network and coordination theory (coordination and network aspects of the problem, termed here as NPG), and spatial equity theory (geographical aspect of institutional outcomes). It has important implications for reform: if spatial inequality is governance-produced, then spatial equity cannot be achieved through supply-side facility expansion alone but requires institutional reform—changes in accountability systems, incentive structures, inter-agency coordination, and legislative frameworks.

3. Methodology

3.1 Study Design

This paper uses the systematic scoping review approach as outlined in the five-step methodology initially proposed by Arksey and O'Malley (2005), later specified by Levac et al. (2010), and further clarified by the Joanna Briggs Institute (Peters et al., 2020). This research adheres to the reporting checklist of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses for Scoping Reviews (PRISMA-ScR) guidelines formulated by Tricco et al. (2018). Scoping reviews differ from

systematic reviews in terms of their broader and more flexible approach aimed at mapping evidence, concept identification, and highlighting research gaps, rather than generating effect size estimates by combining findings of homogenous studies. In light of the inter-disciplinary character of research on governance and elderly health access in Bangladesh, the use of a scoping review approach is appropriate and justified (Colquhoun et al., 2014).

3.2 Research Questions

The Population, Concept and Context PCC model was applied to formulate the research question according to the methodology recommended by JBI (Pollock et al., 2021). Population: Adults 60 years and above living in Bangladesh. Concept: governance structures, institutional mechanisms, and spatial patterns related to healthcare access. Context: Bangladesh's public health system, including the tiered facility structure from community clinics to district hospitals, and the administrative geography spanning divisional, district, and upazila levels.

3.3 Search Strategy and Databases

A detailed search process was conducted on six different electronic databases: PubMed/MEDLINE, Scopus, Web of Science, Google Scholar, Bangladesh Journal Online (BanglaJOL), and the Global Health Library Database of the World Health Organization (WHO). Grey literature was found systematically from the following websites: Ministry of Health and Family Welfare (MoHFW) Bangladesh, the World Bank Bangladesh Country Office, United Nations Population Fund (UNFPA), the Asian Development Bank, and WHO South-East Asia Regional Office. For each of these grey literature sources, a publication archive of that particular website was searched using keyword combinations similar to those used in the search for academic databases, and documents collected through grey literature log. Search period extended from 2013 to 2025, covering a time span of twelve years, including both pre- and post-HPNSDP literature, although some relevant foundational literature will be included in spite of being outside the above-mentioned time span.

Keyword selection process was iterative and included the formation of three groups of concepts joined by Boolean Operators: (1) Population: elderly OR older adults OR aged population OR aging OR geriatric; (2) Concept: healthcare access OR health service utilization OR governance failure OR health inequality OR spatial equity OR physician distribution; (3) Context: Bangladesh OR South Asia OR low-income country. Where appropriate, Mesh terms were used. References of all included articles were manually screened for further relevant sources.

3.4 Inclusion and Exclusion Criteria

Peer-reviewed journal articles, government reports, working papers, and international organization reports were eligible for inclusion if they: (1) were published in English or Bengali; (2) addressed healthcare access, health service delivery, or health governance in Bangladesh; (3) included older adults (60+) as a study population or discussed age-related dimensions of access; and (4) contained empirical data or substantive policy analysis. Studies were excluded if they focused exclusively on child health,

maternal health, or communicable disease control without addressing older populations; were published before 2013 (unless foundational methodological works cited for theoretical grounding); or lacked sufficient methodological transparency to permit data extraction.

Among the total 176 articles that were assessed to be included, 118 were eventually excluded from the review. The reasons behind excluding those were as follows: wrong target population (studies that examined health outcomes of non-senior individuals only without age-specific data), n = 47; wrong context (health system-related studies from South Asian countries besides Bangladesh which were not applicable for Bangladesh), n = 29; insufficient methodological information (policy documents which did not have any evident source of evidence or analysis), n = 24; out-of-date articles (articles prior to 2013 that lacked any foundational aspect), n = 11; and duplicative entries, n = 7. The inclusion rate for this study is 6.5%.

3.5 Data Charting and Synthesis

The data were coded based on the following information: study design; geographical coverage of the studies (nationwide, regional, district, upazila); population under study; major findings related to governance and access; policies highlighted by the authors of the papers; and used theories. Thematic synthesis of the data was carried out following the guidelines suggested by Thomas and Harden (2008): line-by-line coding of key findings; identification of descriptive themes; identification of analytical themes. The quality appraisal was not performed since no scoping review has ever been conducted within such framework (Arksey & O'Malley, 2005; Peters et al., 2020). Any methodological notes obtained in the course of data charting have been considered in the context of interpreting the evidence presented in Section 4. A wide range of methodologies are represented in the analyzed body of literature including surveys, interviews, GIS-based analysis, systematic reviews, and policy documents, which implies that peer-reviewed empirical evidence be given more attention than other sources. The detailed selection process for the included studies is presented in Table 1.

Table 1
PRISMA-ScR Flow: Literature Search and Selection Summary

Stage	Action	Result (n)
Identification	Records identified via database searches	n = 847
Identification	Additional records via hand-searching and grey literature	n = 43
Screening	Records screened (title/abstract)	n = 890
Screening	Records excluded (irrelevant topic/population)	n = 714
Eligibility	Full-text articles assessed for eligibility	n = 176
Eligibility	Full-text articles excluded (wrong population n = 47; wrong context n = 29; insufficient transparency n = 24; outside date range n = 11; duplicate n = 7)	n = 118
Included	**Studies included in thematic synthesis**	**n = 58**

4. Findings: Mapping the Evidence Landscape

4.1 The Demographic Transition and Its Institutional Non-Response

The existing reviewed literature provides an empirical foundation that is quite consistent, whereby Bangladesh is witnessing rapid demographic aging on a pattern that was predictable, in one form or another, for a couple of decades already, but no corresponding policy response can be considered adequate or coherent. As far as projections show, the population aged 60 years or older is expected to grow from around 15 million in 2023 to over 43 million by 2050, which means more than tripling the number of elderly within one generation of policies (Akter, 2025; Afrin et al., 2025). This development occurs amidst an increasing prevalence of chronic diseases, including diabetes, high blood pressure, heart disease, and bone/muscle disorders, which require ongoing treatment in most cases (Akter, 2025).

What makes this demographic reality particularly significant from a governance perspective is the near-total absence of institutionalized geriatric care infrastructure. Akter (2025), in a systematic review of elderly care modalities in Bangladesh, found no evidence that any public authority had initiated, evaluated, or scaled a residential or formal home care program for older adults. This institutional absence is not a product of fiscal impossibility—it reflects a governance failure of omission: the collective inability of Bangladesh's health and social welfare ministries to place the needs of older adults onto the policy agenda in any operationally meaningful way.

4.2 Spatial Inequalities in Healthcare Access

4.2.1 Urban–Rural Disparities

Approximately 66% of Bangladesh's population resides in rural areas, where healthcare access is structurally constrained by facility scarcity, poor road infrastructure, and limited transportation options (Hossain et al., 2023). Urban centers—particularly Dhaka—benefit from a significantly higher concentration of secondary and tertiary facilities, specialized personnel, and private sector health providers. Rural residents, including older adults, must travel substantial distances to access even basic curative care at Upazila Health Complexes, which are frequently located in the urban core of each subdistrict rather than in the dispersed rural hinterland where the majority of elderly residents live.

A geospatial analysis carried out by Rahman et al. (2024) assessing the accessibility of healthcare services in Bangladesh reveals that there is a great degree of geographic inaccessibility for tertiary healthcare hospitals in five districts of Bangladesh, moderate geographic inaccessibility in another five districts, and only 19 of the total 64 districts display low geographic inaccessibility. Thus, it is apparent that there are structural obstacles for access to tertiary healthcare faced by a large number of the Bangladeshi population. These issues are more noticeable in relation to senior citizens, as their mobility limitations make distance more of an obstacle than for other population groups.

The following analysis carried out by Rahman et al. (2025) focusing on the spatial accessibility of multi-tier healthcare for senior citizens in Bangladesh supports the claim about scarcity of healthcare facilities in rural settings, requiring people to cover long distances to have access to essential services. It appears that transportation obstacles are always present in the literature on the matter; in particular, it is common for rural areas not to be served by any reliable means of public transportation, while poor road infrastructure and distances to healthcare providers force senior citizens to use informal transport such as rickshaws or even walk to clinics (Rahman et al., 2025; Zafri et al., 2021).

4.2.2 Intra-Urban Inequalities

Even as the rural-urban continuum marks the key form of spatial inequality, it can be argued that there are also important forms of inequalities within cities. Specifically, the elderly population living in poor urban neighborhoods face challenges that are similar, in many ways, to the elderly population living in rural communities, but worsened because of issues such as congestion, poor quality due to overutilization in public institutions, and the prohibitive cost of alternative private facilities. As shown in Hossain et al. (2023), there is inequality in healthcare provision in Bangladesh where socioeconomic stratification leads to exclusion from specialist health facilities for economically vulnerable groups, including older adults with no income source, despite their geographic proximity.

4.2.3 District-Level Resource Maldistribution

The reviewed evidence consistently documents that healthcare resources in Bangladesh are distributed in ways that do not track population need. District hospitals and Upazila Health Complexes (UHCs)—Bangladesh's 421 primary-level public hospitals serving approximately 150 million citizens—face severe resource constraints, including inadequate bed capacity, equipment shortfalls, and medicine supply disruptions (Ahmed et al., 2019). The vacancy rate for doctor posts at rural health facilities is substantially higher than the national average—with 58.5% of doctor-level positions unfilled at rural

health complexes compared to 39.4% nationally (Bashar et al., 2024)—creating a functional absence of physician care precisely where older rural populations are concentrated.

4.3 Governance Failures in Bangladesh's Health System

4.3.1 Physician Absenteeism and Accountability Deficits

The issue of physician absenteeism from public health care facilities is perhaps the most well-documented governance problem in the literature under review. An extensive qualitative study of the factors leading to absenteeism in 51 interviewed medical officers working in 17 UHCs and nine district hospitals identified structural causes such as the lack of surgical instruments, drugs, logistics, and the non-enforcement of discipline (Islam et al., 2024). In a separate study, Bashar et al. (2024) found that although more than 70 percent of surveyed physicians had completed their rural posting periods without being absent, the main causes for physician absenteeism among the remaining 26 percent were training possibilities (65 percent) and family matters (41 percent).

Regulatory attempts to solve the problem of physician absenteeism by installing fingerprinting attendance machines and conducting disciplinary action against violators have proven to be ineffective (Bashar et al., 2024). This ineffectiveness is itself a symptom of the disease because it represents an attempt at solving a political economy issue through purely technical means. The reason why such regulation is unlikely to work is the absence of any motivation for physicians to serve in the rural areas as long as they cannot be financially compensated for their work there or promoted on the basis of this experience. According to Haque et al. (2022), document cases in which politically connected physicians were able to transfer out of rural postings after minimal attendance, with no institutional consequences.

4.3.2 Absence of Geriatric Policy Frameworks

The governance failure most directly relevant to older adults is the systematic absence of age-sensitive policy mandates within Bangladesh's health architecture. Bangladesh has no dedicated Geriatric Health Policy, no national standards for elder care in public facilities, no mandated geriatric training in medical education, and no ring-fenced budget line for elderly health services within the national health sector programme. The National Strategy for Community Health Workers (2019–2030) includes provisions for community health care providers (CHCPs) trained through a 12-week program, but these provisions do not specifically address the needs of older adults with chronic conditions or functional limitations.

Akter (2025) argues that this represents a systemic failure of acknowledgment: Bangladesh has not institutionally recognized the significance of its demographic transition, and consequently has not initiated the policy and programmatic response it demands. This is compounded by the fragmentation of responsibility for older adults across multiple ministries—the MoHFW, the Ministry of Social Welfare, the Department of Social Services, and local government bodies—without any effective coordination mechanism, creating what NPG theory would characterize as an inter-organizational governance vacuum (Osborne, 2010).

4.3.3 Health Workforce Maldistribution

Bangladesh faces a compound health workforce crisis characterized by absolute shortages, geographic maldistribution, and skill-mix misalignment. While the government has implemented policies including mandatory rural service requirements for newly qualified doctors and financial incentives for rural retention, the evidence consistently indicates that these policies have been insufficiently enforced and inadequately resourced. The WHO Human Resources for Health Country Profile for Bangladesh (WHO, 2024) documents a mandatory two-year rural posting requirement under the Transfer and Posting Policy for Health Service Officers, alongside a district quota system for health education designed to promote geographic representation—yet vacancy rates in rural facilities remain persistently high, suggesting an implementation gap rather than a policy design failure.

For older adults, this maldistribution is particularly consequential because the management of chronic conditions—the dominant health burden in this population—requires consistent physician contact over extended periods, which is structurally incompatible with a health system where physician presence at rural facilities is irregular and subject to abrupt disruption.

4.3.4 Collapse of Informal Care Networks

The reviewed literature documents a structural transformation in Bangladesh's informal care economy that has particular implications for older adults. The traditional model of elderly care—in which extended family networks, co-residential arrangements, and community reciprocity provided the primary support system for older persons—is being eroded by urbanization, labor migration, changing household composition patterns, and shifting generational norms (Akter, 2025). As younger family members migrate to urban labor markets or emigrate abroad for work, older adults in rural areas are increasingly left without informal caregivers, rendering them dependent on a formal health system that is institutionally unprepared to accommodate them.

The overlap between the decline of informal care and the ill-preparedness of the formal sector results in a phenomenon referred to as a "care gap," which is a normative and geographical distance between the declining support of care through families and the lack of available institutional options. Qualitative evidence from healthcare-seeking experience studies (Islam et al., 2023) confirms that older Bangladeshis frequently report an inability to pay for health services, an inability to physically reach facilities, and deep uncertainty about where to seek care for chronic conditions—a constellation of barriers that points not merely to poverty but to institutional abandonment.

4.3.5 Out-of-Pocket Expenditure and Financial Barriers

Financial barriers to healthcare access are pervasive among Bangladeshi older adults. Without universal pension coverage or institutionalized health insurance for the elderly, out-of-pocket expenditures represent the dominant mode of healthcare financing for this population group. The reviewed literature documents that many older citizens are unable to pay for health services and are effectively beyond the reach of the formal system, resorting instead to informal drug dispensers, traditional healers, or

untrained village practitioners (Islam et al., 2023). The proximity and informality of pharmacies—which allow medicine purchase without prescription and at any time—make them the de facto primary contact point for a population that cannot navigate the barriers of the formal system (Hossain et al., 2025).

The fiscal governance dimension of this problem is critical. Bangladesh allocates approximately 2.5% of GDP to public health expenditure—well below the 5% threshold recommended by the WHO—and within this constrained envelope, older adults receive no preferential allocation (World Bank, 2023). This financing structure guarantees the perpetuation of both the access barrier and the impoverishing consequences of health-seeking for the elderly.

5. Analytical Discussion: Mechanism, Reproduction, and Institutional Logic

5.1 Governance Failure as a Mechanism of Spatial Inequality Production

The evidence synthesized above supports a specific causal argument: spatial inequality in healthcare access for older Bangladeshis is not primarily the product of natural geographic disadvantage or simple resource scarcity. It is institutionally produced through a set of governance failures that operate through identifiable mechanisms at multiple levels of the public administration hierarchy.

At the central level, the absence of a geriatric health policy framework means that the healthcare needs of older adults are structurally invisible to the planning and budgeting processes of the MoHFW. Without legislated mandates, dedicated budget lines, or performance indicators related to elderly health outcomes, health planning documents treat the aging population as a residual category—one that will ostensibly benefit from general health system strengthening without targeted provision. This is a governance failure by omission: the failure to act in the face of a foreseeable and quantified demographic challenge—precisely the ‘scope deficit’ that Fukuyama (2013) identifies as distinct from, and no less consequential than, institutional capacity failure.

At the meso level—the level of district health administration and Upazila Health Complex management—governance failures take the form of implementation deficits and accountability gaps. Physician absenteeism, drug supply disruptions, equipment shortfalls, and facility understaffing are documented as persistent, institutionally tolerated features of public health service delivery in rural areas. These features are not random—they reflect the predictable outcomes of a patronage-inflected health bureaucracy in which rural postings carry no career benefits and accountability mechanisms are either absent or performative, consistent with the ‘strength deficit’ dimension of Fukuyama’s framework and with Hood’s (1991) characterization of public sector failure under weak incentive structures.

At the local level—the level of community clinics, Union Health and Family Welfare Centres, and local government bodies—governance failures manifest as coordination deficits between formal health

services and social support systems, the absence of outreach mechanisms for mobility-limited older adults, and the non-integration of community health workers into geriatric care pathways. The NPG framework (Osborne, 2010) anticipates precisely this failure mode: in a pluralist governance network without a coordinating authority, boundary-spanning functions—the functions most essential for reaching isolated elderly populations—are systematically underperformed.

5.2 The Spatial Reproduction of Inequality

A key analytical contribution of this review is to demonstrate that spatial inequality in older adult healthcare access is self-reinforcing—it contains mechanisms of its own reproduction. Physician maldistribution leads to overcrowding and service quality degradation at the few functioning urban facilities, which in turn reinforces the perception that public facilities are inadequate and pushes those with financial means toward private providers in urban areas, further concentrating health investment in cities. Rural facilities, starved of patients who have lost confidence in their quality, attract even less political attention and resource allocation, perpetuating their underfunded status.

For older adults specifically, the collapse of informal care networks intersects with this dynamic in a way that amplifies vulnerability. As younger family members migrate to urban areas, older rural residents lose both their informal caregivers and their primary intermediaries with the formal health system—the relatives who would previously have accompanied them to facilities, negotiated with providers, or facilitated referrals. The resulting isolation is not merely social; it is systemic, in the sense that it severs older adults from the practical network resources through which health systems in Bangladesh are actually navigated in practice.

5.3 Comparative LMIC Context: Bangladesh in Regional and Global Perspective

The Bangladesh case is not analytically isolated. Comparable patterns of governance-produced spatial inequality in elderly healthcare are documented across LMICs in South and Southeast Asia. The same situation exists in Nepal, where according to Adhikari et al. (2024), affordability issues, inadequate provision of healthcare facilities for senior citizens, deterioration of family-based care associated with internal migration, and lack of qualified personnel are identified as major obstacles. The structural factors mentioned above are very similar to those found in Bangladesh even though Nepal developed the Geriatric Health Services Strategy much later in time (Ministry of Health and Population, Nepal, 2021). In sub-Saharan Africa, findings from the Ghanaian context reveal that the institutional neglect of elderly healthcare results from the focus on other age groups, while the majority of seniors (70% live in the countryside) face multiple challenges (Older People’s Challenges and Expectations of Healthcare, 2021; Gyasi et al., 2018). WHO (2021) documentation further identifies the institutional invisibility of older adults in national health sector plans as a shared driver of service inaccessibility across LMICs, a diagnosis structurally identical to the Bangladeshi case.

The analytical implication is significant: the governance failures identified in Bangladesh are not country-specific idiosyncrasies but characteristic features of health systems in LMICs undergoing demographic transitions without commensurate institutional adaptation. The framework developed here—treating spatial inequality as the spatial expression of governance failure across levels of the public administration hierarchy—has applicability beyond Bangladesh and constitutes a theoretical contribution to the comparative governance of health systems in aging LMICs.

5.4 The COVID-19 Punctuation: Governance Failure Under Stress

COVID-19 became a stress test of governance capacity and provided evidence of the persistent governance gaps discussed in this paper. One cross-sectional study that examined a group of 1,032 elderly Bangladeshi patients suffering from chronic non-communicable diseases during the pandemic showed that the lockdown led to significant disruptions in accessing routine care for these patients. Most importantly, the study proved the lack of any contingency plans to ensure continuity in providing necessary healthcare services to elderly patients in the event of emergencies. Such results cannot be regarded as a criticism of any attempts at spontaneous problem-solving during the pandemic period but reflect on the insufficient health system of Bangladesh that was unable to protect, activate, or adapt to the emergency situation (Mistry et al., 2021).

5.5 Intersectionality of Disadvantage

The current body of literature indicates consistently that the spatial dimension of health-care access disadvantage is unequally distributed with respect to factors such as gender, socio-economic status, disability, and geographical location. In particular, the problems faced by older women are amplified by a combination of restricted mobility due to patriarchy at home, less participation in wage labor, and having to take care of other household members and oneself when dealing with any health issue. Elderly persons living in haor, char, and hill tract districts face geographically specific difficulties beyond what the general population in rural plain-lands experience—namely, seasonality in access, longer travel distances, and lack of specialized treatment facilities.

This is important analytically in that it suggests that the extent of disadvantage of the most vulnerable groups within the elderly population in rural areas of Bangladesh is understated by aggregated indicators of health-care access. Policies that take into account the needs of the "average" elderly rural person would be inadequate for addressing the situation of the elderly women in chars, the disabled elderly in haors, and ethnic minorities in the Chittagong Hill Tracts.

6. Towards an Equity-Centered Governance Framework for Older Adult Healthcare

The analytical synthesis above generates a set of governance reform directions grounded in the institutional mechanisms of inequality production identified through the review. These are presented as a

sequenced framework for reform prioritization, as outlined in Table 2, organized across three tiers of governance action. The sequencing reflects both political economy logic and institutional dependency: central legislative foundations must precede meso-level accountability reforms, which in turn create the enabling conditions for local-level implementation. Without central mandates, meso-level actors lack the authority to reallocate resources; without meso-level accountability, local-level community workers lack the backing to enforce geriatric care protocols.

A critical caution about political economy is warranted. The reforms proposed here face structural resistance from the actors whose interests they threaten: urban-based physician networks, ministry officials accustomed to planning processes that exclude the elderly, and patronage networks within the health bureaucracy that benefit from the current distribution of posts and resources. Effective reform sequencing must anticipate this resistance and identify coalitions—elderly advocacy organizations, international development partners, subnational government bodies—whose support can provide the political leverage for institutional change. Bangladesh's engagement with international health financing mechanisms, including the Global Fund and World Bank health sector operations, creates external accountability levers that reform advocates can utilize. Sequenced framework for reform prioritization is presented in the Table 2 below.

Table 2

Proposed Governance Reform Framework for Older Adult Healthcare in Bangladesh (Sequenced by Tier and Priority)

Governance Tier	Identified Failure	Proposed Reform Direction	Sequencing Priority
Central (MoHFW)	Absence of geriatric policy mandate	Enact National Geriatric Health Policy with legislated standards	Immediate (enabling foundation)
Central (MoHFW)	No dedicated health financing for elderly	Ring-fence elderly health budget line in HPNSP	Immediate (concurrent with policy enactment)
Central (inter-agency)	Inter-ministry coordination vacuum	Establish Elderly Health Coordination Council (MoHFW, MoSW, LGD)	High (follows policy mandate)
Meso (District/Upazila)	Physician absenteeism and vacancy	Incentivized rural retention with career progression; community accountability boards	High (requires central authority)
Meso (District/Upazila)	Equipment and medicine shortfalls in UHCs	Geriatric drug formulary for UHCs; chronic disease management protocols	Medium (concurrent with workforce reform)
Local (Community)	No outreach for mobility-limited elderly	Geriatric mandates within CHCP roles; home visit protocols for 70+	Medium (requires meso-level backing)
Local (Community)	Collapse of informal care networks	Caregiver support programs; community-based care groups via NGO partnerships	Medium
Cross-cutting	Data invisibility of older adults in health information systems	Age-disaggregated HMIS reporting; geriatric indicators in BDHS	Immediate (data foundation for all tiers)

6.1 Central Governance: Legislative and Policy Foundations

However, the most essential and fundamental reform requirement is the enactment of the National Geriatric Health Policy that will set out the minimum standards for the delivery of elderly health services, integrate geriatrics into the curriculum of both undergraduate medicine and nursing education, and create accountability measures for the delivery of elder health services. Bangladesh already has a National Policy for Older Persons (2013) under the Ministry of Social Welfare, but this policy is social welfare-oriented and does not establish health service delivery standards. A dedicated geriatric health policy under the MoHFW, developed in consultation with the Ministry of Social Welfare, would close this critical governance gap and address the scope deficit identified by Fukuyama's (2013) framework.

Concurrently, the next Health, Population and Nutrition Sector Programme must incorporate spatial equity metrics for older adult access as performance indicators—including age-disaggregated service utilization rates by division and district, physician-to-elderly-population ratios at Upazila level, and catastrophic health expenditure rates among older households. Without these data foundations, accountability for elderly healthcare outcomes remains structurally impossible.

6.2 Meso Governance: Accountability and Workforce Reforms

At the district and upazila level, physician absenteeism requires structural solutions rather than punitive ones. The evidence reviewed suggests that effective rural retention combines financial incentives, career pathway enhancements (rural postings that confer promotion points or research opportunities), housing provision, and locally accountable governance structures. Community accountability boards—including representatives of older adults, local government, and civil society—with the authority to rate and report facility performance represent a potentially powerful accountability mechanism that has been underutilized in Bangladesh's health governance architecture. The political economy risk at this tier is real: accountability boards can be captured by local elites or rendered ineffective through resource starvation. Robust terms of reference, independent reporting channels, and links to central ministry performance management systems are essential design features.

6.3 Local Governance: Community-Level Geriatric Integration

The most proximate governance intervention for mobility-limited older adults is the integration of geriatric care protocols into the existing community health worker (CHW) infrastructure. The CHCPs who are working as part of the community clinic system have a presence in rural areas. However, training of such professionals does not include the concept of reaching out to elderly patients with chronic illnesses. If this task were incorporated into their responsibilities through organized house calls, monitoring the chronic illness in older patients, and referring them to higher centers, it would be a cost-effective and efficient way of overcoming the barriers posed by distance and transportation. This local-level reform depends on meso-level backing—without district health management support, training resources, and referral pathways, CHCP geriatric mandates will remain nominal. The sequencing is therefore critical: community-level reforms are medium rather than immediate priority not because they are less important, but because they are institutionally dependent on the meso-level reforms that precede them.

7. Limitations

Several limitations of this review must be acknowledged. First, the search strategy privileged English-language sources, supplemented by BanglaJOL for Bengali-language materials; sources published in Bengali outside this index may not have been captured. This represents a potential publication bias that may undercount community-level and grey literature evidence from within Bangladesh. Second,

consistent with established scoping review methodology, no formal quality appraisal was conducted on included studies. The heterogeneity of study designs—ranging from cross-sectional surveys and qualitative interviews to geospatial analyses and policy documents—means that findings carry varying levels of evidential weight, which this review has sought to acknowledge contextually rather than through formal scoring.

Third, the grey literature search, while systematic in its approach to major institutional websites, cannot be considered exhaustive. Reports from subnational government bodies, district health offices, and Bangladesh-based NGOs without web-accessible archives may contain relevant evidence not captured by this review. Fourth, the inclusion of a twelve-year search window (2013–2025), while designed to capture the post-HPNSDP policy era, means that the reviewed evidence base does not uniformly reflect conditions in 2025, given variation in publication lags and data collection dates across included studies. Finally, the comparative LMIC discussion in Section 5.3 draws on a selective range of country cases and is intended as illustrative rather than systematic—comparative claims should be interpreted accordingly.

Additionally, this review was not pre-registered in a publicly accessible registry such as PROSPERO prior to commencement, which represents a methodological limitation; the absence of a registered protocol means that deviations from the original search strategy, had any occurred, would not have been transparently documented."

Despite these limitations, the review's disciplinary breadth, systematic search across multiple databases including grey literature, and adherence to PRISMA-ScR reporting standards provide a robust foundation for the findings and analytical framework presented.

8. Conclusion

This systematic scoping review has demonstrated that the healthcare access challenges faced by older adults in Bangladesh are not simply the product of poverty or under-resourced public systems. They are, more precisely, the institutionally produced outcomes of governance failures operating across multiple levels of the public administration hierarchy: the failure of central government to enact age-sensitive health policy; the failure of the health bureaucracy to enforce accountability for service delivery in rural facilities; the failure of inter-ministerial coordination to bridge the gap between social welfare and health policy for older populations; and the failure of the community health system to extend its reach to the most isolated and mobility-constrained elderly citizens.

These governance failures are spatially expressed: they produce a geography of health access deprivation that maps onto Bangladesh's rural–urban divide, its district-level resource gradient, and its sub-district patterns of facility distribution and workforce deployment. This spatial expression is not accidental—it reflects a consistent historical pattern of resource concentration in urban centers and policy inattention to geographically peripheral, politically marginalized constituencies.

The analytical framework developed in this paper—integrating governance failure theory, new public governance, and spatial equity perspectives to treat spatial inequality as the institutionally produced outcome of multi-level governance failure—constitutes a theoretical contribution with implications beyond Bangladesh. In a global context where demographic aging is accelerating in LMICs without commensurate institutional adaptation, the Bangladesh case illustrates what happens when a health system built for a younger population confronts, unmodified, the onset of an aging demographic transition. The governance vacuum that Bangladesh has permitted is structurally likely to be replicated across South and Southeast Asia over the coming two decades.

The sequenced reform framework proposed in this paper is organized around the principle that spatial equity in older adult healthcare cannot be achieved through supply-side facility expansion alone. It requires institutional transformation: new legislative mandates, redesigned accountability systems, reoriented workforce incentive structures, and enhanced inter-agency coordination—organized in a sequence that respects both institutional dependencies and political economy constraints. Bangladesh has the demographic data, the policy capacity, and—with appropriate international partnership—the financial resources to undertake this transformation. What has been lacking is the institutional will to recognize that older citizens represent a governance obligation of the first order.

Future research should prioritize longitudinal, geospatially granular studies of older adult health outcomes at the upazila level; qualitative investigations of the governance and accountability dynamics within UHC management; and comparative analysis of subnational variation in governance performance across Bangladesh's eight divisions. Integration of HDSS (Health and Demographic Surveillance System) data with facility-level administrative records would enable research of a precision and policy relevance not currently achieved in the existing literature.

Declarations

Ethics approval and consent to participate: Not applicable. This study is a systematic scoping review of publicly available published literature and does not involve human participants, human data, or human tissue. The study was conducted in accordance with the principles of the Declaration of Helsinki.

Consent for publication: Not applicable.

Availability of data and materials: All data generated or analysed during this study are included in this published article and its supplementary information files.

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synthesis, and wrote the manuscript. M.S.J. contributed to the spatial analysis framework and reviewed the manuscript for intellectual content. All authors read and approved the final manuscript.

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Conflict of Interest

The author declares no conflict of interest.

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