Implementation Plan for the Bangladesh Health Care Financing Strategy
"Health Protection for All"

As of 16 June 2013

The Health Care Financing Strategy

The Government of Bangladesh adopted a Health Care Financing Strategy (HCFS) that aspires for the universal coverage of all Bangladeshis by the year 2032. The strategy responds to the increasing demand for complex and expensive health care brought about by rising household income and an ageing population. It will ensure maintaining and sustaining the impressive performance of preventive and primary care, particularly for the poor. It expects to reduce high out of pocket health spending and the catastrophic impact of health care spending for many families. It addresses the health financing challenges of inadequate health financing resources, inequity in health financing and utilization, and the inefficient use of existing resources for health.

The HCFS has three strategic objectives of mobilizing more resources for health; improving equity and access to health care services; and enhancing health system efficiency. It argues for increased public resources dedicated to health and for mechanims that would shift inefficient and inequitable private spending for health into efficient and equitable pre-payment and pooling arrangements. It prioritizes financial protection to the poor but aspired for financial protection for the whole population. It builds on the country's commendable efforts on being on track to achieve the Millennnium Development Goals; the rapid expansion of both the government and private health sector; and the growing global consensus for all countries to pursue universal health coverage.

The strategy calls for increasing budgetary allocation for the health sector and the establishment of a social health protection system. With the social health protection system in place, household out of pocket health spending is expected to decrease from 64% to 32% of total health spending. This will be accompanied by institutional and purchasing innovations that would include a shift to payment for output and performance, and improved efficiencies of government health care providers.

The startegy provides for the introduction and implementation of eight comprehensive policy actions namely:

a. Social Health Protection System
b. Increased budgetary allocation for health
c. Health Protection Fund
d. Expanded results-based financing
e. Retention of incentives and other payments by government health facilities
f. Needs/performance-based allocation
g. Strengthening national and local health system capacities
h. Improved financial management and accountability

The eight policy actions are expected to drive the establishment of a social health protection system that covers the poor and vulnerable first followed by the coverage of each and every Bangladeshi in a single risk pool. As it covers everyone, the social health protection system is expected to gain significant purchasing power that will be strategically used for further improving equity and increasing health system efficiencies.

A discussion note was prepared to raise and tackle issues in the HCFS while a rapid health system assessment was conducted to provide guidance in the drafting of the implementation plan for the strategy.

The discussion note generated consensus that increased funding for health should not be limited to increasing the health budget but should include work on generating efficiency gains such as closer linkage between government planning, budgetting and expenditures for health. Other efficiency gains measures are increased efficiency in the procurement, distribution and utilization of medicines and medical equipment; and improved performance delivered by government health workers.

With regards to new financing sources, this could include earmarked taxes and fees and innovative ways to mobilize money from formal sector and migrant workers such as a "percentage fee for the health protection fund" from export earnings and remittances from overseas Bangladeshi workers.

The discussions confirmed the need for an autonomous government agency to drive the implementation of the HCFS. It acknowledged that although there was no explicit benefit package written up in the strategy, this should be determined and agreed soonest. Finally, questions on political will and implementation capacity should be immediately addressed.

Health System Assessment (HSA)

The rapid HSA showed that there had been impressive performance in health service delivery. By 2010, infant mortality rate had been reduced to 36/1,000 while maternal mortality ratio has gone down to 194/100,000. Life expectancy has increased to 67 years. This has been supported by improved health information systems and expanded use of information technology in the health system particularly in the collection and aggregation of routine administrative health data.

The country is capable of fast production of human resources for health which can allow the country to address the current low health workers to poplation ratios. There are 18.2 physicians, 5.8 nurses and 0.8 dentists per 10,000 population in urban area while the corresponding figures are 1.1, 0.8, and 0.08 per 10,000 population respectively in rural areas. However, in addition to the current efforts increasing the production of health workers, there is need for measures and incentives to improve the efficiencies and performance of health workers, particularly government health workers.

The government has an extensive health service delivery network complemented by NGOs health providers and a growing private health sector. There are around 100,000 hospital beds in the country with the private sector providing 52% of the beds. However, most private hospitals are small hospitals with 10 ore less number of beds. Out of the 2,983 registered private hospitals, 80% or 2,376 have 10 or less beds with only 75 hospitals with more than 50 beds. Out of these 75 "big" hospitals, thirty one has more than 250 beds.

More than 40% of the private hospitals are in Dhaka division with the 1,222 private hospitals accounting for half of all the private sector beds (26,242 beds). Khulna and Chittagong divisions have a combined total of approximately a thousand hospitals with each division having around 6,200 hospital bed each. The divisions with the least number of hospitals and beds are Sylhet and Barisal. Sylhet has 105 private hospitals with a total of 1,747 beds and Barisal has 74 private hospitals with 884 beds.

In addition to the hospitals, there are around 4,000 private sector diagnostic centers with Dhaka division having the most number at 2,332. Chittagong division has 1,150 while Khulna and Rajshani have more than 400 centers each. Similarly, the least number of diagnostic centers are in Sylhet and Barisal.

With regards to the government sector, there are 47,130 government hospital beds distributed in specialty hospitals, 22 medical college hospitals, 61 district hospitals, 425 Upazilla health centers and other government health facilities. Most government hospitals have 50 or more hospital beds.

As a general rule, government hospitals have to remit to the central Treasury all revenues as section 7 (1) of the Treasury rules governing district and sub-district accounts states that "All moneys received by or tendered to government servants on the account of the revenues of the Government and all moneys received for deposit in the custody of Government shall without undue delay be paid in full into the Bank and shall be included in the Government Account".

But, the following section (Section 8) of the Treasury rules provides an exception by declaring that if the money received is not considered a revenue, it is not necessary for these money to be included in the government account. A precedent for this type of money is the incentive received by government health care providers in the Demand-Side Financing or DSF project which provides incentives to providers of maternity care services. The DSF incentive are retained and kept by both the government health facility and health staff.

Furthermore, the laws on the Upazila Parishad (sub-district council) and the Zila Parishad (district) councils provide a mechanism for fund management of Upazilla level government hospitals as the councils are allowed to manage funds including incentives that would be received by these government health care facilities.

There are on-going web-based innovations on procurement and distribution which are expected to improve the efficiency of the procurement, distribution and utilization of medicines and medical equipment. They are expected to improve the supply of essential medicines which are defined as drugs addressing the priority health care needs of the population.

Sixty percent of the production of local pharmaceutical manufacturers are mandated to be invested in the production of the drugs listed in the Essential Drug List (EDL) with the price of more than half of the listed drugs controlled by the government.

Unfortunately, despite all these efforts and increasing budgetary allocation for the MoHFW, high out of pocket payments for health services persist and numerous people suffer from financial hardships due to ill-health.

The budget for the MoHFW nearly doubled in the last five years with the actual budget for FY 2008-2009 at 5104 crore takas increasing to 9333 crore takas budgetted for FY 2012 to 2013, but the share of the MoHFW budget to the total government budget decreased from 5.5% in FY 2010-2011 to 4.9% in the current fiscal year.

Although the MoHFW budget did increase 14.5% for the FY 2012-2013 compared to the previous fiscal year, the total government budget increased 17% in the same period. This is was similar to FY 2011-2012 wherein the MoHFW budget increased 12% compared to the previous fiscal year but the total government budget went up by 24%.

Even with the increasing MoHFW budget, household out-of-pocket (OOP) expenditures continue to be the predominant source of financing at 64%. MoHFW accounts for 26% of health spending with external funding through nongovernmental organizations (NGOs) financing 8% of the total health care expenditure. In 2007, all these health spending from private and government sources was estimated to be equivalent to a per capita health spending of 16.2 US dollar per capita, and to 3.4% of the gross domestic product (GDP).

As to the distribution of the MoHFW budget, payment for staff accounted for 51% of the recurrent budget which most of the payment for staff coming out of the non-development or revenue part of the budget. If the budget for capital outlays are added, payment for staff account for 40% of the total recurrent and capital budget. Recurrent expenses account for 79% with capital outlays the other 21% of the total budget.

Table 1. MoHFW budget (in current crore takas)

Fiscal Year	REVENUE	DEVELOPMENT	TOTAL
Budget 2012 to 2013	5508	3825	9333
Revised 2011-2012	5114	3036	8150
Actual 2010-2011	4736	2551	7287
Actual 2009-2010	3803	2468	6271
Actual 2008-2009	3169	1935	5104

Table 2. Percentage increases of MoHFW budget and total government budget

FY	% of total Revenue (R) Budget	% of total Development (D) Budget	% of Total R+D Budget	% increase of MoHFW budget as to prior FY	% increase of Total Government Budget as to prior FY
2012-2013	4.1%	6.8%	4.9%	**14.5%**	**17.20%**
2011-2012	4.4%	6.4%	5.0%	**11.8%**	**23.80%**
2010-2011	5.1%	6.4%	5.5%		

Currently, there is no exisiting government-run health insurance program. In the private sector, 14 insurance companies offer some forms of health insurance products. These private health insurance schemes are mainly group health plan for the office or factory employees covering mostly the cost of hospitalization. Individual voluntary policies are also available, usually as supplemental to other insurance schemes such as life insurance. They would also mainly cover inpatient care.

Micro health insurance (MHI) products had been offered by microfinance NGOs since the late 1990s and early 2000s. Thirteen out of total 36 microfinance NGOs include health insurance but the enrolment has been low. Studies show that most of the schemes experienced high dropout rates and community based health insurance schemes have not been able to contribute in over-all total health expenditure of the country due to a very low coverage.

Fiscal space calculation for the health sector had been calculated for the FY 2008-2009 with the space estimated to range from 2743 crore takas to 8937 crore takas. Given that a critical objective of the health care financing strategy is mobilizing more money for the health sector, a scan of the Bangladesh economy follows.

The Bangladesh Economy

The economy hass been growing significantly with Gross Domestic Product (GDP) sustaining increases from 6.1 to 6.4% in the last three years. The GDP is estimated at 118.7 billon USD with per capita GDP at 923 US dollar per capita. The GDP comes mostly from services (54%) with industry accounting for 28.6% and agriculture contributing 17%.

A key part of the economic growth are the increasing flow of remittance from overseas Bangladeshi workers (OBWs) with the remittance in 2003 at 3.18 billion US dollars increasing to over 14 billion US dollars in 2012. The number of OBWs had increased from 254,190 in 2013 to 875,000 in 2008 before going down to around 600,000 in 2012. Remittance income is the second highest foreign currency income next to export earnings from ready made garments (RMGs). For the FY 2012-2013, export earnings from RMGs is expected to reach 19.3 billion US dollars.

The labor force is estimated at 77 milion by the end of 2012 with 45% employed in the agriculture sector. Industry accounts for 30% of employment ith services at 25%. Unemployment rate has been declared at 5% but an estimated 40% of the working population are considered under-employed with many working only a few hours a week.

The extent of under-employment is supported by data showing that thirty one and a half percent (31.5%) of the population still below the poverty line. Income inequity also persists with the highest income decile earning 27% of total household income while the lowest income decilde earning only 4% of the total household income.

Taxes and other government revenues are estimated to account for 11.8% of the GDP in 2012. The budget deficit is 4.8% of the GDP while the public debt is 32% of GDP. For FY 2012-2013, the main source of tax revenues was Value Added Tax (VAT) expected at 4100 crore takas followed by tax on income and profit estimated at 3530 crore takas. It is interesting to note that collections for tax of tobacco and other similar products or the so-called sin taxes were quite low at 72 crore takas . This is in contrast to taxes on vehicles and revenues for services provided which were both at just over 1000 crore takas.

As for the national budget, the Ministry of Finance recently proposed a budget for FY 2013-2014 that would be 22% higher than the current FY budget. The budget deficit is estimated at 55032 crore takas which will be financed by projected domestic borrowing of 33968 crore takas and overseas credit of 23729 crore takas.

Implementation Scenarios

Based on the health care financing strategy, the rapid health system assessment, and the discussions and agreements triggered by the discussion note; three implementation scenarios are foreseen.

The first scenario is deemed the HIGH-PRIORITY IMPLEMENTATION scenario wherein legislation enacting the Health Care Financing Strategy takes place before the middle of 2014 mandating the immediate implementation of the strategy. This scenario would require a rapid build up of the implementation capacity and capability. However, there would a risk that the failure to build up this capacity and capabilioty coupled with the lack of understanding and support from the public, other MoHFW units and other government offices would lead to a backlash against the strategy. This would be a challenging scenario which may not likely take place.

The second scenario would be the MEDIUM-PRIORITY IMPLEMENTATION scenario wherein immediate legislation can be passed enacting the strategy but the law would allow a three to four period to build up capacity, capability and support before full implementation. An alternative would be deferring the enactment of the legislation until the end of 2015 but with full implementation upon enactment. With the planned full implementation of the law by 2016 in both alternatives, the scenario

will have the MoHFW coming out with decrees implementing the Health Protection Fund for the poor (Health Protection Fund-poor) and the registration of independent health pre-payment schemes in the interim. These MoHFW decrees will provide policy cover, guidance and support for these HCFS innovations.

The scenario which is a coordinated step-wide building up of organization and institiutional capacities and capabilitites will be discussed in detail in the work plan. It would include transitional implementation units organized and operational for at least 3 and a half years, the strengthening of the Health Economics Unit (HEU), and the outsourcing of technical work to Bangladeshi organizations.

The final scenario is the LOW PRIORITY IMPLEMENTATION scenario which assumes delay in the enactment of the necessary legislation compounded by the failure to organize the transitional implementation units and the strengthening of the HEU. In this scenario, the focus would be in the implementation of the health protection funds in pilot sites with possible outsourcing of the implementation of the said fund to private organization/s. We can also expect various pre-payment schemes and efficiency gains interventions independently implemented all over the country.

Implementation Framework and Platforms

In the medium prioity implementation scenario, the proposed implementation framework calls for expanded dissemination among the various stakeholders and the identification of implementation bottlenecks. It proposes the organization of transition implementation units (TIUs) that addresses the bottlenecks, and supports the building up of the necessary capacity and capability to implement and sustain the strategy once the needed legislation are enacted.

Dissemination meetings and forums would be conducted for the various of stakeholders with one set of meetings and forums for “influentials” which would include Members of Parliament, other Ministers, senior staff in other Ministries, business leaders, health care providers, employees’ associations, media and other influentials. The second set of meetings could described as “internal dissemination in the MoHFW” focusing on the officials and staff of the different MoHFW units including the heads and staff of government hospitals.The final set of dissemination would target civil society and the general public. This would also include include division-level assemblies and forums.

Five implementation bottlenecks were identified to hinder the implementation of the strategy. These are the need for:

- **Necessary Legislations and Policies** including financing and budget laws (i.e. added budgetary allocation/mandatory premium payments/ earmarked taxes) and operational policies
- **Coordination** with on-going innovations particularly the Health, Population, Nutrition Sector Development Program (HPNSDP) and demand-side financing (DSF) initiatives
- **Implementation Capacity** for the management of a health protection fund for the whole population with emphasis on the poor; the regulation of health pre-payment schemes in

preparation for the eventual integration into the health protection fund; and the implementation of other demand-driven health system interventions
- **Efficiencies** in the government health care delivery system
- **Public Support** from all stakeholders

Four transition implementation units (TIUs) are proposed to be immediately set up to address the bottlenecks. However, the setting of these units is premised that there is a strengthened Health Economics Unit (HEU) that would support the TIUs. The strengthening of the HEU would require the addition of at least six technical and all necessary administrative staff.

The TIUs will form the core of the formal structures that is expected to be created once the necessary legislation is enacted to fully implement the HCFS. This framework allows the critical capacities, capabilities and expertise to be built up while the strategy is institutionalized in the country. It ensures that the "low lying" policy actions which can be implemented without need of new legislation, such as coordination and efficiency gain measures, can be implemented intensively.

Upon the enactment of the necessary legislations, the different TIUs and the strengthened HEU provide the experience and knowledge to establish the expected legislated formal structures and implementing units. There will be no expectation that the TIUs or their members and the HEU would be guaranteed job positions in the legislated formal units but they are expected to readily step in if they called upon or to guide and assist those who be assigned in those positions.

Table 3. Proposed Implementation Framework

Platform	Transition Implementation Units	Expected Legislated Formal Structures
Necessary Legislations and Policies	HCFS Advisory Council *Supported by Outsourced Policy Development Organization*	Governing Board
Coordination	HCFS Coordination Team	Management Team
Implementation Capacity	HEU- Operations unit HEU- Regulatory unit *Supported by Outsourced Providers of Technical Services including Health Financing, Health Information Systems, and Monitoring and Evaluation Services*	Operations Unit Regulatory Unit
Efficiencies	HCFS Efficiencies Unit *Supported by Outsourced Providers of Management Training*	Health Care Provider Support Unit
Public Support	HFCS Stakeholder Alliance *Supported by Outsourced Marketing Firm*	Marketing and Communications Unit

The **HCFS Advisory Council** will have a broad based representation from members of parliament, other ministers, the business or employer groups, formal sector and informal sector workers, non-government organizations, and physician and hospital associations.

It is recommended that the Advisory Council be chaired by the Health Minister and co-chaired by the Finance Minister. Possible members would include the Minister of Local Government and Rural Development, the Minister of Social Protection, and the Secretary of Health. Government members of the current Health Financing Resource Task Group (HFRTG) may be members of the council. Other members would be representatives from Business/Employers; civil society/NGOs; formal sector employees and informal sector workers; and health care providers (doctors/hospitals). The Director General of the HEU shall be a member of the Advisory Council with the HEU staff acting as the secretariat. Representatives of DPs may sit as observers in the council.

The council is expected to generate consensus and advice on draft legislation and policies, and resolve implementation issues. It shall lead the drafting and advocacy for the enactment of a law institutionalizing the HCFS and will be supported by a government or quasi-government agency which be contracted to help draft the policies and legislation. It is expected to act similar to the role of a governing board of the autonomous government agency that would eventually be created by legislation to oversee the HCFS.

It shall spearhead the enactment of the Health Protection Fund with a single national risk pool composed of a non-contributory scheme for the poor, mandatory scheme for formal sector workers, and contributory scheme (with possible partial government subsidies) for the non-poor informal sector. Initially, the non-poor informal sector are expected to be covered by government-regulated independent health pre-payment funds before they are integrated into the single national risk pool.

Then options that can be considered as the three health financing fiunctions of resource generation, risk pooling and strategic purchasing are presented in Annex A. The decision of the options will be deferred for the Ministry of Health and Family Welfare and the soon to be oragnized HCFS Advisory Council. Hopefully, the options in **Annex A** and all other options per health financing option that may be added would be deliberated soonest and the decisions on each of the three health financing options incorporated in the draft legislation

The future law is expected to establish an autonomous government agency to implement the HCFS and would include provisions granting retention of health protection fund payments to government health facilities as incentives; increased investment in information technology; the registration and regulation of providers of health pre-payment schemes to non-poor informal sector and some formal sector employees; contracting with private/NGO health care providers; and the possible integration of DSF into the NHPS. Other provisions that would be drafted are increased budgetary allocation and laws for new revenue sources to finance the HCFS (preferably earmarked shares from taxes particularly VAT, sin taxes and vehicle taxes; and earmarked fees on remittances of OBWs and

prossibly RMG exports). However, these provisions may be enacted in a separate law or be made part of the national budget law.

With the effective collection of VAT and vehicle tax, the HCFS law can copy how other countries financed their Health Protection Fund or similar funds by earmarking part or a percentage of the VAT or vehicle tax for the implementation of th HCFS. Another approach that can be copied is for increased tax rate for tobacco and other products that may be harmful or the so-called sin products. Earmarks from increased collection of sin taxes can be another financing source. Given that remittance from OBWs and exports from RMGs are the main pillars of the Bangladeshi economy. Fees can be charged for remittances and RMG export sales to help fund the implementation of the HCFS. The fees can also be applied to exports of other products. Finally, given that the public sector debt to GDP has gone down to 32%, there is space for domestic and overseas loans to finance the jump-starting of the HCFS.

The **HCFS coordination team** will be organized to coordinate the implementation of the HCFS with other programs in the health sector. The team will be headed by the DG of the HEU and will ensure coordination with other health innovations. It will support the implementation of the "Health Protection Fund-poor" in 3 sites and the incorporation of the HCFS in the Health Population Nutrition Sector Development Program (HPNSDP) during the mid-term review in September 2014.

The team may include government officials working on the demand side financing; community clinics; urban health; health information technology (IT) and systems; improved drug procurement and distribution; and hospital autonomy and quality of care programs. The experience and lessons from the team would inform the subsequent management team that would be tasked by future legislation to sustain the implementation of the HCFS.

Among these experiences would be lessons on member management (particularly the use of IT-enabled member identification cards), fund management, provider contracting, and purchasing health services from the "Health Protection Fund-poor" implementation. It will bring lessons on contracting and paying provider incentives from the DSF and the Urban Health projects. It will learn from the coordination of the implementation of the HCFS with the community clinic expansion project, DGHS hospital autonomy and automation projects, the drug procurement and logistics portal project and other innovative projects.

There will be a need for a **strengthened HEU** who will build up operations and regulatory capacities while improving the capability to manage outsourced contracts for health financing technical work**.**

Upon the release of the MoHFW decree providing the policy guidance for its pilot implementation, the HEU shall lead the implementation of the "Health Protection Fund-poor" non-contributory scheme with the intention to build capacity on fund management, management of members, contracting with health care providers and purchasing of health services. This would be valuable lessons for the Health Protection Fund as it expands to include the formal sector and the rest of

the population once the necessary legal provisions mandating compulsory membership for the formal sector employees and the rest of the population are enacted.

The HEU shall also implement the regulation of micro-health insurers and other providers of health pre-payment schemes once the MoHFW decree is made. It will eventually integrate the independent health pre-payment schemes into the Health Protection Fund either through volunatary self-payments with possible partial government subsidies of their membership, or by compulsory membership. The final manner of integrating these independent schemes and the rest of the non-poor informal sector in the Health Protection Fund will be based on the lessons of the pilot implementation.

The HEU will be supported by outsourced providers of health financing research and other related research and technical work. Among the providers for consideration are the Institute of Health Economics of Dhaka University to conduct rapid studies in the development of the following: i.) benefit package design; ii.) fund management processes; iii.) member management rule and policies; iv.) contracting with public and private providers; v.) provider payment policies; and vi.) other health financing policies and guidelines.

HEU will also need to work closely with Director General for Health Services (DGHS) Management Information Service (MIS) as they plan the scale up of the automation of the information systems of government hospitals. This would need the possible outsourcing to a local organization the preparation of a HCFS health information enterprise architecture, and the development of health data dictionaries and inter-operability protocols.

Finally, it would be preferable that the MoHFW through the HEU outsource to a research non-government organization the counduct of independent third party monitoring and evaluation of the implementation of the HCFS.

The **HCFS Efficiencies Unit** will be organized to champion interventions that would generate efficiency gains. The unit will be led by the Director General for Health Services (DGHS) or his designate and will focus on intensifying on-going efforts to improve the efficiencies of the government health care providers. These efforts include increased supervision to improve human resources for health (HRH) performance, transparent procurement processes, expansion of DSF, and the implementation of needs-based budget allocation. It will also intensify the application of information technology tools to improve performance reporting by hospitals and other facilities; and the procurement, distribution and utilization of medicines and medical equipment.

It will be supported by an outsourced government or NGO/private training institution/s which will be contracted to develop management training modules. They may also be contracted for the conduct of management training for government and even private health care providers. The conduct of the training may be contracted to the National Institute of Preventive and Social Medicine (NIPSOM).

In order to build public support for the strategy, **HCFS Stakeholder Alliances** shall be launched supported by a private firm that would be contracted to draft and support the implementation of the HCFS marketing and communication plan. This national alliance would be led by the Secretary of Health with the division-level alliances organized under his supervision.

Implementation Steps

July 2013 to December 2013

1. CONDUCT DISSEMINATION FORUMS and MEETINGS
   a. One set for MPs, Ministers, senior staff of Ministries, business and labor sectors, health care providers, media, and other influentials
   b. Internal dissemination to MoHFW officials and staff including heads and staff of government hospitals
   c. Forums and meetings for civil society and the general public including division-level foras and assemblies

2. ORGANIZE the following:
   a. HCFS advisory council
   b. HCFS Implementation team
   c. HCFS Efficiencies Unit
   d. HCFS Stakeholder Alliance with division-level alliances to be organized after the organization of the national alliance

3. CONTRACT OUT the following tasks:
   a. Institute of Health Economics of Dhaka University for rapid studies to assist the development of benefit packages and other health financing policies and guidelines
   b. A NGO or private organization to develop management training courses and possiblt the conduct of these courses to government health facilities and hospitals
   c. A government or quasi-government agency to help draft legislation and policies
   d. A research NGO to do the independent third party monitoring and evaluation
   e. A private firm or NGO to develop and support the implementation of a marketing plan

January 2014 to December 2014

1. HCFS incorporated in the HPNSDP after the mid-term review in September 2014

2. MoHFW DECREE for the registration of all organizations independently providing health pre-payment schemes by June 2014. This would include requirements for the sharing of databases and consensus on the benefit packages. The HEU shall implement this decree.

3. MoHFW DECREE for the implementation followed by the implementation of the "Health Protection Fund-poor" by June 2014

4. STRENGTHEN the HEU by recruiting of at least six technical staff and the necessary administrative support staff by July 2014. In addition to the technical staff, HEU shall recruit at least eighteen (18) operations staff who will man the "Health Protection Fund-poor" central operations unit and field operations unit by July 2014.

January 2015 to December 2015

1. Draft legislation (as described above) crafted and submitted for enactment

2. Assuming the legislation/s had been enacted during 2015, initiate the following:
    a. Organize the new autonomous agency tasked to oversee the implementation of the HCFS.
    b. Launch of the mandatory "Health Protection Fund-formal sector" scheme by the middle of 2015
    c. Build on the formal registration and regulation of the independent health pre-payment schemes for the their eventual integration into the Health Protection Fund
    d. Expand the "Health Protection Fund-poor" upon allocation of government subsidies for additional poor families

January 2016- December 2018 (3 years)

1. Expand the Health Protection Fund now a single fund of the formal sector, the poor (with increasing government budgetary allocation for the poor), and the non-poor informal sector

2. Expand the autonomous government agency but continue the outsourcing of technical services

3. Sustained implementation of the activities enacted by the laws implementing the HCFS

4. Intensified monitoring and evaluation (M and E)

January 2019- December 2019

- Review of the HCFS legislation and draft and advocate all necessary amendments
- Among the decision whether there will be the final decision on how to implement the single risk pool. Shall it be MANDATORY for all people to be members of the Health Protection Fund?

The Work Plan

The attached work plan (**Annex B**) is prepared until the end of 2016. For 2013, the remaing six months are broken down into quarter. For 2014, it is broken down into semestral periods while 2015 and 2016 have annual periods.

The plan are organized in the five implementation platforms with indicative lead MoHPW and other government offices for each activity identified in the workplan. The operational plan or component of the operational plan expected to fund the activity are identified in the work plan.

The Health Economics and Financing (HEF) office of the HEU is the lead office for most activities with the Gender, NGO, Stakeholder and Partnership (GNSP) office of the HEU expected to take care of Public Support implementation platform. The office of the Director General for Health Services (DGHS) is expected to spearhead the work in efficiency gains.

The Operational Plan of the HEU is the main funding line for the initial implementation of the stratey. An estimated 3.78 crore takas are proposed to be added to the "Research" line items of both offices of the HEU (HEF and GNSP). This amount is expected to primarily fund the contracting out of the health financing technical work to local organizations and firms. Most of the work and associated funding are needed in July to December 2013 in order for the immediate start of the necessary technical work. Draft terms of reference are attached to facilitate this activities.

Another line item in the HEU OP that would need augmentation is the "Staffing" line item and the associated running costs and capital expenses related to the increased staffing. The strengthening of the HEU would need increased staffing and an estimated 3.51 crore takas are needed up to the end of CY 2016 with the hiring of additional staff proposed to start by early 2014.

The third line item in the HEU OP that would need additional funding is the "Dissemination" line item of HEF and GNSP. An estimated 396 crore Takas are needed until the end of CY 2016 to mostly cover the cost of generating public support among the general public. The dissemination will be primarily led by the GNSP office as they spearhead the organizing of national and division level HCFS workshops and assemblies. The HEF will be tasked to support the forums/meetings for the influentials and the internal MoHFW disseminations. It will also support the organizational meetings of the Advisory Council, Coordination Team, and Efficiencies Unit.

In addition to the HEU OPs, there were non-HEU OPs and new OPs which were identified. These include the possible augmentation to the OP of NIPSOM of at least 3 crore takas if it will be assigned the conduct of management trainings for government hospitals and health faciltiies.

The MoHPW OPs that would need augmentation to support the implementation of the different activities of the health care financing strategy are as follows:

1. OP1 (Maternal Newborn Child and Adolescent Health or MNCAH) for the expansion of the Demand Side Financing or DSF. In the HPNSDP, it has five year budget of 830 lakh takas from the government (GoB) and 42430 lakh takas from the pooled donor commitments (RPA).

Any proposed increased allocation will be based on the decision of how many more health care providers would be added to the DSF scheme.

2. OP9 (Hospitals) for the expansion of the grant of management of hospital autonomy to more government hospitals. Currently, three hospitals are targetted annually for the grant of autonomy. A rapid scale up of the grant of autonomy would need additional funding to the current five year budget of 746 lakh takas. Additional funding should also be provided to the work that would drive improved quality of care such as accreditation (currently with five year budget of 319 lakh takas), referral systems (454 lakh takas), total quality management or TQM (267 lakh takas) and hospital quality assurance or QA (1783 lakh takas). At the minimum, this would need an additional 3000 lakh takas for all the above activities from 2014 to 2016 to support the increase of the number of hospitals that would be granted autonomy and the expansion of the accrediation, TQM, hospital QA and referral innovations.

3. OP13 (Planning) for the implementation of improved planning and its linkage to coordination and expenditures. The would require additional funding of at least 300 lakh takas for the current five year budget of 619 lakh takas for this OP to support training, dissemination and supervision.

4. OP14 (Health Information System and e-Health) for further acceleration of the e-Health interventions, the preparation of an information technology enterprise architecture for the health care financing strategy, and the drafting of health data dictionaries and connetivity policies. In the HPNSDP, the GoB has budgeted 19690 lakh takas with pooled donor commitment at 22840 lakk takas and direct donor commitment at 17900 lakh takas. Although this OP would require substantial additional funding, it is critical that the current programmed allocation is actually provided and that the planned inputs are provided to the hospitals and the health centers.

5. OP16 (Procurement and Logistics) for improving the procurement, distribution and utilization of medicines. The current five year HPNSDP budget totals 41974 lakh takas. The amoung needed for the augmentation of this OP would depend on the speed of the deployment of the web portal (which is currently being developed) all over the country.

6. Other OPs that would be augmented are OP 29 detailing the Human Resource management activities and OP 31 describing the activities to improve Financial Management.

7. An OP that would support the implementation but would need no augmentation is OP on Sector wide Program Monitoring and Management (OP30). The health care financing strategy would be prioritized in the areas that would be covered in the annual program reviews, the 2014 mid-term review, meetings and seminars, and technical assistance.

In addition to these OPs, new operational plans would be needed for the implementation of the strategy. The two main OPs would be the subsidies for the poor in the health protection fund, and the

costs for organizing and operating the new autonomous agency that would run the health protection fund. If the decision is to subsidize all the families below the poverty line with an annual "premium costs" estimated for the Health Protection Fund-poor at 1000 takas per family per year is adopted, the annual subsidy costs would be 960 crore takas.

The possible activities that the autonomous agency are expected to implement are enumerated in **Annex C** in a table based on the Rajkotia-Sato framework. In addition to the activities, the table also proposes the offices, units or partners that would be needed to implement the identified activites. The activities are grouped into governance activities, the day to day operations, the purchasing administration which would include the contracting with health care providers and the payment of coverered health care services, and the product development and utilization work focused on on designing and updating the benefits and payment methods based on the needs and utilization of the covered population. The costs related these activities would include staffing costs, capital expenses for offices and information systems, and the running costs.

The costs for starting up and operating of the autonomous agency (the administrative costs) would range from 8 to 10% of the annual transfers and payments total health protection fund including the government subsidy for the poor. However, an initial fund transfer equivalent to an one year requirement (based on the planned covered population) would be needed to kick off the health protection fund before it can begin to generate its own funds from the collections from the formal sector and the subsequent government subsidy payments for the poor.

The initial transfer can be calculated with an assumed coverage of all poor and the formal sector families. With this assumption, the initial outlay is etimated at 1500 crore takas. The new autonomous agency may then be allowed to use an 15% of the allocation as the start up cost with the remaining 85% allocated for the payment of services. As the agency begins to collect the compulsory payments from the formal sector and the government subsidies for the poor, it will now be limited to use 8% to 10% of the collected funds for its operating expenses including staffing costs.

With regards to possible collections, if we assume the same premium costs of 1000 takas per family per year for the rest of the population, the expected premium collection for the formal sector would 537 crore takas while the rest of the informal sector which is above the poverty line is expected to pay around 1900 crore takas.

Table 4. Preliminary calculation of the indicative annual collections at full population coverage

	Population	Estimated Family Size	Families	Estimated Collection @ an annual premium of 1000 takas/family
Below Poverty Line (BPL)	48,000,000	5	9,600,000	960 crore takas
Informal (Above the Poverty Line or APL)	85,700,000	4.5	19,044,444	1904 crore takas
Formal	18,800,000	3.5	5,371,429	537 crore takas

Possible Sources of Funding

Possible sources of funding were identified for the OPs needed to move ahead with the Health Care Financing strategy.

For the HEU "Research" line item, the contracting out of the technical work including the contracting out of local organizations and firms to conduct health financing research, the health care financing strategy monitoring and evaluation, the development of health management modules; and the development of th marketing plan for the strategy can be sourced from the joint technical assistance (TA) fund of the HPNSDP. Similarly, the contracting of individual consultants who will support the strengthening of these firms can also be funded by the joint TA fund.

The contracting of consultants for the annual program reviews and 2014 mid-term review of the HPNSDP can be funded by the development partners (DPs).

For the augmentation of the HEU dissemination line item, the current budget can be augmented with re-allocations from other OPs. The dissemination activities can also be supported by funding from the DPs.

The augmentation of the HEU budget items for staffing and the related capital and running costs would need re-allocations to the HEU OP's on staffing, capital and running costs by CY 2014. This augmentation would have to be sustained in subsequent government budgets.

An option that can be explored for funding the strengthening of the HEU would be DP providing direct funding grants to the HEU which will then use these grants to hire the additional staff as contractuals or job-order contractors. The HEU would avoid bringing in additional staff as directly hired staff by DPs.

As to the health protection fund, the formal sector is expected to pay the compulsory contributions while the non-poor informal sector may initiall voluntary self paytheir contributions to the fund before they are eventually expected to do mandatory self-payments.

The government subsidies for the poor or BPL which is estimated at 960 crore takas a year (at 1000 takas a year per BPL family) can be potentially funded by increased budgetary allocation for the health sector in the general budget. It can also be funded by earmarked shares from sin taxes, vehicle taxes and the value-added tax (VAT). Other potenial sources are "health protection fund charges" on remittances from overseas Bangadeshi workers and other specific "health protection fund charges and fees" on mobile phones, export sales and others. Another option is securing a loan/s or a combination of loans and grants from development partners to initially finance or partially finance the health protection fund provided there is a government commitment to assume the financing of the subsidies once the loans or grants have ended.

Timelines

	7/13 to 9/13	10/13 to 12/13	1/14 to 6/14	7/14 to 12/14	1/15 to 12/15	1/16 to 12/16
DISSEMINATION to three sets of audiences • infliuentials • internal disseminaton to MoHFW units • civil society and general public						
ORGANIZE • HCFS Advisory Council • HCFS Coordination Team • HCFS Efficiencies Unit • HCFS Stakeholder Alliance						
CONTRACT OUT the following: • Health financing research including benefits coverage and levels; and provider contracting and payment methods • Development of management training modules and the conduct of management training (including financial management) of government health facilities • Independent monitoring and evaluation • Development and implementation of marketing plan • Policy research and the drafting of legislation, policies and guidelines						
MoHFW DECREES on: • pilot implementation of the Health Protection Fund-poor • registration of pre-payment providers for informal sector for HEU to implement						
Implementation of the contracted technical work						
STRENGTHEN HEU including the setting up of the Health Protection Fund central/field operations cells						
Health Protection Fund central operations unit and field operations unit established						
HCFS incorporated into the HPNSDP						
Draft legislation/s drafted and submitted						
Legislation/s passed to: • ORGANIZE autonomous government agency • LAUNCH "Health Protection Fund" with both formal sector, the poor and eventually the non-poor informal sector in a single national risk pool • INITIATE compulsory regulation of informal sector providers of pre-payment schemes						
REVIEW of the National Health Protection System and possible amendments of law						2018