Draft Implementation Plan for the Health Care Financing Strategy
As of 7 May 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. It has three strategic objectives of more resources for health; improved equity and access to health care services; and enhanced health system efficiency.

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 include a shift to payment for output and performance, and improved efficiencies of government health care providers.

The objectives shall be attained with the introduction and implementation of 8 policy actions namely:

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

The 8 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 which can be strategically used for further improving equity and increasing health system efficiencies.

Last month, a HCFS discussion note was prepared to raise and tackle issues while a rapid health system assessment was conducted to provide guidance in the drafting of the implementation plan for the strategy. The initial findings of the rapid HSA showed that there had been impressive performance in health service delivery with an improving health information system and expanding use of information technology in the health system. There are on-going innovations in medicine procurement and distribution which are expected to make medicines more accessible. Such innovations are needed in improving the efficiency of the procurement, distribution and utilization of medical equipment. The

country is capable of fast production of human resources for health but measures and incentives are needed to improve the efficiencies and performance of health workers. NGOs working in the health sector and a growing private health sector have and will continue to help expand access to health care services. Despite all these, high out of pocket payments for health services persist and numerous people suffer from financial hardships due to ill-health. The centralized government health system can simplify the implementation of the envisioned HCFS policy actions but can also deter policy changes such as increased management accountability and autonomy of government health care facilities.

The discussions triggered by the note came to a consensus that increased financing for health should come from increased budgetary allocation, new financing sources, and efficiency gains. New financing could include earmarked taxes and fees and innovative ways to generate money from formal sector and migrant workers such as a "percentage fee for health protection fund" from export earnings and remittances from overseas migrant workers. The discussion confirmed the need for an autonomous government agency to drive the implementation of the HCFS. It acknowledged that although no explicit benefit package was written in the strategy, this should be determined and agreed soonest. Finally, questions on political will and implementation capacity should be immediately addressed.

Implementation Framework and Platforms

Based on the health care financing strategy, the rapid health system assessment, and the discussions; the proposed implementation framework identifies the bottlenecks, creates transition implementation units (TIUs) that addresses the bottlenecks, and builds the up necessary capacity and capability to implement and sustain the strategy once the needed legislation are enacted.

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 HPNSDP and demand-side financing (DSF)
- **Implementation Capacity** for the management of a health protection fund for the formal sector and the poor; the regulation of health pre-payment schemes for the non-poor informal sector and the implementation of other demand-driven health system interventions
- **Efficiencies** in the government health care delivery system
- **Public Support** from all stakeholders

Five transition implementation units 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 be the core of a TIU and help oversee the other TIUs. The

strengthening of the HEU would require the addition of at least 10 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 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 would be guaranteed taking over the legislated formal units but they are expected to be readily step in if called upon or to guide and assist those who be assigned later.

The proposed implementation framework will be as follows:

Platform	TIU	Expected Legislated Formal Structures
Necessary Legislations and Policies	HCFS Advisory Council *Supported by Outsourced Policy Development Organization*	Governing Board
Coordination	HCFS Implementation Team	Management Team
Implementation Capacity	HEU- SSK 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	Marketing and Communications Unit

The **HCFS Advisory Council** can be built up from the current Health Financing Resource Task Group with representatives from other ministries, the business or employer groups, formal sector and informal sector workers, non-government organizations, and physician and hospital associations joining the council. The Advisory Council will be chaired by the Health Minister and co-chaired by the Finance Minister. The HEU shall continue to be the secretariat while the DPs shall be observers to the council.

The council shall resolve implementation issues and shall lead the drafting and advocacy for the enactment of a law institutionalizing the HCFS. It 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 National Health Protection System (NHPS) with a single national risk pool composed of a pooled fund of non-contributory scheme for the poor pooled and mandatory scheme for formal sector workers, and a regulated multiple pre-payment funds for the non-poor informal sector. This future law is expected to establish an autonomous government agency to implement the HCFS and would include provisions granting user fee retention of government health facilities; increased investment in information technology; the registration and regulation of providers of pre-payment schemes to non-poor informal sector; contracting with private/NGO health care providers; and the possible Integration of DSF into the NHPS. Other proposed laws that would be drafted are increased budgetary allocation and laws for new revenue sources to finance the HCFS (preferably earmarked taxes and fees).

The **HCFS implementation team** will be organised 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 also support the implementation of the "SSK-poor" in 3 sites and the incorporation of the HCFS in the 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 IT expansion; improved drug procurement and distribution; and hospital improvements. 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 ID cards), fund management, provider contracting, and purchasing health services from the SSK implementation. It will bring lessons from the DSF and the Urban Health projects to the implementation of the HCFS. It will learn from the coordination of the implementation of the HCFS with the expansion of the community clinics, DGHS hospital automation project, the drug procurement and logistics portal project and other innovative projects.

The third TIU would be a **strengthened HEU** which will build up operations and regulatory capacities while improving its capability to manage outsourcing contracts**.**

HEU shall lead the implementation of the "SSK-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 as the SSK is expanded to include the formal sector once the necessary laws mandating compulsory membership for the formal sector employees into the SSK.

With regards to the non-poor informal sector, it shall implement the regulation of micro-health insurers and other providers of pre-payment schemes to the non-poor informal sector once the MoHFW decree is made.

The HEU will be supported by outsourced providers of technical and other services. Among them would the Institute of Health Economics of Dhaka University which shall be contracted to do rapid studies and assist 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 work closely with DGHS MIS to rapidly scale up the automation of the information systems of government hospitals including data dictionaries and inter-operability protocols. It will outsource to a research NGO the independent third party monitoring and evaluation of the implementation of the HCFS.

The **HCFS Efficiencies Unit** will be organized to champion of interventions that would generate efficiency gains. The unit will be led by the DGHS or his designate and will focus on intensifying on-going efforts to improve the efficiencies of the government health care providers including increased supervision to improve HRH performance, transparent procurement processes, expansion of DSF, and the implementation of needs-based budget allocation. It will also intensify the implementation 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 conduct management training for government and private health care providers.

In order to build public support for the strategy, a **HCFS Stakeholder Alliance** 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 alliance would be led by the Secretary of Health.

Implementation Steps

July 2013 to December 2013

1. ORGANIZE the following:
    a. **HCFS advisory council** to generate national consensus and advice on draft legislation and policies. It is proposed that this would be chaired by the Minister of Health and co-chaired by the Ministry of Finance. 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 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 DG-HEU shall be a member with the HEU acting as the secretariat while representatives of DPs may sit as observers.

b. HCFS Implementation team

c. HCFS Efficiencies Unit

d. HCFS Stakeholder Alliance

2. STRENGTHEN the HEU by recruiting of at least ten technical staff. In addition to the technical staff, HEU shall recruit at least 20 operations staff who will man the SSK central operations unit and the SSK field operations unit.

3. DECREE for the registration of all organizations providing pre-payment schemes to the non-poor informal sector from the MoHFW. This would include requirements for the sharing of databases and consensus on the benefit packages. The HEU shall implement this decree.

4. 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 government agency and/or NGO/private organization to develop management training courses and 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/NGO to develop and support the implementation of a marketing plan

January 2014 to December 2014

1. Draft legislation submitted for possible enactment before the end of 2014
2. HCFS incorporated in the HPNSDP after the mid-term review in September 2014
3. Launch "SSK-poor" scheme implementation by June 2014
4. Assuming the legislations had been enacted
   a. Organize the new autonomous agency tasked to oversee the implementation of the HCFS.
   b. Launch of the mandatory "SSK-formal sector" scheme by October 2014
   c. Establish formal registration and regulation of the informal sector schemes

January 2015- December 2018 (4 years)

1. Expand the SSK now a single fund of the formal sector and the poor (with increasing government budgetary allocation for the poor)
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 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 a "single fund" for ALL or shall it maintain the single fund for the poor and the formal sector while allowing the non-poor informal sector to become members of government-registered pre-payment schemes?

DRAFT TIMELINE

	7/13 to 12/13	1/14 to 12/14	1/15 to 12/18	1/19 to 12/19
ORGANIZE - HCFS Advisory Council - HCFS Implementation Team - HCFS Efficiencies Unit - HCFS Stakeholder Alliance				
STRENGTHEN HEU including the setting up of the SSK central and field operations cells				
DECREE from the MoHPW on the registration of pre-payment providers for informal sector for HEU to implement				
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				
SSK central operations unit and SSK field operations unit established				
Draft legislations drafted and submitted				
HCFS incorporated into the HPNSDP				
LAUNCH "SSK-poor" scheme				
Assuming the necessary laws are passed: • ORGANIZE autonomous government agency • LAUNCH "SSK-formal sector" scheme • INITIATE compulsory regulation of informal sector providers of pre-payment schemes				
EXPANSION				
REVIEW of the National Health Protection System and possible amendments of law				