MINUTES OF MEETING

HEALTH FINANCING DEVELOPMENT PARTNERS
WHO Conference Room
24 November 2013, 01:30-04:30 PM

0	**Agenda**	
		• Introduction and welcoming of new participants by Dr. Katayama • Presentation Update on SSK • Presentation Update on RMG • Technical Discussion on Resource Generation • AOB
1		**Introduction**
		Dr. Katayama from WHO chaired the meeting and welcomed all the development partners to the technical session on resource generation and updates on SHP schemes. The meeting was organized to discuss on key issues of health financing design in relation to Bangladesh context; to provide an update on SSK scheme; and on the development of RMG pilot scheme.
2		**SSK Update**
	Presentation	Ms. Lisa Steinacher, KfW Director for Special Programmes Health, presented the updates on SSK. She informed the group that the German Development Cooperation supported the HEU in the development of SSK concept and that there is remarkable ownership of the project. The DPs were also involved during the development through several discussions but there are some reservation and issues on the design of the scheme. Anyhow, SSK will be the first pilot to provide coverage for the poor, within the HCFS goals and objectives. Specifically, the objectives of SSK are: (1) Testing structural elements of a SHP scheme and allowing MOHFW/HEU gain experience in implementation; (2) Some direct improvement for the poor in the pilot upazilas. Thus, it is more of a system building approach. Mid-term review will be conducted by a research institute after two years of implementation, then fine-tune and adapt for the remaining 2 years. The design of the scheme will be modified based on the experience prior to scaling up coverage. The next steps will be to make the funds available by June 2014 and to provide technical support to HEU by recruiting an implementation consultant before June 2014.
	Discussion and Comments	After the presentation, there was an active discussion of the following key issues : 1. **Ownership of the scheme** – in view of the approaching election and possible change in government, who owns the scheme? Is there a need

	to do something about it (AusAID). The KfW representatives suggested to wait for the results of the election. Commitment of the HEU DG is remarkable but there is a need for a broader engagement/ buy-in of other departments and ministries in the process, especially with the social protection group and finance ministry(DFATD) Consider as well the position of the MOHFW on SSK implementation and the pressure to HEU. With the on-going discussions and issues surrounding it, there is some sensitivity on the issue. 2. **Need for Monitoring and Evaluation** -With the pilot implementation, the need for an evaluation of the scheme based on its objectives is highlighted (WB). While the scheme is intended to build capacity on HF implementation, it is expected that it will have a modest impact in OOP reduction (KfW). We cannot lose more time, initiate the implementation, monitor closely and evaluate the results (EU) A rigorous M&E design with a baseline is necessary and will be highly appreciated if shared with the development partners (USAID) 3. **Target Population** -The pilot is usually called a health insurance for the poor – why? This is because of government's commitment to prioritize the poor population. Similarly, KfW's priority is to promote equity and target their support to poor population. But as the pilot takes a system building approach, it is aimed at evolving a national health insurance scheme for the whole population(KfW) Propose to consider the near poor population as well as this group will be high risk of being pushed down into poverty with catastrophic health expenditures (AusAID) 4. **Sustainability** – How to ensure sustainability and duration of KfW support? (JICA). The funding will be 8million Euros for 4 years covering 3 Upazilas in 1 district. What is the expectation of HEU in terms of rolling-out the scheme and the role of donors? (USAID) The basis of the scheme is the HCFS which is endorsed by stakeholders. The role of DPs should be anchored on the strategy (KfW) 5. **Availability of Service Providers** – mapping of health service providers and utilization rate of hospitals in pilot sites need to be undertaken (USAID) – This was already conducted and will be closely monitored during implementation(KfW) 6. **SSK Design** – We need to keep the momentum going and comments from donors are welcomed – when is the deadline? (SIDA).

		The HCFS is a visionary document and needs to be translated into concrete implementation. Options and choices on the design need to be carefully assessed and discussed broadly beyond HEU (WB) Recommendations on the design of the scheme may be accommodated by HEU as previously communicated by the DG (KfW) The Chair summarized the issues discussed, the agreements and next steps.
	Action points	1. Communicate to HEU the key issues discussed and convey the suggestion for broader discussion on HF and take necessary measures for greater buy-in of key stakeholders on HCFS implementation. 2. Move forward on technical issues: -Circulate the SSK Concept Note to all HF DPs (KfW) - DPs to provide feedback and comments on the concept note of SSK and send to Dr. Olivia for consolidation before end of January 2014 3. Share the studies conducted on SSK as soon as possible (Lisa) 4. Develop M&E design/ baseline assessment for the pilot and share with DPs – between now and June 2014 (HEU/KfW) 5. Clarify the expectations/position of HEU on how to sustain the funding after pilot implementation (KfW)
3		**Updates on Ready Made Garment(RMG) Scheme design**
	Presentation	Mr. Roland Panea, from GIZ Headquarters, is currently on a 2-week mission to propose some options and design for the pilot SHP scheme for the garment sector. He presented the proposed Health and Welfare Fund (HWF) and assumptions on design features; base scenario simulation and results based on data available. The HEU specifically requested for estimates on premium and benefits. The goal of having a single fund pool (Bangladesh Central Health Fund) in the long run was highlighted. However, at the initial stage a Health and Welfare Fund for RMG was proposed in the design. Moreover, 10 basic design elements assumptions were identified: 1. Comprehensive benefits 2. Family coverage 3. Freedom of Choice for providers 4. Standard benefits-identical benefits for RMG and comparable with population 5. Contribution based on ability to pay 6. Contribution split 50-50 between employer and employee 7. Compulsory enrollment- no opting out 8. Retention of reimbursement rates in health facilities 9. Collective negotiation on reimbursement of health services 10. Cashless insurance- settlement directly by insurer

		There are also some constraints which need to be considered in the interpretation of the model results such as : Lack of population-wide micro data, in particular with regards to utilization rates, Lack of country-wide health facility cost data, No reliable sample data from private (for-profit) health facilities, Lack of disaggregated pharmaceutical cost data, Challenges in computing economically homogenous cases (DRGs), Risk of underestimating utilization rate due to financial barriers Using the model, the results showed an average contribution of employee per month at BDT 454, translating to 7.57% of monthly income. This will be shared by the employer at 50% so that each will pay an average of BDT 227 per month.
	Discussion & Comments	Clarifications and comments after the presentation: Consider current initiatives on health insurance and consultation with factory owners on the benefits and proposed premium. Management cost at 8% is quite high (USAID) Did you conduct a willingness to pay study on the garment sector ?(SIDA) No study available but was asked during the FGD – on average, workers are willing to pay 450BDT per family of 5 per month (about 7.5% of income) (GIZ) Who will provide the services – public or private? Suggested to learn from the pilot on how to address health system issues to improve coverage (UNICEF)The intention is to have both private and public as health care providers but the main determinant is good quality of health services (GIZ) Willingness to pay of members into a scheme depends also on the quality of services they get as shown by the Sweden experience (SIDA) Financial coverage and access is mutually reinforcing quality of care (EU) Suggest to use the Household Income and Expenditure Survey results (WB) How to address the issue of leakage in fund use in the proposed model? (JICA) The scheme should have a regulatory framework and strong independent organization as purchaser. How confident are you in getting sufficient enrolment from the sector? (WB) We can hope for a snowball effect but it is a real challenge because we cannot make it compulsory for now. A legislative framework and strong partnership are critical in this aspect(GIZ) Linking with the discussion on RMG sector, what do development partners think about the current approach of having several schemes (SSK, RMG and civil servants) as a starting point? Fragmentation of schemes is not consistent with the proposed single pooled fund vision shown earlier (WHO) Fragmentation will cause a lot of problems as shown by country experiences but Bangladesh need to learn and adapt what is feasible in the country (JICA)

4		The ideal is a single fund but the issue is how to start, and starting big and comprehensive is difficult. The risk of fragmentation is always there but we need to start somewhere. We should always consider the goal of having a single fund and minimize fragmentation but we need to show concrete results at the same time. (WB, DFATD, EU) Another issue that needs to be discussed is donor-driven fragmentation (USAID) Legal and regulatory framework is necessary to address fragmentation. Take for example the case of Ghana where multiple district mutuelles are linked with the NHIS (AusAID)
	Action Points	1. Share data and information with GIZ to increase the accuracy of results from the calculation model (DPs) 2. Continue the good practice of having technical discussion on HF elements with DPs but also with the government (WHO) 3. Development of the design of RMG need to be aligned with the principles of HCFS and with the results of consultation with HEU and key stakeholders (GIZ)
4		**Technical Inputs on Resource Generation /Closing Remarks**
		The Chair inquired from the group on their preference for the discussion of issues related to Resource Generation. The group unanimously agreed to have the presentation for the next DP Meeting. Nevertheless, an introduction on the rationale and format of discussion was provided by WHO. Everyone is encouraged to go through the draft presentation – validate the issues and propose for evidence/ materials if necessary. The series of sessions is meant to inform and generate consensus on the necessary elements of the HF system to meet the goals of UHC in Bangladesh. The participants appreciated the initiative of WHO to provide a platform for technical discussion on health financing. The Chair thanked all DPs for their active participation. Jackie Mahon of WB will complete her assignment and will leave Bangladesh in December 2013.
	Action Points	Minutes of Meeting, presentations and the schedule of next meeting will be communicated by email (WHO)

PARTICIPANTS

24 November HF DP Meeting, WHO Conference Room

	NAME	ORGANIZATION
1	Jan Borg	AusAID
2	Momena Khatun	CIDA
3	Peggy Thorpe	DFATD
4	Pierre- Yves Lambert	EU
5	Roland Panea	GIZ Eschborn
6	Keiko Tsunekawa	JICA
7	Habibur Rahman	KfW
8	Lisa Steinacher	KfW
9	Ylva Sorman Nath	SIDA
10	Zahirul Islam	SIDA
11	Shukhrat Rakhimdjanov	UNICEF
12	Melissa Jones	USAID
13	Niaz M. Chowdhury	USAID
14	Jacqueline Mahon	WB
15	Bert Voetberg	WB Washington
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