Notes of P4H CD Visit to Bangladesh, 17-19 Feb 2014

Context

The Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MoHFW) in collaboration with WHO, the World Bank and GDC organised a **National UHC Workshop** on 18 Feb 2014 and a **Round Table Discussion** on the way forward on 19 Feb 2014.

Several **P4H members sent their experts** to participate in these events. The visiting team comprised WHO: Rob Yates, Priyanka Saksena; WB: Mukesh Chawla, Jean-Jacques Frere; GIZ: Roland Panea; KfW/GFA: Lars Kyburg; and P4H CD: Michael Adelhardt.

The **P4H CD** organised an informal meeting at the WHO country office prior to the UHC workshop to provide the visiting team with an update on the current process (see presentation in annex 1) and to exchange views on each other's perspectives and positions. The CD then participated in the UHC workshop, moderated the Round Table Discussion and attended a HEU/DP meeting after the RTD.

Highlight / main result

The most prominent result of the visit was a suggestion - taken up by the HEU - that MoHFW should **send a bold funding proposal to the MoF for covering the approx. 50 Mio. poor** under the Health Financing Strategy (HFS).

Events and interactions

1. P4H informal meeting on 17 Feb 2014 at WHO office

WHO provided an update on the status of the implementation of the Health Financing Strategy (HFS). The visiting team could familiarise themselves with the current situation and discuss some of the DPs positions: it is important that the politicians drive the UHC agenda; we need to sell the political benefits, social and development benefits. The CD pointed out that though there may be some differences on details it would be in the spirit of P4H to speak with ONE voice in the context of the bigger goal of UHC. The upcoming events would provide a good platform for inclusive dialogue. *Critical issues raised*: Some DPs question the GOB commitment to implement HFS; DPs would like to see additional resources allocated instead of *reallocating funds from the SWAp budget* to finance the HF strategy. Others pointed out the capacity and staffing issues at the HEU; though numbers have increased, there would be only a few which are committed and competent to support the HFS implementation. KfW mentioned that the decision by the German Government (BMZ) of moving forward with the SSK (SHI scheme for the poor) is still pending.

2. National UHC conference on 18 Feb 2014 at Ruposhi Bangla Hotel)

The agenda and presentations can be accessed here

The **new MOHFW Minister commits to supporting the goal of UHC** and the National UHC Workshop was his first official event. The event was an opportunity to strengthen the advocacy for UHC and support for implementing the HFS, to have a common understanding of UHC and elevate the HCFS beyond the health sector. On several occasions, the HF DP group has requested the MOHFW for broad inter-sectoral dialogue on health financing issues. So in this view, this event served as a starting point towards active engagement of national stakeholders and the establishment of an Inter-ministerial Committee on HF – a kick-off for a series of technical discussions to follow.

The Ministry of Finance reported a nominal increase in the health budget over the past decade. On the other hand, *some Development Partners (DPs) are questioning the commitment to UHC* since the government spending on health in relation to GDP is rather declining. However, during both national events, the MoF representative indicated that there was more room for pending on health, in particular when the tax to GDP ratio could be increased from 10 to 12%.

The HEU pointed out the low government spending on health (1.4% of GDP), the high level of direct payments (64% OOP) and inefficient resource allocation. The HEU would like to start implementing the HFS, however has still many open questions, e.g. about effectively targeting the poor, as near-poor can easily fall below the poverty line due direct payments for health.

For the key messages from the DPs see: P4H Intranet

3. Round Table Discussion (RTD) on 19 Feb 2014 at CIRDAP

The objective of the **Round Table Discussion (RTD)** was to come up with practical recommendations and next steps regarding the implementation of the Health Financing Strategy 2012-2023. The RTD was structured in four sessions: resources and how to make a case for health; pooling for UHC; benefits package development; supply side issues (see annex).

Session1: Mobilising resources for the implementation of the HFS - how to make a case for health and social health protection

Nominal spending on health has steadily increased, however Total Health Expenditure as % of GDP has declined; DPs well aware of this; MoF recognises the constitutional obligations to health, and sees room for improving the tax/GDP ratio and fiscal space; overall message: more funds could be allocated to health.

WHO outlined the importance of resources are generated and spent in an equitable, efficient and effective manner: direct payments (OOP 64%) are a tax on the sick, inequitable and inefficient; voluntary private health insurance does not work if a country wishes to move towards UHC; key message: public finance - either raised through taxes or mandatory social health insurance contributions are the way forward. GIZ asked to also consider innovative ways of financing, e.g. tapping into remittances. WB would like to move away from having the same discussions over and over again and suggests a bold proposal to MoF! It would be time to move on and be more practical. The HEU welcomed the suggestion to **send a funding proposal to the MoF for covering the approx. 50 Mio. poor** under the HFS.

Making a case for health, KfW stated that health should not only be seen as a cost. The health sector is in many developed countries one of the biggest sector for employment (e.g. in Germany the health sector employs more than 2 Mio people, more than the German car industry). The WB points out that money is often not the issue - it is more important to convince the MoF (and the population) that funds are being spent properly.

Session2: pooling - prompt the bigger picture question of an overall architecture for various schemes

The idea of having one fund with the same benefits and contributions according to income appeared to be acceptable to all participants. Fragmentation through various schemes (SSK, RMG, CBHI, etc.) should be dealt with right from the start that all schemes work under a common framework of principles and rules. It was also proposed that the health fund should be initially managed by the MoF.

The questions about pooling health with SP funds: There was a clear *yes* to conceptual and strategic coherence of Health and SP policies and strategies, however, physical pooling of funds of health with other social security funds is *NOT advisable* as they are operating on different principles.

Session 3: benefits package development
The question of what to include from essential services to 'everything under the sun', whether to work with positive or negative lists and how to go about it in terms of process (who to involve, role of costing) seems to be a burning question. The WB suggested to get on with it and work with the limited resources we have. One important suggestion (mainly to the SSK team) was not to cover inpatients only. KfW mentioned that they would be flexible to include out patient services as well.

Session4: supply side readiness
Key findings were that HR for Health in Bangladesh would require a 400% increase to reach WHO recommended levels; DPs have raised the HR issue repeatedly during policy meetings, however no action - some voiced their frustration. Can the HFS contribute to changing the incentives for improving the HR situation?
WHO: HR can spend money quickly and wisely; salary increase difficult because of general civil servants issue (though it can happen in some cases: Sierra Leone)
WB: concluded that service delivery important [shortage of funds slows down UHC agenda, no services kills it]; however there would be no quick fix; the main issue would be political will for change.

3. HEU/DP meeting after the RTD
The HEU again pointed out that they need some break through regarding the implementation of the HFS and picked up on the idea of a substantial funding proposal to the MoF.

Some suggested elements of the proposal:

- Start with asking for funds to cover 48 Mio. poor
- Work on supply side issues, define the benefits and use the SSK as learning experiment; define benefits
- Explain the main effects of this investment, how the world will change
- Include options on how to include the rest of the population (formal sector + 86 Mio. informal)
- List indicators for the implementation of the proposal

The World Bank and WHO offered their support to developing the proposal.

HEALTH CARE FINANCING ROUND TABLE DISCUSSION

19 February 2014, 9:00AM – 2:00 PM

CIRDAP Auditorium, Chameli House, 17 Topkhana Road, Dhaka

PROGRAMME

TIME	ACTIVITY	MINS	RESPONSIBLE
9:00	Registration of Participants		Secretariat
	Opening Remarks from the Chair	10	Mr. M. M. Neazuddin, Secretary Ministry of Health and Family Welfare
9:20	Introduction and Process for Discussion - Moderator	10	Dr. Michael Adelhardt, P4H CD
9:30	Input Presentation on HCF Key Issues	30	Md. Ashadul Islam , DG HEU
10:00	***Key Issue 1: What steps need to be taken to mobilize the necessary resources to attain the proposed coverage in the HCF Strategy and increase budgetary allocation for health?***		
	Local Expert Input	5	MOF
	International Expert Input	5	Mr. Rob Yates, WHO
	Discussion	30	
10:40	**COFFEE BREAK**		
11:00	***Key Issue 2: Based on the proposed pooling mechanism, how can we further improve equity and efficiency? Who shall manage the single health protection fund?***		
	Local Expert Input	5	MOF Ms. Tahmina Begum, Consultant
	International Expert Input	5	Ms. Priyanka Saksena, WHO
	Discussion	30	
11:30	***Key Issue 3: What considerations and principles in benefit package development do we need to consider based on Bangladesh context? Who shall pay for what services?***		
	Local Expert Input	5	Dr. SAJ.Md.Musa Director, PHC, DGHS,MOHFW
	International Expert Input	5	Mr. Roland Panea, GIZ
	Discussion	30	
12:10	***Key Issue 4: What steps need to be taken to address service delivery challenges particularly the issue of inadequate health workforce and governance?***		
	Local Expert Input	10	Dr Md Jamal Uddin Chowdhury Secretary General, BPMPA
	International Expert Input	5	Dr. Lars Chr. Kyburg KfW/GFA Consultant
	Discussion	30	
	Highlights of Discussion and Summary	10	Dr. Mukesh Chawla, WB
	Next Steps and Closing Remarks		DG HEU
2.00	**LUNCH**		

ROUND TABLE DISCUSSION ON HEALTH FINANCING
BRIEFING NOTES FOR RESOURCE SPEAKER

19 February 2014 (Wednesday), CIRDAP Auditorium
Dhaka, Bangladesh

Venue / Time: **CIRDAP Auditorium, Chameli House, 17 Topkhana Road**
Wednesday, 19th February 2014
9:00AM -2:00 PM

Chair: **Secretary, MOHFW**

Moderator: **Dr. Michael Adelhardt, P4H CD**

Documenters: Key Issue 1- Md. Hafizur Rahman, HEU
Key Issue 2 - Dr. M Sabbir Haider, HEU
Key Issue 3 - Dr. Aminul Hasan, HEU
Key Issue 4 - Mr. Khan Suleman, HEU
Consolidation – Mr. Jaidev Singh, GIZ

Format: After the input presentation from HEU on Health Care Financing Strategy and background of key financing issues, the Moderator will open the floor for discussion of the key issues beginning with key issue 1 until key issue 4.

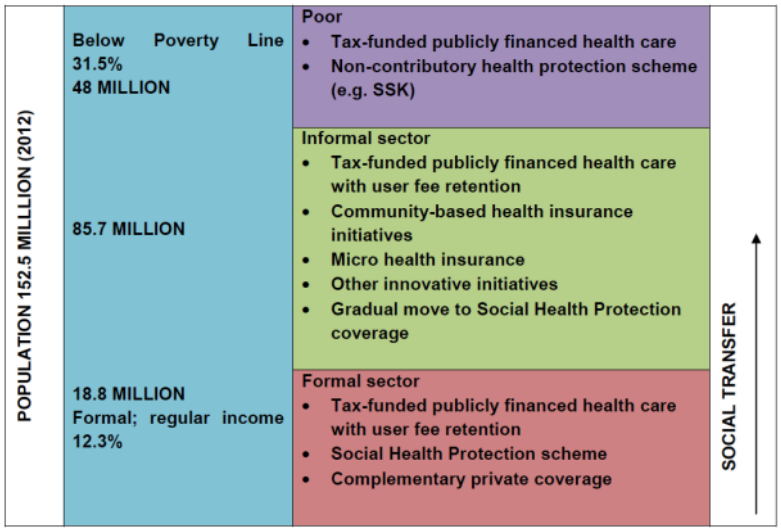
5 minutes: Local Expert Input
5 minutes: International Expert Input
25 minutes: Plenary Discussion
5 minutes: Summary recommendations

Please refer to attached background presentation on HF in Bangladesh.

Key Issue 1: What steps need to be taken to mobilize the necessary resources to attain the proposed coverage in the HCF Strategy and increase budgetary allocation for health?

One of the key challenges in the Bangladesh health system is inadequate resources in the health sector. As of 2010 NHA data preliminary results, total health expenditure is 3.5% of GDP. Household out of pocket spending at 64% of total health expenditure continues to be the predominant source of financing, resulting to catastrophic spending and impoverishment. The HCFS envisions providing social health protection coverage for the poor, informal and formal sector in a phased-in approach and funded as follows:

Coverage and Mechanisms



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Proposed Funding Sources for Social Health Protection

- Compulsory Payroll Contributions for the formal sector
- Self-payments for the informal sector (above poverty line)
- Subsidies for the poor
- **Government subsidies from:**
  - ✓ **General budget**
  - ✓ **Earmarked allocations from sin taxes, vehicle taxes, VAT**
  - ✓ **Earmarked allocations for fees on remittance from overseas workers and other fees**
- Co-Payments
- Donations/Grants (domestic and external resources)

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Local Expert Input: Representative, MOF

- Comment on the proposed coverage and funding mechanism, particularly on the sources of government subsidies in Bangladesh
- Recommendations on sources of financing and how to increase resources for health given the fiscal constraints in Bangladesh

International Expert Input: Rob Yates, WHO

- Comment on the proposed coverage and funding mechanism based on international experience and best practice
- Recommendations on increasing resources for health in Bangladesh

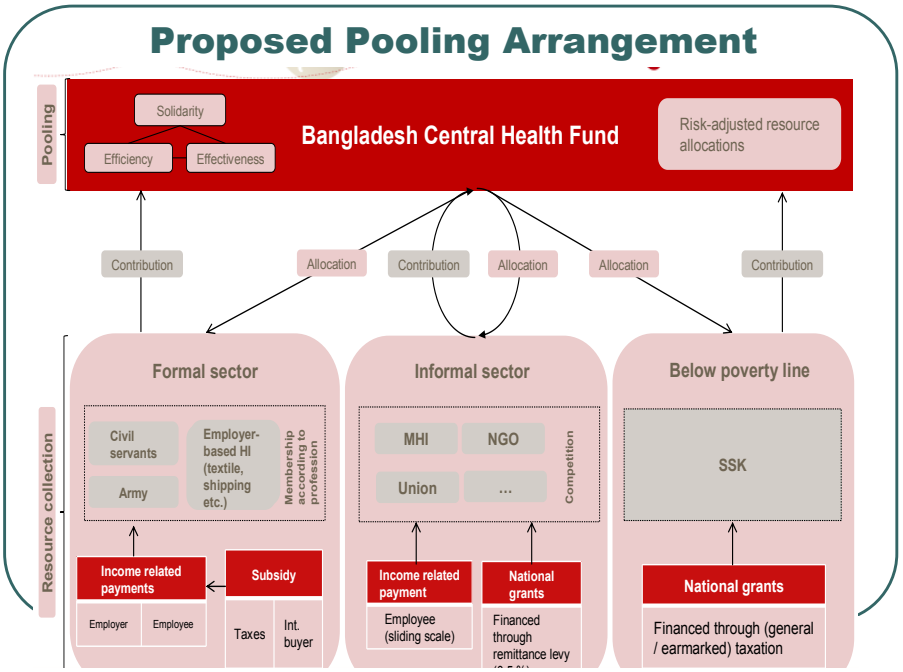
Key Issue 2: Based on the proposed pooling mechanism, how can we further improve equity and efficiency? Who shall manage the single health protection fund?

The goal of pooling is to ensure solidarity-based financing and to maximize financial protection. The achievement of this goal will depend on the composition of risk pools, extent of fragmentation and how the risk pools are managed. Current funding arrangement in the country is shown below:

Pooling in Bangladesh

- Not pooled – 64% OOP
- Government – 26% and External -8%
- Allocation of public resources from central to local level is not based on actual needs but on a static input based formula (bed, staff)- on-going development of Needs based RAF
- 14/44 insurance companies offer health insurance, mostly for private formal;13/36 MHIs offer health insurance but small membership

In Bangladesh, there is a general consensus among government and stakeholders that a **single national fund pool** composed of 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, is the desirable design. This fund will be administered by an autonomous body with multi-sectoral representation.



The government intends to immediately to implement the SSK pilot as soon as possible. Recently, the MOF recognizes the need to generate additional resources to cross-subsidize the poor, and suggested covering the formal sector as well. This will be done in a phased-in manner, beginning with the Civil Servants (public salaried) and the Ready Made Garments (private salaried). All these schemes will follow the same design principles, generate lessons and will cease to exist under the NHIF which will be established by law. The schemes are meant as starting point for coverage, testing the feasibility and building up the capacity for health insurance management.

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Local Expert Input: MOF Representative/ Tahmina Begum, Consultant

- Comment on the proposed pooling structure and collection mechanism. Based on Bangladesh experience, how can this arrangement be further improved for equity and efficiency?
- What type of organization will manage the single health fund? Government, semi-autonomous government body, private?

International Expert Input: Priyanka Saksena, WHO

- Comment on the proposed pooling arrangement based on international experience and best practice
- Recommendations on possible steps for Bangladesh to maximize the benefits of its pooling arrangement.

Key Issue 3: What considerations and principles in benefit package development do we need to consider based on Bangladesh context? Who shall pay for what services?

Bangladesh has been implementing Essential Service Delivery in its public health facilities. This is the priority package that the government has defined to provide to its entire citizen for free. It is composed of the following components: support services and coordination, limited curative care, urban health services, medical waste management, mental health and tribal health. However, high out of pocket spending remains high and utilization of health services is low due to many contributing factors.

In this regard, the HEU MOHFW would like to spearhead the development of an affordable and sustainable benefit package within the capacity of the system to deliver.

Local Expert Input: Dr. SAJM Musa, MOHFW DGHS

- Share some considerations in benefit package development based on the local context to make the package responsive, effective, affordable and sustainable.

- Propose for services that should be funded by the general budget, health insurance or supplemental insurance

International Expert Input: Roland Panea, GIZ

- Share some principles and best practices in benefit package development that is relevant to the country context
- Recommendations on possible roadmap for benefit package development for Bangladesh

Key Issue 4: What steps need to be taken to address service delivery challenges particularly the issue of inadequate health workforce and governance?

Based on the rapid health system assessment conducted by HEU/WHO in 2013, the main issues in service delivery include shortage of health workers in general and governance issues.

The HR issue was proposed to be addressed by Lancet series through the following:

- Invest in developing non-physician healthcare workers (Midwives, nurses, paramedics)
- Redefine task and responsibilities of nurses and community health workers with emphasis on health promotion and prevention
- Use incentives to rectify workforce shortages and to take services to hard to reach areas and disadvantaged populations eg, link postgraduate admission with service in rural areas, setup training facilities in poorly served areas, encourage high quality private sector provisions

Likewise, hiring of HR at local level, minimizing the political influence, Involvement of local representatives for monitoring and evaluation process, strict adherence to rules and policies, minimizing geographical differences, etc.

HPNSDP (2011) pointed out few challenges in governance of the health sector, which are

- Too many Operational Plans are diluting and duplicating program priorities and activities.
- Insufficient coordination between various sub-sectors in health, population and nutrition may lead to wastage
- Parallel and non-pool development partner harmonization is yet to be achieved.

Efficiency in health spending could be enhanced by improving governance

Local Expert Input: Dr Md Jamal Uddin Chowdhury, Secretary General, Bangladesh Private Medical Practitioners Association, Member Bangladesh Medical Association

- Based on your experience in health service delivery and the various strategies suggested on human resource management, what are priority steps to address the needs for HR as the country progress towards UHC?

- Recommendation on steps to be taken in the short and long term to improve governance and capacity in the health sector

International Expert Input: Dr. Lars Chr. Kyburg, KfW/GFA

- Share some principles and best practices to address the service coverage, HR and governance issues of Bangladesh
- Recommendations on steps to be taken in the short and long term to service coverage, HR adequacy and over-all governance of the system