



# Health Watch

*“Universal Health Coverage is the single most powerful concept that public health has to offer”*

Dr. Margaret Chan, WHO

## Bangladesh's path to UHC: the Health Care Financing Strategy – 2012-2032

The economic consequences of ill health for the poor households, especially the bottom 15-20% are well documented in Bangladesh. Cost burdens of healthcare may deter or delay healthcare utilization or promote use of less effective healthcare sources or practices, particularly by the poor. In the absence of any risk-pooling mechanisms and pre-payments, expenditure on health is mainly met by out-of-pocket payment by the households (>60%). This mode of payment for health-expenditure is the most regressive one and exposes people, especially poor and other disadvantaged people, to great financial risk and makes the health system inequitable.

The benefit of tax-based financing system is limited by regressive nature

of tax system, poor management and leakage of available resources, lack of transparency and accountability and informal payments. In addition, the generalized perception of health insurance and community financing for healthcare are yet to take root in Bangladeshi society due to poverty and other factors.

As a commitment to the movement towards UHC, the govt. has formulated the Health Care Financing Strategy 2012-2032 (HCFS 2012-'32) aligning with the current Health, Population and Nutrition Sector Development Program (HPNSDP) 2011-2016 and the National Health Policy 2011. It provides a framework for mobilizing resources for achieving UHC in a stepwise manner and puts emphasis on extending financial protection to all

segments of the population. This strategy document aims at maximizing the complementary role of private sector, both for profit and non-profit, through public private partnership, and continuing the engagement of Development Partners' in financing the health sector.

**Short term:** Government will initiate the *Shasthyo Shuroksha Karmasuchi* (SSK) pilot with Below Poverty Line (BPL) population in three sub districts with the designing key elements of social health protection will be: the health equity fund /National Health Security Office (NHSO) will finance the social health protection scheme and develop a mechanism to bring this scheme for the formal sector of the population, both public and private.

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## Where Does Bangladesh Stand with Universal Health Coverage?

So what exactly is Universal Health Coverage (UHC)? UHC has morphed chronologically from a straightforward notion of making sure everyone has coverage to something much more complex and useful. For example, Thailand already had a network of government facilities even before it launched its health coverage scheme. Mexican families without a social security number already had access to the network of government facilities run by the

ministry of health even before the popular concept of "Seguro Popular" scheme was launched.

UHC isn't about getting everyone coverage, since everyone already has it. So what exactly is UHC? It means that in practice everyone – whether rich or poor – gets the care they need without suffering undue financial hardship as a result of interaction with the health system.

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## Where Does Bangladesh Stand with Universal Health Coverage?

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UHC is about equity: linking care to need, not to ability to pay. UHC is also about financial protection: making sure that people's use of needed care doesn't leave their family in poverty. And UHC is about quality of care: making sure providers make the right diagnosis, and prescribe a treatment that is appropriate and affordable.

On the note of "service coverage" dimension of UHC, we need to look beyond what services people are entitled to. Service coverage is about people getting the care they need. We can't get at this by looking at the number of contacts with a provider. We need to look at what happens during the contact, comparing the services the person receives (or doesn't receive) to what's needed.

It is not true that health insurance is possible only in countries with more resources. It is more to do with devising an "innovative" mechanism. It's also possible in countries like Bangladesh, for instances in Sri Lanka, Kerala in India, Rwanda and Ghana where the system has been developed within a decade. Extracting users' fee from hospital patients has, in fact, worked as a deterrent. "There is plenty of evidence to prove that it discourages people from coming to hospitals." The government could instead collect that money and form a pool to introduce a prepaid system. Raising and reallocating of resources within the government and reducing out of pocket expenditure through some form of risk pooling for pre-payments can be an approach to reduce barrier for UHC.

In Bangladesh, to adopt the concept of UHC to deter people slipping into poverty and challenges with regard to disease burden, the Government has recently renewed its commitment to UHC in its health policy of 2011. The initiative to increase health manpower for hospitals and health centers and also revitalize 13,000 community clinics with commitment to make 18,000 community clinics functional by 2021 are but a few bold steps towards strengthening health system. With a clear vision towards UHC, the government adopted health care financing and health workforce strategies with updated country profile on human resources for health.

If the current steps are diligently taken forward by the government and if it can prepare a strategic plan to implement these steps in a logical way with "best fit" innovative health financing mechanism, Bangladesh will be in the right path, gradually moving towards UHC at par with other nations.

### Tidbit

**Reform existing health system or expand insurance coverage: Which is a "best buy"?**

The developing countries in the South Asia region have evolved a single-payer health system to be financed by resources generated from tax revenues and ensure availability of free health services for all at government facilities. But largely, due to underfunding and poor management, this system has functioned inefficiently, as indicated by low facility utilization rates and in general, people's reluctance to aware the government health facilities due to long waiting time. Meanwhile, the private health sector has mushroomed with little public oversight.

It can be argued that improving the existing government health system can be far less complex than expanding health insurance for universal health coverage. Health sector reforms can improve the efficiency, equity, and effectiveness of the sector to better prepare the government system to initiate insurance scheme for different segments of population.

Evidence from international experience suggests that shifting from a "single payer" to a health insurance model would be a very dangerous path in context of a developing country because of barriers to regulating the system as well as lack of resource mobilization across different ministries. Health insurance system can only work well if the government tightly regulates the insurers and health providers, both in the fees charged and in the services provided. If not monitored, can leave people at the mercy of insurance companies that could refuse coverage (or charge very high premiums) to all but the healthy, and find pretexts for refusing to reimburse an insured person who needed treatment and care. Meanwhile, costs can be further inflated by doctors' financial incentives to increase the number of tests and procedures. Fees for the same service also vary widely between providers as evident in the private markets. Private sector health services have grown with little proactive public policy with regard to their size, service quality and costs of care.

In strengthening the health sector, national health systems need to play stewardship role to ensure alignment and coherence of policies, priorities amongst different stakeholders; and manage and coordinate health financing schemes at national and sub-national levels.

*Source: Gupta, et al.: Universal Health Coverage: Reform of the Government System Better than Quality Health Insurance. Econ & Pol Wkly, Aug. 30, 2014*

## Bangladesh's path to UHC: the Health Care Financing Strategy – 2012-2032

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**Medium term:** The social health protection scheme during short term will cover until 2021 to coincide with the vision of Bangladesh becoming a middle income country by then. The SSK will be scaled up for BPL. The mechanism for social health protection scheme for the formal sector will evolve and the coverage for the informal sector will emerge with voluntary subscription.

**Long term:** Within 2032, Bangladesh will be destined to achieve universal health coverage with provision of quality and affordable health services with financial safety net for all segments of population including the informal sector.

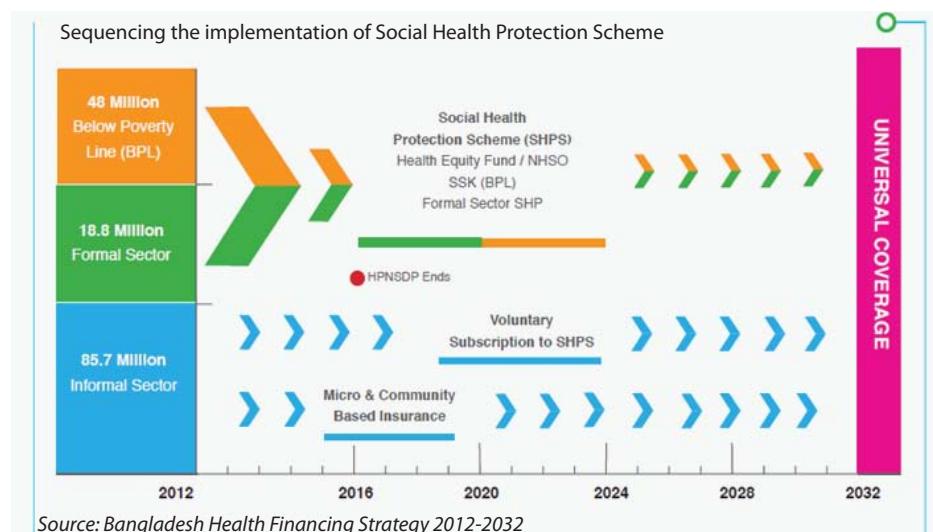
Strategic interventions and supportive actions proposed in the HCFS are briefly described below:

### 1. Social Health Protection Scheme

- Determine institutional arrangements that shape and respond to market forces for Social health protection scheme and implement for people at below and above poverty line
- Generate health equity fund and link it to NHSO

### 2. Develop a financing model with provision of public health care services

- Implement needs and performance based allocation based on political negotiation, incremental budgeting



and allocation according to health care needs

- Scale up/reinforce Result Based Financing by linking incentives with results from supply and demand sides
- Retain user fees at point of collection

### 3. Capacity development at national level

- Support information exchange platform across relevant Ministries- raise institutional capacity to design and manage the social health protection scheme
- Strengthen Financial Management for resource allocation and Accountability
- Improve monitoring and evaluation to understand the impact of financing scheme
- Introduce mechanisms to support

the production of additional qualified health workforce for health service delivery.

### Challenges:

The three main challenges to create a safety net to reduce out-of-pocket payments at point of service are:

- Raise enough revenues to provide individuals with package of health services to avoid catastrophic health expenditure,
- Manage these revenues to pool health risks equitably and efficiently; and
- Ensure that the payment for or purchase of health services is carried out in ways that are allocatively and technically efficient.

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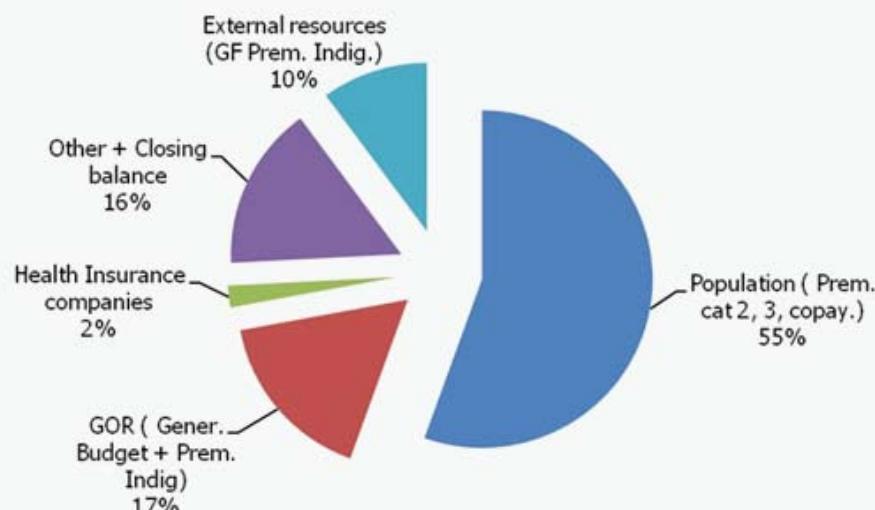
#### Universal health coverage in Rwanda: dream or reality

Since September 2012, Rwanda is recognized as one of the nine countries in Asia and Africa which is on the verge of achieving universal health coverage based on community-based health insurance, unique in the world. There is plenty of literature available on Rwanda's journey to UHC but few have examined its financial sustainability, given almost exclusive dependency on external financial assistance. In a recently published paper, authors have tried to do a SWOT analysis of the period 2000-'12 based upon WHO definition for achieving UHC such as health insurance and access to care, equity, package of services, rights-based approach, quality of health care, financial risk protection, and CBHI self financing capacity (the last one added by the authors).

Analysis revealed quite positive results in terms of access, services, quality of care and health rights with limited performance for equity, financial risk protection and CBHI self-financing. People at the lower strata of income quintile are facing difficulty in paying the annual

premium in single installment and thereby, problem with access during the interval from one to the next enrollment. Financial risk protection through CBHI promoted use of services when needed, resulting in increased health service utilization compared to non-insured. Finally, findings revealed cost recovery quite high which is a reflection of the CBHI's financial sustainability. However, the study also documented weak cost-control measures

and a high overhead at 19% of total expenditure which places self-financing of CBHI under further scrutiny. Rwanda is trying to solve this problem by exploring resource generation from other sources such as VAT, sin tax etc. The authors conclude that, according to the indicators studied, the success of UHC in Rwanda is based on solid ground and it is not a dream, but a stark reality.



Source: generated by Ministry of Health. Health financing unit/CTAMS. Annual report 2011-2012

Source: Médard Nyandekwe, Manassé Nzayirambaho, Jean Baptiste Kakoma. Universal health coverage in Rwanda: dream or reality. The Pan African Medical Journal 2014;17:232

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