Key Informant Interview 2

Challenge:

There were many challenges in this, because SSK or Health Insurance is entirely new. A major challenge for us was that the insurance we have is life insurance, not health insurance. In a life insurance scheme, once you get it, then you get the benefit. But health insurance is a continuous process. And the health insurance that exists in the private sector has several limitations. For example, if you are seriously sick, you are not eligible for this life insurance. Because by default, you have already used up all its money. And if you are over 65 years old, then you are not eligible. Also not if you are under 15. Those with a higher possibility of sickness and greater vulnerability are excluded from their design. The reason is that they do this to maximize their profits. For instance, that health insurance has numerous limitations. The few that exist, and even for those who have it, because of these criteria, the people who truly need health insurance are not getting it. They might be getting it in a fragmented way. For instance, some programs have recently been taken for garment workers, but overall, what we understand globally is a system where everyone pays a premium, and that premium is somewhat compulsory, not voluntary; our country has never been at that stage, nor is it now. But the challenges that come with introducing something new from the beginning are certainly there. Everything was new at the start; initially, there was no design at all. It's not as if there was a pre-existing design or a tested model. You have to start everything from the beginning.

We had to review a lot of literature. For example, a component might exist in Korea, and it can be modified for our country. Again, it might be different in Thailand. Furthermore, each country starts in a different way; for instance, some countries have done it separately, some have done it for the poor, and another country has done it for the formal sector. Later, these were gradually brought under one umbrella. Again, India's RSBY has similarities with our demand. Compared to other countries, because our country's context or socio-economic context has some similarities, there is also some similarity in the mindset. Due to all these similarities, it aligns with RSBY. But we have considered not just our socio-economic context but also our culture. We have designed our model considering the culture. It must be homegrown. We have to say this. Because we have to gain experience. Because I am completely blank. We are all blank now; if we have to start something, the job of a technical assistance team is to explore what exists where and then create something accordingly to fit the country's context; that is the job of our TA team. The formal launching of the TA team's work, we can say, started on March 24, 2016, in Kalihati. But before that, we had a field preparation phase. We started the field preparation after 2015. In January 2016, we were doing work like facility preparation; the preparation work was ongoing. Field preparation. But before the field phase, we developed the model itself. Even various donors supported us at different times, saying it should be this way, not that way. There is also the matter of convincing our donors. The biggest challenge is to convince the government and make the government own it. If I create something for you, but you are not convinced, then you will not own it. We have created the thing, but to carry it out, take it to implementation, convince donors, take it to a higher level, take it abroad—meaning, the responsibility to establish it globally lies with the government. And how will the government do it? Until it develops that level of confidence in itself. That is why, as I mentioned, at various times we might have reached a certain stage, but due to some element, they might say, no, this is not right for our country, it is not possible in our country. Then we might have to start anew. There are various actors—the government, donors, and experts—we are always doing this through consultation. So, after doing this, we established the model at a certain stage. This is the model we are working with now. It took us about 4-5 years like this. Now that the model is made, its main task is that the entire thing is new. And another reason the challenge is big is our negative perception of insurance. In our culture, insurance is a negative thing. That insurance will give, I am paying money for insurance, but I am not getting the money back. We have a psychological mindset of getting things in cash, that they will give, when will I get it, will I get

it at all, will it be there or not. This uncertainty in our culture is a huge deal. And the image of insurance is not very good in our country. Considering all these issues, we had to convince many people. From the field level up to the top-level policymakers at various levels. Since there is a huge commitment from the government here, what we call political will is a massive support. They might have told us, "Not this way, that way is not possible in our country, you think about it for us," and they will do it until they are convinced. They have done it up to that point. But as I said, the field level was very difficult; challenges were coming from all sides.

I have been in this project since 2009. The first phase was the design phase. In the design phase, my role was to carry out some research studies, a baseline survey, and various component issues were carried out by 8 organizations. They conducted 8 studies. My role there was to organize them. To ensure the studies were done according to the TA requirements. And a major role was to design the SSK model. What we call concept development. This was my big role in SSK, and to find out the senior consultants, various international consultants in health finance or health insurance who came here. To bring them and further develop the concept through them. So, my role was actually in both the internal and external context, that is, to communicate with those who are experienced in these sectors, bring them in, and design the model—that was the first phase. And the second is the implementation phase. In the implementation phase, I worked as the National Coordinator. Since I worked in the design phase, I was in the design phase. An advantage for me was that we could easily start thinking about how to do the implementation. And the first phase of implementation was designing for facility readiness, fixing the facilities. For facility readiness, we saw that in our hospitals, the outdoor, emergency, and IPD were in different places, but according to our concept, we reorganized and redistributed these hospitals. Since we will have an SSK booth there, an SSK pharmacy, and since I know that the SSK booth will be in the hospital, I knew which department would have more interaction with it according to the concept—would it be with OPD, IPD, or emergency? So when we rearranged these facilities, since I knew the concept well, I had a good role, and still do. We rearranged the facilities in such a way that the patient service flow becomes smooth. We might face many troubles. We had to do reconstruction, renovation, but we tried to ensure that SSK patients could move smoothly within the facility. So that they can understand where to go from where. This was the role initially in the first phase of implementation. Now that service delivery is happening, many new rearrangements are taking place. In the existing service delivery model, we are seeing how they are working with our concept; this is my role in the design and implementation phase. Now, I am continuously supporting the HEU's SSK cell with overall coordination. Coordination actually means not just coordination, it's rather about facing challenges; since I understand the SSK concept with great confidence, when a new situation arises, I ensure that no one can provide a solution that contradicts the concept—this is my current role.

First came the matter of getting the facility ready. Getting the facility ready plus, for facility readiness, there were 3-4 dimensions: facility renovation, structural renovation, and another was to ensure your equipment, machineries in these places. And another is human resources. We know that we have many sanctioned posts. There should be 10 consultants and 11 medical officers. There are many vacancies there. Our commitment was that the government would fill these posts. We gave one crore Taka to each facility from the project for renovation. The HED (Health Engineering Department) appointed the contractor. We gave them the contractor; they work under the Ministry of Health, and they are supervising the contractor. We have stated our requirements, and accordingly, they have tendered and appointed a contractor, and then the work is being accepted through the upazila's UHFPO sir.

A major task for us is to implement this according to the concept, because many things might seem good in one context and easy to do in another, but we always had to think about scaling it up with a long-term perspective. We decided we would not do anything that the government cannot carry out. That is not feasible in the long perspective. We will not do something like appointing a few doctors. The government

might not have that position, and when we go to another upazila, those posts might not exist there. We are doing these things now just because we have the money. Our constant work is to implement according to the SSK concept. Another thing is to update the concept based on the learnings from implementing at the field level. It is a project, so there is huge space for updating and modifying. So it's a pilot project. We are not going as a project now. We are going as a pilot project; when we can give it a complete shape, then we will call it a program. We can then present it as the Health Protection Program. So we are in a very sensitive place. At the end of the pilot, we have to ensure that the project can be scaled up. It must be sustainable and financially feasible. We will not do anything that requires implementation with government funds. For example, creating a new post is very difficult for the government. It would be good to appoint one person here. But we are trying to see how it can be done within the existing structure by providing training, developing capacity, and filling vacant posts.

When the pharmacy submits the bill, the bills have to be checked. Because the names of the medicines, for example, patient number 10 or a patient named Sumon has come, we need to see the evidence to check if the medicines were given according to the doctor's prescription and if the tests were done. We check the medicines given by the doctor, plus at least the necessary administration forms, then the discharge form, and whether the signature of the RMO or UHFPO sir is present in every place; we have given this task to Green Delta because no one has the capacity to do all this. No one has the capacity or experience for claim processing. That is why Green Delta Insurance Company was engaged. Another reason is that when we do the household registration work in the field, the government does not have huge manpower.

When they process the claim and send it to HEU, HEU processes it and submits the bill; it comes from the hospital through the Green Delta company, but here. What will it (HEU) do? It will make the payment directly to the hospital; the financial transaction will be government-to-government. But in between, it's a private company. Which sometimes causes problems for us. Government-to-government transactions can sometimes involve favoritism. Then there will be no chance for this to happen. Because the private company will be held accountable. Since there is a private company in the middle, if someone says that money has been shown unnecessarily here, or a bill has been shown for a non-existent patient, then Green Delta will have an office in the upazila, a booth in the hospital, which will be open 24 hours. Their job is to process the patient, meaning the patient is being admitted through Green Delta. So the hospital has nothing to do here. The hospital will only submit the discharge process to Green Delta at the end of the month. Green Delta will do the work of checks and balances. Our design is made that way. So that the mismanagement or lack of governance that exists in the government does not remain. As a result, there will be no shortcomings on the government's part.

What capacity does an upazila hospital have? Capacity means in terms of infrastructure capacity, human capacity, equipment capacity; the government knows what posts they will have here, what expert doctors they will have, what equipment the doctors will have, X-ray, ECG. So considering everything, which services are affordable here. That is, which services these doctors can provide, or with these machines, what can be done here, or whether more than 50 patients can be kept in this hospital—considering all these things, we have identified 50 diseases.

We will revise this benefit package; in the second benefit package, we have identified almost 19 diseases. In the upazila where we have worked for the past year, we have spoken with the doctors, and from the medical records of the past year, we are finding out which diseases need to be added and which need to be removed. But we are not in favor of removing any disease. Because we are thinking that when this becomes nationwide, if a disease is removed from one upazila, it might be found in another. Since that is our approved list. We have a steering committee, the Minister is the chairperson, we have to get approval

from them. We want to keep the approved list and add 19 more to it so that ultimately there is a complete list. We have already identified 19 diseases that will be added to it.

In the design phase, the first problem was that the thing was completely new. Completely blank. Everybody is blank. Yes, we started it, and when we, as national consultants, started, we were also blank. What we had to do first was to review the social health insurance systems of countries with a similar socio-economic context. This was a big challenge. To revise it in our country's context. The model that exists in our country, for example, at the district level, upazila level, union level, then the health sector and family planning are two separate wings. We had to think in a way that the model would be such that it could make the existing service delivery model in our country more active. If we can use it more, that is a challenge.

Many have a negative perception of insurance. In our country, no one has any practical implementation experience that we could share. Considering these issues, we had to do something completely new. On one hand, we had to develop a model, and on the other hand, we had to do advocacy on why it is important.

We have to think from a long-term perspective; a major challenge is that multiple actors are engaged in this. Each actor needs to be continuously and equally clarified and made capable. This was a big challenge.

Another challenge was political. We had an advantage that the government wanted this.

Another challenge was that since this is new, many of us were confused, and donors had a concern about whether it is feasible in our country's context. Our SSK cell had some limitations as it was new. So we first started it in one upazila. We started in Kalihati. Then we started in Ghatail.

There was a problem with facility readiness. Our role there was to distribute the rooms according to the SSK concept, arrange the internal rooms of the facility, plus we had to consider medical ethics, for example, if someone comes for a stomach wash, a poison case, the condition should not remain as it was but should be an ideal situation, and then we had to think about ensuring quality. We gave our requirements; one crore Taka was allocated for each upazila; we told HED, they tendered, they appointed a contractor, they supervised the work. Because this is an engineering issue. We might say that we want this room here, a window here, and then they have done it. In each upazila, one building is new and one is old. We are having problems working in the old building. Water leaks from here, it can't be stopped. And the contractor says that with our budget, this won't be possible, this can't be broken, this is not a column or a beam, it's a very old building, if you try to make a window, it will collapse, or it's not possible. We had to adjust many things like this. We might have had to shift from this building to that building; we might have wanted to set up the SSK booth in a place that is very comfortable for the patients. We always think about the patients.

The upazilas are under HED, and the district hospital is under PWD; there is a problem here. Not exactly a problem, it's a government convenience. Since we are doing renovation work directly in the upazilas within the ministry, it has been very easy to pay their bills financially, as is the case within the ministry. But the responsibility was on our upazila's UHFPO sir to accept these works, but at the end of the day, we have seen that in some places, we did not get the work up to date; the contractor might have taken the bill and left without finishing the work. But later, when we went to set it up, for example, where a pharmacy was supposed to be, we went to set up the pharmacy, he might not have understood it properly. Where a counter was supposed to be for taking medicine, I had to get that counter made later through HED. Some problems like this have occurred.

Those who qualified for our work came. NGOs participated here; this time we had 13 participants, of which only 4 were insurance companies. The rest were NGOs; many NGOs have worked in the health sector, so they had experts, they have some experience in insurance. What we call micro-insurance. They have some experience in micro-insurance. They also bid but perhaps couldn't perform as well. Perhaps a major component of ours was what we call claim processing. They might not have had that much experience, which is why they might have fallen behind in recruiting. But out of 13, 4 were insurance and the rest were NGOs, so a big part of our TA team's work was that we went through the recruitment process twice to recruit.

We have created an ideal model. But the thing was not ideal in any way. For example, it might be seen that there are no facilities, or perhaps no electricity, the lab or equipment does not work. The sanctioned posts are mostly vacant, then perhaps there is a cleaning problem. The reason for this was that perhaps those posts were vacant, then there is a matter of security, and then it was seen that there are no security guards at all. These posts are vacant. In our model, it was stated that these things must be present. And some things will be from the government, and some things we will provide. Because this is a public facility. We might go to private facilities at some stage. If we have accommodation problems here, if the patient bed occupancy is over 100%, then where will they keep the patient?. Then according to our condition, we have to provide a bed to the patient; then we might include a private facility within a certain rate. Here we had a challenge, not exactly a challenge, we had to do the work properly. We had to innovate the facility, we had to negotiate with the government to fill those vacant posts. Then we made a list of some equipment, for example, there are 50 beds at the upazila level, some beds might be broken, some might be missing, some beds might not have a mattress. We know that with one bed, there will be one saline stand, one table; this is the ideal . which we have mentioned in our model. It was seen that those were not there or were there but not usable; we repaired them. We told them to paint them. We provided some funds from here and made them functional. We might have seen some problems with equipment in the pathology lab; for instance, there might be a microscope in pathology, but perhaps no rotator. But we have to make the pathology active. And to make it active, everything must be present. Pathology requires blood tests, urine tests, X-ray machines, etc.. If one thing is missing, the whole thing will be ruined. We cannot say that our pathology is functional. So we had to ensure every single thing. We said that among the 50 diseases, for disease number 5, this test is needed, or an X-ray is needed; we had to ensure these things before starting. They cannot tell us that they don't have X-ray plates. They cannot tell us that they don't have reagents. They must have reagents. Straight talk. What we did was we provided some financial support from our project fund to purchase the reagents. Gradually, what happened is that the SSK cell generated its own funds. They decided that they have to keep these reagents available. They bought those things.

At the beginning, we had to look at 3 broad perspectives. Equipment, human resources, and another is infrastructure. Along with this, what we ensured was cleaner and security.

If the hospital is not clean, then we cannot say that it is usable. The facility is functional, but service in a dirty environment is not functional. So it has to be cleaned according to our guidelines. The support for cleaning has to be given.

If we ask the UHFPO, "Why don't you clean your hospital's bathroom?" He won't do it. He has to be given that support. We saw that in the government's number of positions, there are two or three people. Now if he says that's not enough. We have always kept the government under pressure to fill the vacant posts.

We need cleaners for washing bed covers, washing beds.

Let's talk about the hospital; the kitchen for feeding the hospital patients is in such a place that its smoke comes into the hospital. We have closed that and moved it far from the hospital so that the hospital environment remains good. These are the realities; we had to do these things. We found such problems when we went to the field.

The big problem is that there are no people, and the posts for those whose capacity will be developed are vacant. The second problem is that frequent transfers are happening. And a major problem is the lack of motivation in the mid-setup. What's happening is that it's not like we'll go at 10 AM and leave at 12 PM. What's happening here is that they are feeling a kind of frustration that they have to work more because of SSK. Actually, this is what they are supposed to do. They are supposed to come at 8 or 9 AM, and you are supposed to stay until 2 or 2:30 PM. We are not asking you to do more. Actually, they are not used to even this much. Even coming 6 days a week, they are not used to that either.

That's why they feel as if they are being kept under a kind of pressure. So when will they build capacity?. When you enjoy it, take ownership of it, learn, and try to use it. We have to change that kind of mindset.

The capacity building that is needed is for service delivery. In those service delivery areas, there is no motivation.

Frequent transfer is a huge problem. We might train someone, and then they leave. Again, there are vacant posts. People don't even want to go to the upazila in the first place. Many service provider posts in the upazila are vacant. After much effort, we trained the UHFPO of Ghatail and Madhupur; he is aware of SSK. When our launching was about to happen, a few days before, he got a promotion, and before the promotion, he got transferred with the promotion. These are huge problems.

Here, the Upazila Chairman is the president, and the member secretary is the UHFPO sir, the RMO sir is a member, the UNO sir is a member, then the social welfare officer is a member. And there is one medical officer. We have formed it with a few such people so that there is representation from everyone. Among them, again, it is seen that many are not interested; they do not participate in activities. But our objective was that everyone would actively participate.

People don't go to government hospitals for two reasons. One is that doctors are not available, and the other is that medicine is not available.

One of our tasks was to be available 24 hours, but we are not able to be here for 24 hours.

It was said to take a picture of the prescription and send it so that the doctor's signature would be at the bottom, then one could immediately say whether the treatment is happening according to the protocol or not. Then it might be seen that the doctors would naturally feel a bit like, "Oh, you sent my picture.". Then a little while later, a call would go from Dhaka, and they would understand that this is the work of that person, it's happening because he sent it. He would be told to give the treatment in that specific way. "Where did you learn to give treatment?". "This is not the treatment for this disease. You wrote one thing and are giving another. Either you write it that way or give the treatment correctly," something like that. We face problems doing this. But now they understand that we are perhaps not harmful to them; we are perhaps only monitoring them. What used to happen in the beginning was a kind of problem. "Oh, you took my picture and sent it, he is calling me and telling me.". When we go physically, we sit with them again. A team of doctors from here goes there, then they say, do it this way, not that way.

There is a bit of a problem with claims. Since there are many actors, it is a bit slow. For example, the claims for a certain month, we might see that we are now in August-September, and we have received the

claims for June. One reason for this is that until the hospital pays the pharmacy's bill, they cannot check it. Until the senior staff nurses check it, it does not become part of the claim. This is a very time-consuming task. First, they have to see if the supply slip and the request slip from the hospital match. Second is whether this request slip is consistent with the doctor's prescription. Did the doctor actually ask for this medicine according to this prescription? This is time-consuming. Otherwise, it's not exactly a problem; it's just time-consuming.

Then it is seen that we have done some C-sections. It was found that some claims have come in. Among them, it was seen that a signature is missing, some evidence is missing; an X-ray was done, but the X-ray report is not there. The prescription mentioned an X-ray, it was shown in the procedure, but there is no evidence. Then perhaps this file would be sent from Dhaka, but in that lot, his claim might not have been passed at all. It might be seen that we still haven't been able to pay the bill for May due to a lack of evidence.

We scan the evidence for every admitted patient. This is the job of the SSK booth. He scans and prepares the documents then and there, and a soft copy of each is kept on the computer. But when we send the documents to the accounts officer, a hard copy is needed. That's why it's a bit slow. But the claim process is new for us as well. It is mainly new for the hospitals.

There are two problems here. One is that the thing is new, and another is that there are no skilled people. Again, it is seen that they always say, "We don't have people in this post. You have given us work, now give us people.". Actually, this is their job, they would have done the work, but this work has to be done in a slightly different way. Then they say, "No, someone else does this work. Give us people.". Then they leave the work pending. As a result, the work slows down.

In the beginning, the problem was, what is a claim? How do I make a claim?. Things like that.

For example, we refer to the district hospital; the claims from the district hospital take some time to arrive. For this reason, it is seen that we have received the claims for December, January, February, and March all at once. For instance, we have received the bills from last May to this year's May all at once.

We have said that it must come 99% clean from the district hospital. Then they don't send it to us; it is sent from the district or from Tangail. Their head office has some experts who verify and check these again to see if they are correct. After that, they send us a list of diseases and patients with a forwarding letter; this is the process. That's why it gets a bit slow.

At the below-poverty level, it is seen that this is not exactly a problem. There are some political dynamics; it was seen that number one is the list. It is seen that we prepared this list some time ago when we started work in the field. Initially, there were some errors in that list. Over time, it was seen that some political changes occurred there. For example, when we did it during the BNP era or the Awami League era. Because at the ground level, it is not clear who is BNP or who is Awami League or how they came to be elected. And at that time, there was no boat or sheaf of paddy symbol; the election happened in a different way. Anyway, when we now go to the field and give it to the UHFPO, they say that this list is not ours. We did not make this list. There are more people from this party, fewer people from that party. Our advantage is that we have come through a process. Their argument does not hold there, since we have come through a neutral process. Because they are government employees, they have no political involvement. If we had it done by a member, they might have said something, but there is nothing to be done for those who were left out. And there is nothing to be done for those who are on the list either.

In our country's context, when the list was first being made, the HA thought of including my own child, and what usually happens, included all the neighbors. They might not have understood its use. Now, perhaps these things will have to be revised later. So this list has a political influence, and nothing else.

The donors had some misconceptions. In the beginning, they thought this won't work, that can't be done. This is not possible; the government cannot afford this cost, things like that. But now it is seen that the government itself is bearing all the costs. It is giving the premium, all the money for the project. So the donors have no more confusion about this. Before, there was a question of whether it would happen at all.

Many donors have visited these sites of ours; perhaps they came and saw that some things are weak here, some things are weak there, that's it. We know that weaknesses can exist. And some things might be unknown to us. So the donors now... previously the donors' stance was that it will happen, or it won't happen. We have overcome that stage. The suggestions that are coming from them now can be accommodated. Again, perhaps our concept is not clear to many. Then we say that our model is actually like this; we have designed it this way. Although we say it's advanced, what is being implemented now is not the complete design. What is happening now is only for BPL, only IPD, only public facilities, but our design is, we should include OPD, we should include private facilities, we should include APL. Only then will it be insurance.

Initially, we did everything as a soft opening; if you open everything, it is unnecessary. But the design is for APL, BPL, public, private, IPD, OPD, everything. We are going step by step. For example, we are taking one of three upazilas, we are giving IPD instead of OPD, we are using public facilities instead of private. These things need to be understood. Why is this being done? This is being done for better management, efficient management. If you know that you don't have the capacity, and you still do it, it will be foolish, it will be suicidal. So we are only taking public, only taking IPD. Now we are gaining experience.

The challenge is that people are coming to the OPD with the card, with the expectation that with this card, we will get everything for free. They come and see that they have a fever, a cold, or a cough. The medicine that the doctor prescribed for them is not available from the government supply. They are not getting it in our pharmacy. Because we don't have OPD, only IPD. Then they think, what's the use of this card?. They shout. "Why did you tell me? I wouldn't have come from so far. I would have bought medicine from near my house.".

The internal challenge of SSK is human resources. This is a big challenge. The government is very sincere about IT; we have introduced telemedicine with help from UNICEF, but we have no control. The problem is human resources.

People go to government hospitals for two things. One is human resources, meaning no doctor, and the other is no drugs. And both of these are the government's responsibility. The government has to ensure these things, which we are not able to do. Many are giving advice like outsourcing this and that. But it's not a solution. A suitable solution. Outsourcing might work for security, but for doctors and human resources, this perspective is totally different. The government has to ensure these.

Retaining staff; sometimes they are providing staff, sometimes appointing, sometimes transferring, they are going on deputation, but they cannot be retained. They might be going on study leave from various sources, taking deputation to different city centers. They are going to the district hospital on deputation. Then there is nothing to say. This is the system. That I will go to study, you will give me leave, this is the normal system, the law there. According to that law, they are not doing anything wrong. But we are facing a lot of problems. Because all those posts are becoming vacant. For example, if there is no

consultant for medicine, it will be a big problem for gynecology. Gynecology needs two things. One, it's not enough to just have a gynecology doctor; if there is no anesthetist, gynecology can't do anything. This is a pair. These things are very important.

We have done a survey at the upazila level; the business of every clinic is surgery. That is, a lot of deliveries happen. They survive on this. What happens? It is seen that doctors come on weekends, after office hours, and perform surgery. It is seen that they stay for two or three days. From there, they get 13,000 or 14,000 Taka. Now they are surviving by doing this. Our statistics show that in an upazila, maybe 130 deliveries would happen, of which 3 happen in the upazila facility. As I said, there are no people at that time, the pair is not there. These are the problems. These things need to be ensured.

We have arranged residences for doctors in Kalihati, but still, they do not want to stay there. Then perhaps it is seen that we have chosen a location near Dhaka for the convenience of monitoring, but still, it is seen that many doctors travel from Dhaka. We set out and they leave, arriving by 9 in the morning, while they might arrive at 10 or 10:30 AM. So what will be the image of this hospital, that the doctor does not come in the morning?.

When I need surgery, the doctor will not be available. This security image is a big problem. The availability of doctors is a big problem. Doctors are not being found in public facilities. But the same doctor is working in private. If you call the private clinic, that doctor goes there. They leave during office hours. By 11 or 12, it is seen that they have left within an hour.

There are also many vacant positions in management or administrative issues. It is seen that where there should be four people in accounts, there are two. For our SSK, if we want to give someone specifically to only look after these files, the SSK store, they say they do not have the people. This exists at every level. First at the cleaner and security level, then at your service provider level, and at the office administrative level. Overall, this is the situation.

And frequent transfer is a problem. Transfers among service providers are more frequent than in administration. The problem in administration is more about vacancies. Along with vacant posts, this is a problem. Someone might come, stay for two months, six months, then go on study leave.

To do it with a broad perspective, the number one problem is that you cannot do many things at once. There is a matter of capacity building.

At the central level, there are some limitations at the moment. When we phased out Green Delta, when we went to a new phase. We identified those problems by changing some organograms. Now we are trying to solve them. For example, we have assigned a coordinator at the district level. We have assigned a project manager at the district level. There is a financial manager at the central level. The things that used to come here before, particularly claims, are now being filtered and solved from there. If there is a need to go to the field, they are going from there. It is easy to go to the upazila level from Tangail. So when it is filtered from there, here it will be more or less 90% accurate. An error of 5 to 10% is acceptable for us. We have thought about it that way. We have kept a field facilitator for the SSK cell in the field, but we have created 3 posts for the next 3 upazilas. The money is allocated in the OP, and also in the salary. This is the government's project. Because they say that they don't have staff; they have 4 posts, but only two people. Those two people spend all their time running to the bank and typing letters. That's why we have taken one person dedicated to SSK.

Recommendation:

What capacity does an upazila hospital have?. Capacity means in terms of infrastructure capacity, human capacity, equipment capacity; the government knows what posts they will have here, what expert doctors they will have, what equipment the doctors will have, X-ray, ECG. So considering everything, which services are affordable here. That is, which services these doctors can provide, or with these machines, what can be done here, or whether more than 50 patients can be kept in this hospital—considering all these things, we have identified 50 diseases.

We will revise this benefit package; in the second benefit package, we have identified almost 19 diseases. In the upazila where we have worked for the past year, we have spoken with the doctors, and from the medical records of the past year, we are finding out which diseases need to be added and which need to be removed. But we are not in favor of removing any disease. Because we are thinking that when this becomes nationwide, if a disease is removed from one upazila, it might be found in another. Since that is our approved list. We have a steering committee, the Minister is the chairperson, we have to get approval from them. We want to keep the approved list and add 19 more to it so that ultimately there is a complete list. We have already identified 19 diseases that will be added to it.

Now a change has come within them; they themselves have learned something. It's a way of another capacity building. Our biggest capacity building process is learning by doing. We will include some courses, not just do some courses and leave them after a month or two. We will build up their learning capacity very closely. We have said that you recruit a doctor; it's a new project, a new phase, we have faced problems, so we have recommended it.

If someone thinks they have been left out, because we have included BPL and we have also included APL, the possibility of being left out is low. Even so, if someone is left out, then alright, you prepare a list of BPL, a ward-wise list, and then we will put that list through a process. Everyone has to come through the process. Tell your union's ward member, he will give it to the union, if the union agrees, then it will be given to the chairman. Then if the chairman agrees, it comes to us. Then we will give it to Green Delta. Green Delta faces problems. Because they work in the field.

Insurance is cross-subsidy. You are a rich APL, he is BPL. You are giving one thousand taka, he is also giving one thousand taka. But he is a poor person; as someone vulnerable, his will be used more. So until we include this APL, the element of insurance is not really there. Then, we currently have public facilities; if we do not include private facilities, then it is not working for us. For example, a facility has 50 seats; if our 51st patient comes, where will they stay?. So one is to accommodate private facilities, and the second is to start OPD.

We are now implementing in 5 areas. The most frequent, most important ones. Addressing catastrophic illnesses. For example, a poor person fell ill; now if he goes to the doctor and becomes even poorer, or a family is completely destroyed, our goal is to address that situation, to provide support in that area. For instance, an elderly person has diabetes, a chronic disease, then it is seen that they have to buy medicine every day. For example, medicine for blood pressure is cheap. But that is a burden for them. Buying medicine every day. If we can adopt this, very cheaply, often these medicines are available from government supply. So we have identified 4-5 items; we will include those in OPD from the next phase.

To include our private sector, we need to fix a pricing. The price at which we provide service in public facilities, we will not give the same in private. We have to negotiate. Before that, we need to try to figure out what the price will be like. We are continuously figuring out an acceptable price through studies.

OPD, private, APL. How will APL come?. We cannot force APL. You have to approach APL with a voluntary approach. When the hospital's reputation is created, the system develops, drugs are available,

doctors are available, the lights are on for 24 hours, then they will say, why should I go to the district?. Why should I go to a private facility?.

Giving an incentive to the doctor, whether it's on top of the doctor's profession or on the hospital's reputation.

Building an image takes a lot of time. It takes overnight to destroy a person's image, but if you want to build it, it takes a long time. Private facilities are bad in terms of equipment and staff. They have many conditions, like having a full-time doctor. We want to make a traditional policy plus fix the pricing. Why are we not moving very fast?. We ourselves are not confirmed if this price is right. We are testing this price on public health. Once you confirm that this is the price for this disease, these drugs will be needed for this disease, these drugs will fall within this price, then we will negotiate with the facility. Then, keeping a profit margin, they will provide this service. But this is the criteria, the process, the standard they have to maintain.

We have addressed 3 dimensions. Gradually, the first one, the short-term one, is to include OPD; the medium-term one is to include the private sector, and the long-term one is to include APL. When these three happen, only then will we call it the SSK model. That is our insurance model, the social protection health scheme model.

We are providing service to poor people in a systematic way. If we can make the hospitals functional, you see, like at a train station after Eid, thousands of people at the ticket counter in the morning, that kind of situation is not acceptable. What have we done? We have sent the ticket counter outside. We have put up a shed in the field. Because the hospital's discipline is being ruined. If we can activate the upazilas, keep doctors, keep drugs, keep patients here, provide service, then it will automatically become functional. The district hospital is for serious patients; why do senior doctors there provide treatment for colds and coughs?. They will do more research, they will do more serious patient surgery and other things; this is actually being misused. So this is the total reform perspective. I said SSK has so many dimensions. Covering the universal health coverage, utilizing the upazila level so that will give you the whole change in health service delivery in Bangladesh. The implementation of SSK is vast. Many are saying that SSK is for the poor, but actually, SSK is not for poor people. SSK is insurance. You cover the healthy people in the project; until you have the rich people in the project, how will you do the cross-subsidiary?.

Unhealthy people, they are more vulnerable; children, they are more vulnerable; the elderly are more vulnerable. So when you provide service to them, if you only provide it to those below the poverty line, then you are at risk. Poor people are sick; poor people need IPD more. If you can include APL, then you will have cost-subsidiary. And through cost-subsidiary, it will be sustainable. Otherwise, it will not be sustainable. How long will the government give money?. So this is the model.

There are 2 approaches to remove these. One is to give incentives. For example, how much will the hospital get for performing a surgery?. Let's say 13,000 Taka for instance. We now want them to get a benefit from this, whatever financial, non-financial benefit of any kind, an incentive. Not a benefit, an incentive, like an honorarium, they will receive. Then they will attend to more patients. What is the need for so much running around?. If they get money from our public hospital. If they get money from the public hospital, they are not supposed to leave.

For example, this month they saw 50 diarrhea patients; they will get 50 x 500 Taka from the hospital. Their cost might have been 30,000 Taka out of the 50,000 Taka. Another twenty thousand Taka is remaining. If we can give a part of this to the providers, then they might say, "Bring more patients, you tell people that diarrhea treatment is good here, C-sections are good here.". "We will do more C-

sections.". So if they get eight thousand out of thirteen thousand Taka, five thousand Taka remains. If the provider gets a portion of this, then the doctor will say, "Keep it, I don't need to go there. Send the patient here.". "Get them admitted, I will do the treatment, I will do the surgery.". It might be seen that they get 25% of the whole package. We have proposed that if a doctor's salary is 50,000 Taka, they might get 5% of that. Those who are senior might get a bit more, those who are junior might get a bit less. By doing this, an amount might remain with the hospital. Management cost, because the facility that is there, we can create a fund for its OT, perhaps the OT light is out, for cleaning, for buying furniture, we kept 25%, and 75% was kept for the providers. This is one way.

We have argued with the government. This had two objectives: one was to motivate them, and another was so that they would be available round the clock. The government says that they have some problems. They will admit it, but their problem is that in one upazila, there are officers from many departments. There is an education officer, an engineer; all kinds of people are in the upazila. If we only give incentives to doctors for their work, it will create disorder in other departments. This is also true. The government has to think about many things. The government is saying not at this moment. We should first see how we can give some more non-financial motivation, incentives. After doing that, we might think about financial incentives at some stage.

Our international consultants came, we had a meeting with them, they said that once you give it, you can't stop it. But still, if the financial aspect is there, it is unmanageable, but if it is non-financial, like providing something. For example, arranging transport. They live in Tangail. They went home from the office; a car can be sent at any moment to bring them. In the morning, 20 staff members are in Tangail city. A car will go by 8 AM to pick everyone up. Everyone is obligated to come to the office by 8 AM. This is not a huge investment either. That car will drop everyone off and leave; they will do their duty as they please. Again, by 2 or 2:30, it will drop everyone back in Tangail. Then those people can ensure your service from 8 or 9 AM to 2 or 3 PM. They will tell a doctor or a gynecology doctor that you will stay for them, a car will be sent for you, you will come; they will say, okay, no problem, let the patient be admitted, we have our doctor. These local-level initiatives are missing.

The difference between private and public is that after work, no one can be found. There is an emergency. Patients are going to be admitted to the emergency, patients are being admitted to the emergency, but we need to ensure the availability of our other gynecological doctors or other necessary things, the doctors that need to be there. Otherwise, the negative perspectives will not be eliminated. If this can be done, then I think it's okay.

We have a steering committee through which we inform at various times. Besides that, we have nothing to do. We are trying not to do anything that is not sustainable. We will not do anything that will be fixed overnight. Or that will not be there after two months, or that we cannot afford. The government will own this at the end of the day. The government will say, "Hey, where did this person come from?". "Where will I get his salary from?".

We will do such a pilot that the government can carry it out in various upazilas. Can scale it up nationwide. That is why we are trying to, with the existing system, if there is 1 person out of 5, then to make it 3 or 4. Then it will come into a system. This is the office administrative thinking.

To do it with a broad perspective, the number one problem is that you cannot do many things at once. There is a matter of capacity building. Each model has to be introduced in each place. And to introduce it, its barriers have to be identified. Each upazila will have different barriers. Somewhere it could be an infrastructure barrier, somewhere a human resource barrier, and somewhere an equipment barrier. The specific problems for a specific upazila need to be addressed. We will tell them that these things must be

present, this equipment must be present, this pathology must be present, this rearrangement must be present, or this staff must be present. When you go to each upazila, you will face different kinds of problems in each one. Then you have to handle the challenge accordingly. For example, it might be seen that there is a doctor; if it is near a city center, perhaps because he cannot come to the city center, he is in a peripheral upazila. There, it is seen that human resources are not a problem. For example, in Dhamrai, human resources are not a problem, for instance. Since they can travel to and from Dhaka, but the problem might be in some other area, perhaps there is no equipment, perhaps the facility is not right. So you have to address it that way. So it cannot be said in one word, this is the solution. The specific problems for a specific upazila have to be addressed according to those problems.

The second reason why this cannot be done all at once is that SSK has to be explained to everyone. How this facility works, how this fieldwork works. When you understand that, then you can start in that upazila. Perhaps you take 10 upazilas, training is given in one of the 10, and you identify different problems or challenges for the 10, and you address those and do 10 at once. Because it cannot be done all over the country at once in lots. We have targeted 3 upazilas initially. Our target is Tangail district; Tangail has 13 upazilas, we are doing 3. We might take another 5 later. In this way, we might take 5 and 5, making 10. This will make two phases for us. The experience we will gain in this pilot, based on that, if we take 5 at a time, it will not take as much time as it does now. After doing it for 6 months, when it starts, then perhaps another 5 can be done in the remaining 6 months; then it might not take that much time. If we divide it district-wise like this, it depends on how many upazilas are in a district, small district, big district, for example, Tangail has 13 upazilas. It has to be taken district-wise for this reason. Since the district hospital is the referral hospital. So when we decentralize this, the district hospital will automatically become capable. The quality will improve. They will then also do the real work they are supposed to do. This is a huge task for us. If we can do Tangail district, then 64 districts like this are no big deal. When your capacity increases at the field level, then we also have to increase our capacity at the central level. What is the concept at the central level?. We have created an SSK cell in HEU. What is the long-term objective of the SSK cell?. NHSO, National Health Security Office; this National Health Security Office will come under the Ministry of Health. Not under DG Health or Family Planning. It will be an independent body. Its capacity needs to be increased. When you take one district, you might add 5 more people with the SSK cell. With that, you can run Tangail district; along with that, if you take two more districts, maybe it becomes 50 upazilas, then you have to manage your growth. If your body is thin and the work is big, then it will collapse on your head. So you have to grow yourself first. You have to grow yourself, and also grow your branches. Even if the branches and the tree grow, if my body is thin, then I will collapse. So this SSK cell also has to grow; it also has to move towards NHSO. Our model is the National Health Security Office. At the end of the day, the SSK cell will turn into NHSO. In NHSO, we have said many things; in our NHSO, who will be there? Service provider, public health service provider will be there, a financial unit will be there, an accreditation health unit will be there. The job of accreditation will perhaps then be not only for private but also for public facilities. Then perhaps the public facility will have to sign a contract with the government. Government-to-government, perhaps they will have to ensure that we will maintain these services, these standards. We have 3-4 models like this. These models will have 3-4 directors. There will be one executive director. They will design the NHSO. This NHSO will then control everything. Our long-term plan is, in the meantime, what we are doing through Green Delta, through the scheme operator, when NHSO has the capacity, this claim process will be done through NHSO itself; if NHSO wants to introduce any private organization for its own interest, this design is for that. The design is being tested. Later, if it is seen that having a third-party private sector is good for accountability, for transparency, and if NHSO can afford it, because what is Green Delta's job?. They are only getting a service charge. Their work is up to a certain part, besides that, there is nothing else. Now we can say that for Tangail district, Green Delta or any one scheme operator, and for another district, we can appoint another scheme operator. The growth of NHSO has to be in line with that. If NHSO grows at that rate, then it will be very manageable for you. This is your final suggestion.

Then, what we said is most important is IT-related. For IT-related software, we have contracted with Heritage. We have an IT consultant from our OPM. When the software is being implemented at the field level, when the users are seeing it, the complaints that are coming from the users, we have to translate those complaints and tell Heritage. Heritage then modifies and adjusts it accordingly and gives it back to them. We have an IT person here, a consultant from our OPM. We have to be in the SSK field. When our IT team is not there, then the growth of the SSK cell must be there. From our experience, we need one IT person, one accounts person. Here, each upazila needs an SSK person. For our SSK cell, those who are there, maybe instead of two, there will be four people. Maybe we will have six people. There will be one director. That is internal.