Key Informant Interview 7

Challenge:

Our upazila selection was supposed to be in 3 categories. One was based on income poverty, and from a geographical location perspective, one would be very close to Dhaka, one would be very far from Dhaka, and another would be in the middle. But we were not able to do that.

Initially, GIZ/KfW was supposed to provide the main funding, but later it came into the hands of our government. Now it is mainly being done with government money. Although there is donor money here, it comes in a way that we spend it and get reimbursed. But basically, the support that was previously available directly from GIZ/KfW is no longer being received from them.

We do not have manpower. We have no people at the field level.

There is consideration of giving incentives to government service providers, and proposals have been made several times. The matter has not yet reached the stage of giving incentives; incentives are not being given, number one. And this money that is being given, a large portion of it is being spent on medicine. The main problem is with medicine.

Since we are Dhaka-based, we have no manpower at the field level. Therefore, we do not have our own people for tasks such as looking after the welfare of the patients, enrolling them, checking if they received proper treatment after coming to the hospital, checking the claims made by the hospital after treating the patients, and communicating this in the field to publicize it among the people.

Our first challenge is the core aspect of the SSK concept; one of the main characteristics is that the hospital will have financial and administrative authority. The health service providers at the upazila level will have autonomous decentralization. But our public finance management's financial rules and regulations do not allow this; this is their automatic rule. Normally, any government office spends money from various allocated sectors in a specific way, but the idea of them budgeting locally, giving more money to those who provided more service, giving more as needed based on local requirements, that they will spend, they will budget, they will plan—we have not been able to give them that power, and for that reason, we have not been able to achieve the main objective of SSK to that extent. This is a challenge.

The barrier is the public financial rules and regulations.

We have had several meetings about relaxing the public financial rules and regulations for our health service providers. This is an ongoing process.

One challenge for us is our doctor problem. The consultant problem. In the upazilas where we are conducting the pilot, the number of people compared to their sanctioned posts is very low, much lower. I think where there should be 10 people, there are 2-3. In total, 25 or 26 posts are vacant. Since these tasks are done by the Ministry and DG Health, we lobby with them. After lobbying, postings are given, and after some time, they lobby and manage to leave from there. Because our health service providers' concept of SSK is still not clear to that extent, the attitude of many of them has not become positive.

Our contract with Heritage has also expired. The agreement was that after a specific time, they would hand it over to us and leave. We would operate it ourselves. But to operate it, we need that kind of skilled manpower.

The problem is with the service providers. Our health facility has far fewer people than it is supposed to have. As a result, patients are coming, we are ready to pay money in exchange for service, but we are facing problems because health service providers are not present at the Upazila Health Complex.

There is really no "no" to transferring doctors. It's possible not to transfer them for two or three years. Many have been there for three years. Many stay for five, seven years. And in many upazilas, doctors stay for a long time. This pilot period is for three years. We have requested that they not be transferred. But what happens is that those who get posted at the upazila level do not want to stay. They try to lobby and get transferred out. We are also pursuing this matter.

Another challenge is our traditional mindset. This is in all work. What we are trying to do is not just a change, it is a revolutionary change. If this is to be implemented in its full phase, it will reform and restructure the health sector. Yes, to do that, our old traditional mindset will stand as an obstacle.

For this reason, dynamic leadership and political commitment are our tasks. The evidence we will create from this pilot, how logically we can present that evidence to the policymakers, will determine whether we can actually carry out the structural reform properly in the future. Then we will be able to overcome these challenges.

Recommendation:

It will take some time to overcome this. If we can show the government the benefits of this pilot, that we have achieved benefits, and that if we had received these services more correctly, we could have done even better. By benefits, there are two things here: how much money the government spends on an upazila hospital, and how much service we have been able to provide with our expenditure—meaning the rate of return. If we can make the government understand that the rate of return in our proposed payment and financial method is higher than the normal procedure, and if the government is convinced, then surely our barriers regarding public financial rules and regulations and providing doctors will no longer exist.

Not a long duration; we are thinking of three years for the pilot. Our job is to finish this pilot within these three years. Within this period, we have created some forums to work with the policymaking circles. For example, we have the Health Finance Advisory Committee, the Health Finance Advisory Working Group, and at the national level, we have formed a committee with the minister as the president and members from other ministries like Finance and ERD. This has been formed in the model of our previous steering committee. Although a bit difficult, the steering committee was only for the SSK piloting. The new Health Advisory committee that we have formed now is to work on how to generate more health financing nationwide, how equitably the money allocated for health can be distributed, and how efficiently it can be spent. This committee that has been formed at the national level will actually work at the national level.

Our other thing is, SSK is only for those living below the poverty line. But our goal is Universal Health Coverage. Our Health Care Financing Strategy has been mentioned. There are many population groups there, and the schemes are also different; not everyone may be brought under the same scheme. Yes, time will tell whether there is one scheme for the poor, or if even within the same social insurance scheme, the rich contribute according to their income while the poor do not. That could also happen. The scheme could also be region-based. In this way, we will advance Universal Health Coverage.

We basically want to see that with the method we are working with, it is possible to provide more service with less money. Health service and quality health service.

Its financing, as you said, one component of our operational plan is SSK, which has two major parts: payment to the scheme operators, and from the premium money, we are paying the hospital's dues. And from the scheme operator's money, the scheme operators are paid. Besides this, we have allocated funds for some training, motivational work, and workshops so that we can provide some training to the health service providers of that area to make them understand the concept and the practical work. By conducting some workshops and orientation meetings, we have also allocated for some operational training activities so that we can involve other local stakeholders, such as government officials and public representatives at the Upazila Parishad.

Any problem related to the committee cannot be generalized. Because the relationship and understanding between the committee's chair and its members, the better it is, the better the team will work. It may be seen that one upazila is doing a bit better, while another is a bit worse. Where the personal relationship between the UHFPO and the Upazila Nirbahi Officer is good, it is seen there that they are going to pass; this cannot be generally called a challenge. Because wherever there are committees like this, it is seen that where the committee's leadership or personal relationships are good, good work is done. A committee is essential. Because our thinking was that local participation must be increased if the community is to be involved. Then you have to form a committee by involving the people of the community.

We have allocated for some manpower, including a Systems Analyst and some Computer Data Operators, among other posts. There are two methods to fill these posts. One is outsourcing, and the other is through regular recruiting.

A Systems Analyst is supposed to be appointed; the ministry is handling that recruitment. The ministry has not yet finalized the rule. There are 29 other operational programs under this sector program; recruitment will happen everywhere, so there will be a common recruitment rule. As soon as we get that rule, we will quickly appoint people who will take over the problems.

The issue is to orient them (the service providers); once oriented, they will understand that it is a positive thing. Then their perspective will become positive.

We will raise the issue at the next steering committee meeting; we have already told the honorable Minister and the DG sir. We will try to ensure that those who are posted here will not be transferred until the pilot is finished.

Another challenge is our traditional mindset. This is in all work. What we are trying to do is not just a change, it is a revolutionary change. If this is to be implemented in its full phase, it will reform and restructure the health sector. Yes, to do that, our old traditional mindset will stand as an obstacle. For this reason, dynamic leadership and political commitment are our tasks. The evidence we will create from this pilot, how logically we can present that evidence to the policymakers, will determine whether we can actually carry out the structural reform properly in the future. Then we will be able to overcome these challenges.