Key Informant Interview 8

Challenge:

We have faced a problem at one particular point, and that is IT—SSK's IT. Since we (HEU) do not have our own capacity to manage IT, we were looking for an IT firm. SSK still does not have the capacity to manage IT. The Indian firm from which we purchased it is currently managing the IT. The time has come for it to be handed over to us. Our contract with them will end this December, and then HEU will manage it. But due to HEU's lack of capacity, we are now seeking assistance from the ministry so that we can appoint a person with the help of MIS who will control the entire IT system. We do not have a programmer either. Our current budget will not cover it. Both the Systems Analyst and the Programmer are not within our SSK budget. Because when SSK is handed over, we have to understand it completely; otherwise, it will collapse. When it is run by HEU, there will be no one to look after SSK's IT. Without IT, SSK will not run. From each patient's registration to the claim, the entire process is IT-based. If there is a mistake or a halt anywhere, SSK will stop. We need to overcome this immediately. For this reason, we are very concerned about whether we will find a qualified IT person. The hospital and facilities for SSK were not completely ready. As with our usual government facilities, there were some infrastructure deficiencies, so some additional work was essential for SSK's needs. There were some challenges in the construction work. We found that some more work was necessary beyond the work plan we had provided. Our hospital did not have a nurse's station. A place for nurses to sit is needed in every ward. When our previous government built the infrastructure, these things were not there. There is no station for nurses within the ward. Because of SSK, what we had planned was that there would be a nurse's station in the ward. The nurse's room has not yet been constructed in many places, which is why we are doing it again. Then comes the lab. We had made a counter for giving medicine. Its repair and further work are still pending. This year's work has not yet begun. The biggest challenge with equipment was that we did not and do not have any capacity to purchase equipment. This office has no authority or approval for procurement. The authority to purchase everything was with CMHD, which was done through the World Bank. Through the World Bank's web portal. In that case, the challenge was that last time when we went for construction procurement, we saw that we upload to the World Bank's web portal, this upload goes to the ministry, they send it to the World Bank, and after the ministry sends it, it gets approved. First, the World Bank approves it, then the ministry does. Then CMHD gives the order to purchase. In this process, for the necessary products and equipment for which we had a budget, we uploaded them for purchase, but the World Bank rejected most of them. For that reason, we could not purchase them, despite having the money. We had a budget for a digital X-ray machine, but we could not purchase it. It can be said that we could not purchase more than 50%. The World Bank did not give approval. Regarding procurement, we still cannot say for sure. The new purchase requisition that we have given to the ministry, based on the UHFPO's requisition and SSK's needs, has reached the ministry. But the process of their approval has not yet started. After it is approved, it will take more time to purchase. This remains a challenge as to when we will be able to purchase it. It will take another ten months, as we saw last year that it took nine to ten months. We have no shortcut to face this challenge, but we cannot make technical procurements. For technical procurement, the government has no other committee except for CMHD. If an expert says to buy an ultrasono machine, there is no expert on ultrasono machines except at CMHD. It has to be given to them as consultants. But CMHD's procurement processes are complex and lengthy, taking almost a year. Whenever you want to procure something, you cannot buy it. The entire tender process starts at the same time and also ends at the same time. We received last year's items this year. So this challenge remains; there is no way out. Even if we want to, we cannot purchase it in a hurry. For example, we still have not been able to purchase a digital X-ray machine. It might take that much time again to get it. It will take eight to ten months. Since we had the demand. We wanted an analyzer for the lab. Due to the lack of an analyzer, many tests have to be done from outside; the UHFPO has to get them done from outside for the patient. This is a problem. When a patient came to the UHC, they had to get the test done from outside as it couldn't be done here. Since they have been given this opportunity. This is causing some inconvenience

for the patient, and the normal activities of SSK are being somewhat disrupted. For example, it was seen that they needed a digital X-ray, so they had to get it done from outside. In this case, there is some delay in SSK's treatment. Then, for instance, we were not getting trolleys and many other things; in that case, it was very difficult to carry the patient. There are not enough stretchers in the hospital. What happens when there are no stretchers in the hospital is that the patient has to be carried in someone's arms. We were facing these kinds of problems. We are still facing them. We still have not received many things. The microscope broke down, now it's not being done here, so it has to be done from outside. And in the lab, our main problem is with our diagnostic equipment. While preparing the claim file, we have seen that the problem that arises is that since the hospital doctor shows no interest in preparing the claim file, when we ask, "Why are you not preparing the file?", they argue that they do not receive any incentive for SSK, that SSK is not their job. I hear many people say this; they consider it (SSK) extra work. The SSK file processing is delayed; this is a challenge for us. Although we have placed a coordinator here, the coordinator, I mean, to prepare that SSK file, he has to get clearance from the doctor, get signatures from the doctor, and fill out many forms for the doctor that were not filled out. So he has to go to the doctor with the file. If the doctor did it voluntarily, he would not have to go and would not have to face this challenge, and the claim would not be so delayed. We want this claim file to be ready within 7 days. For an ideal claim, this is desirable. In that case, it is seen that even after a month, we cannot get it pushed through. Even after many reminders. Because that file has to be taken around to many places. How is the file prepared? We have given a checklist that the condition for this claim is that these papers, these documents must be present, then we will settle or accept the claim. In the case of those documents, it might be seen that they had an X-ray done from outside, but the X-ray receipt is not there. Then the file gets stuck again. That receipt has to be brought again, but bringing these receipts is not always the patient's responsibility. These are then imposed on the hospital. The hospital says, "I am bringing it, I am bringing it," causing delays. The disease with which a patient is admitted to the hospital often turns out to be something else. Perhaps the provisional diagnosis is one thing; the patient cannot always say if it is that disease or not. A patient is admitted with stomach pain; it could be a gall bladder stone. Later, when the diagnosis is made, the disease that is identified at the time of provisional entry, when we determine the expenditure package for that disease at the time of discharge in the claim management, the doctor's cooperation is needed. The doctor will ensure which package the disease falls into. When the patient's claim is being registered, the doctor is not ensuring which package it will go into. A package is assigned then. In that case, the doctor's advice is needed. Before finalizing the claim, there is a column for the doctor; he determines the package, and for that, one has to run after the doctor. The doctor does not give the time to update the file. There are delays for a few more reasons. Firstly, the documents have to be brought here. The conditions for the claim are a slip for medicine, a slip for investigation; if they have done a test from outside, then that bill voucher, and for the pharmacy's drugs, they have to provide a voucher. There is a delay in providing each of these bill vouchers. Especially the person running the pharmacy has to make the bill. We have trained them a lot on how to make a bill. There is no urgency in them to make the bill quickly. The bill is being delayed due to a lack of capacity. The pharmacy is late, the bill for outside investigations is late, and when they go to get clearance from the doctor, it is also delayed as to which package it will go into. After we give the package, it might be seen that they have a credit of 50,000 taka, and from there, the claim is processed by subtracting from the package's value. So we have delays in that area as well. We are seeing the biggest challenge is with the claim. Then, when the claim file comes to us, it goes to Green Delta before coming to us, because since this file is a hard copy, why is the hard copy needed? The hard copy is required under our government's financial rules that a bill cannot be paid without a hard copy. If we think about the technical side, in that case, we have taken the responsibility of the clinical side here. If you talk about the non-clinical side, that responsibility has been given to Green Delta. They are supposed to check the physical side of the clinical aspect, that is, whether the file is correct, whether the physical side is actually correct, whether the patient's ID matches the claim software, and, for instance, whether the few documents we are asking for the claim are really there, physically present. So some time is being spent here as well. After checking, some files have to be returned from there. They are returned because they are incomplete files. For example, it was seen that

they sent it in a hurry without many documents, perhaps thinking if they send it quickly, they will get the money, but this happens because the RMO or UHFPO, who are supposed to be responsible, do not check it properly. However, the coordinator we have placed has also shown some incompetence due to his lack of practical experience in this area. When we receive a month's claims, we have formed an evaluation committee. In that committee, we have included consultants from medicine, gynecology, and surgery; we also have to get a date from them for when the committee will sit for a meeting. We will divide the files: medicine files to the medicine consultant, gynecology files to the gynecology consultant. Often, the consultant cannot even see the files. We also do that. And we don't always get everyone. We cannot settle the claims in one meeting. It might take 2-3 sittings here. Again, it might be seen that the gynecology consultant is busy in a meeting; he does not have time this week. So we ask him to come the following week. Getting time from them is a challenge. When these files are finally settled here, we send them to our accounts officer. After it goes to the accounts officer, the accounts officer sends it to the treasury again. It is sent to the treasury for the bill, then a check will be issued in the name of the hospital, that is, the service provider, for the claim. The challenges I have mentioned, the time that will be required, that is, the solution to overcome this, we actually do not have the capacity for that right now. For this reason, we are dealing with a small number of claims. We are managing somehow, but if there are more claims, this office does not have the capacity. After two more upazilas are added, it will increase again. After more are added, it will increase further. Then these challenges will also increase. We are able to manage it for now. We hope we will be able to manage it during the pilot stage. But later, a separate department for claims will be needed. Yes, a separate claim department will be needed. And that claim department should be outside the ministry. Because constant expert opinion is needed. Because any doctor cannot and should not settle a claim here. Because if they do not have the highest degree, it can be questioned. Now, a government hospital will not challenge it, but if a claim is refused at a private hospital, then they might ask for what reason it was refused, who saw the claim; then it automatically becomes a challenge. The challenge with doctors is that they are not service-oriented; that is a challenge because no doctors are being motivated. That is, the fact that SSK is a national interest, that SSK is a public interest—this matter does not seem to be properly understood by many. For that reason, we are not able to create the mentality to provide good service to SSK patients. This is a big challenge. Especially, there is a frustration among doctors that they have to do extra work, or they feel they are doing extra work. The second frustration is that they think that once someone enters SSK, this project, they can never get out. For various reasons, others are discouraging them. On various pretexts, they find loopholes in the work and harm our, I mean, SSK's work. And where an operation is possible, they do not do it and refer to another place with a different excuse. This is just perhaps their lack of sympathy for SSK. And if we consider the overall situation of the country, we see that the minimum work that is going on in other upazilas, that is, it is seen that in some upazilas operations are happening, in some they are not. But perhaps the doctor is there but does not operate, and in another place there is no doctor, so they do not operate; here the doctor is present but does not operate. "Present" means they are here on paper, but whenever an operation is mentioned, they cannot show any performance on paper. A surgery doctor's primary judgment should have been how many surgeries he has performed in a month. We have not been able to expose that performance. We have not been able to develop that kind of system. There is no method of ours to reward or reprimand based on this performance. For that reason, the doctor gets his salary anyway, whether he provides service or not. Even if he does not perform an operation, he remains in the same condition. So he cannot be motivated in any way. He cannot be held accountable for why you did not perform the operation. We are also trying to work properly. This is happening in two ways: one is through the local committee, and the other is through the directorate general's office. We cannot retain doctors for various reasons. We try to post doctors with a lot of lobbying; we lobby a lot on behalf of SSK. We send letters to the ministry. The ministry sends letters saying we don't have consultants. Since consultant postings are from the ministry. If there are no consultants, we request the ministry to provide consultants. But still, after providing a consultant, we often could not retain the consultant. That is because they also go to another place in some way or another; since they have been appointed through the ministry, they leave again through the ministry. There is nothing we can do here. And second is the medical officer posts; many are vacant here

too. When we request DG Health for these vacant posts, they try to fill them. Some join, some do not. Even after joining, some might leave for a course, or it is still the case that they get transferred; in that case, we repeatedly request the DG of DG Health. But sometimes it is not in their knowledge. In the very beginning, the importance of SSK was not in everyone's mind, which is why someone or other slips away through the cracks. Perhaps a new AD or DD has come; he doesn't know what Kalihati is, he doesn't have it in his mind that there is an SSK project in Kalihati. So everyone has to be oriented. As much as the DG sir knows, when it comes to his attention, if he notices, he might forbid it from being transferred or order it to be filled quickly. Still, it is seen that due to continuous transfers, it is always vacant. Now in the new Ghatail and Madhupur, nine consultant posts are vacant in Madhupur, and in Ghatail, all are vacant except for one consultant. Similarly, medical officer posts are also vacant. Filling these vacant posts is the biggest challenge. Even after posting, it takes many days for orientation. So this challenge remains. There are some challenges in the work of the SSK local committee. That is, the chairman of the committee is the Upazila Chairman, and the respected UNO is kept as a member of the committee. In some cases, due to the conflict between the local government and the UNO, meetings cannot be held properly, and the respected UNO does not come to that meeting. There is still another challenge; some UNOs do not want to come to SSK meetings. In many cases, this creates a lot of complications in the work of SSK. Since they do not come to the meeting, they do not give any decision from the meeting, but later they talk, and this creates some misunderstandings. Although there are many more demands for SSK, since I will not get this from the government. We need manpower for SSK. SSK needs to be monitored. That monitoring has to be done from here now, which is a big problem for me. Our thinking cannot be said. The job of this office is to create policy and options. You can say that we create evidence from here. We are creating evidence through SSK. We will submit this evidence, for example, who will scale it up or whether it will be done at all is outside SSK's capacity. Even if SSK thinks about it, it cannot do it. Because SSK does not yet have the organogram that we had sought for scaling up, because an autonomous body has been mentioned here; in the draft we are preparing named the "National Health Protection Act" for national health protection, we have mentioned that organogram. If we do not get this organogram, then who will scale up SSK? That question will remain unresolved. Although we could have said that we will do something like a National Health Security Office, then we could have said that scaling up SSK is not a distant thought. It is about to see the light of day. But as of now, we cannot say who will scale it up or whether it will be done at all. Since this is not HEU's job either.

Recommendation:

Within the limited budget, if we can bring in a government person on deputation who is experienced, especially in MIS work, then we can face this IT challenge. So, to settle a claim, we must have a consultant. At least a consultant is a must. But to form a body for that consultant and for them to regularly settle claims in that body is not always possible for this office. Since our office has no claim department. Due to the lack of a dedicated claim department, it is running for now, although with difficulty. But it will not run later. It would be better for us if there were a claim department. If this ever scales up, then a dedicated claim department must be kept. Ideally, it should be a different body. A separate claim department body, like the scheme operator. We are trying, in the SSK management committee at the upazila. We are trying to bring these issues to the SSK management committee, so that questions of accountability arise. If each person's performance is discussed in the committee, a sense of accountability may be created among them, or at least some enthusiasm may be created, we believe. Besides, we are trying through the ministry so that special attention is paid to the overall monitoring of SSK. The honorable Minister, the respected DG, so that they keep special track, so that the service providers also know that special watch is being kept on us. Those of us who are working for SSK, you can say we are working with self-motivation. Whatever problems SSK has, I do not consider them problems. If I think I am a government employee or I am such-and-such officer, then I have many difficulties, but that is everywhere. I think that if the monitoring section were separate, it would be better; if the claim section were separate, it would be better; if the admin were separate, it would be better. We don't just have to

work on SSK. Besides SSK, I am also working on Universal Health Coverage, I have to work on the BANA cell, I even have to work on quality. Since we all work together, no separate department has been created here. So I think about the distribution of the workload. In the case of that distribution, it would have been convenient for us if we were more organized. For SSK, what I think is the biggest challenge that is still not being solved is awareness. The local awareness is still low. Even now, if you ask many doctors, if you go to our hospital and ask, they will not be able to tell you the theme of SSK. People from outside will definitely not be able to tell. Those who are outside SSK cannot say. So I think if awareness is not grown from the national level, if sympathy for SSK does not come, we will not get the coordination for the SSK project later on. The respected UNO still thinks, "What is this SSK again?". He is not owning it. That awareness has not yet come to him. Although it is also not there among the general public. Although we are calling the UNO sir to all meetings, everything is being done with him, still, there is a lack of awareness in him. That SSK is a priority project, we should all have a new perspective on this project. A path for our progress, from the current deplorable state of our health system, this could be a path, SSK could be a gateway. This thing has to be brought among everyone. That we need SSK, how we can bring that awareness, everyone needs to think about it. Regarding making it sustainable, my suggestion, which we are repeatedly asking for but still not getting clearance, is that we are still at the below-poverty level, so the government has to provide a subsidy or premium. Whether it's from a donor or from revenue, the government has to pay the premium. So in paying this premium, it must face the question of sustainability, must face the challenge. But if we bring in the informal sector or the formal sector, then premium collection will start, then a common fund will be created, then it will be possible to pay the premium from there. Then it will be sustainable. How much can we bring in at the below-poverty level?. For three upazilas, we managed to get the premium from domestic and foreign donors. But from whom will we ask for the premiums later? But if the government says it does not have money to pay the premium, but if we come to the above-poverty level from now on, then premiums will start to accumulate, right?. We could have created that field. So, give us that kind of organogram. If we can start, then the BPL will be sustainable, and the APL will be sustainable, I believe. Otherwise, if that (APL) cannot be started, the BPL will stop. We need to create a central fund from which everyone will get money.