Key Informant Interview 6

Challenge:

One was whether there would be a separate scheme for different groups, because it is written in books and international experience shows that fragmentation is not good; creating different programs for different groups is problematic. Second, we are trying to launch another government system within an existing system, and the development partners were not comfortable with this. We did not have the opportunity to discard this system and start a new one. The third was that they questioned the sustainability. If we assume that the government will pay a premium of 1000 Taka per household for a benefit ceiling of up to 50,000 Taka, then whether the household's premium is 1000 Taka or 500 Taka, how much money does the government have to be able to pay? How will this be sustainable? Things like this. And some of it was, what should I say, personal—that "so-and-so did it, so I don't like it," there were some things like that. Right after the design phase, we started targeting—who are the poor people? The first step after finalizing our design was site selection. A lot of time was spent on site selection; everyone wants to work in their own area. We agreed on the site selection, and the biggest advantage we enjoyed here was the leadership of the Health Economics Unit. We were able to convince the ministry, the wider government, and the development partner members that we would do it very sincerely, that we would be able to work with great efficiency. As a result, even though they might have had objections, they did not voice them. They said in the meeting, "Alright, they are trying so hard, we should agree with them, we should give it to them." They placed so much trust in us, that yes, they can do it. So this was our biggest, what should I say, determining factor in deciding the outline. After that, we faced the challenge of targeting. The challenge of targeting is not just in our program but in all social safety net and protection programs; identifying the poor is a political process, resulting in targeting issues for many programs. So we made it a bit more inclusive because when we went to do the targeting, according to government statistics, twenty to twenty-five percent of people were poor, below the poverty line. We took a little more, 30%, 31%, so that the complaint wouldn't arise that poor people were left out, alright? Because healthcare is needed by the poor, and also by those who are slightly less poor. Initially, we have these methods in the books on how to target them: a committee at the Union Parishad, health workers, family planning workers, and the family census data of every household. The Union committee will create it based on criteria, the Upazila committee will certify it, and then we will pass it. We did the targeting this way, but still, many complaints came that my people were left out, my party's people were left out. Many such things happened. So we said that we will eventually cover all people, so in that case, everyone will get it. Then they did not object further. After that, we had to get the facility ready because service had to be provided. We prepared the facility, which took a lot of time because it was not possible to implement our planned package within the existing government facilities. As a result, we had to do civil works, we needed some logistical support, manpower, and postings. All in all, it required a lot of preparation from us. Although this preparation is ongoing—because we are posting people and they are getting transferred, we are buying machines and they are breaking down, we are doing civil works and repairs are needed again—still, we started this after a significant investment and a great deal of work. Now, implementation has various challenges and aspects. For example, one is regular management of the situation there—do they need people or not? People are often not available. Patients come after office hours, and they need to be attended to, but at that time, a consultant might not be there. We have set up a pharmacy inside for the patients because we saw that medicine is the main problem. On one hand, patient admission is costly, and since the medicine is outside the government supply, we thought about how we could set up a pharmacy within it. For that, a pharmacy was established, and a contract was given to purchase medicine on a reimbursement basis. This means they will provide the medicine first and later submit a bill to get the money from us. This is very difficult for a small businessman to keep giving medicine on credit. After all this, they will submit a bill, and if we see it is according to our protocol, then we will pay the money. Similarly, with diagnostics, not all diagnoses are done in the hospital; we have to get some done from outside, and the bill has to be made in the same way. So, this is an initiative where we had hoped... at

first, the problem was with registration. We thought that if we could communicate with people, they would be very interested in getting free healthcare. But it turned out that people were not that interested, and since this covers the entire household, we needed to take everyone's photo and fingerprint. We held camps at various times near their homes, in schools, and at the Union Parishad, but they did not come; not everyone could come at the same time. As a result, our initial registration also became very slow. Oh, there are many more challenges left. That is, a card has to be made, an e-card, a plastic card, a laminated card, a smart card with a chip—so many types of cards have to be given. Now, if we make a smart card, it becomes a bit expensive, and then reading it, maintaining everything, is an issue. One objective was that the hospital management would be somewhat technology-based, information technology-based. We had to work very hard to design a system for that. We called many local IT firms and explained to them that we want to provide service in this way. We asked them what kind of program would work. And I was very surprised that although the local firms talked, they could not provide a solution. They could not provide a program. We did not have the technology at the Health Economics Unit; we depended on our DG Health's MIS. The people there held many meetings, said many things, but virtually, that they would create a program like this or that such a program could be made—I personally think they lack that proficiency. The IT we chose, what will happen in the future? I have repeatedly tried to ensure that whatever we take can be sustained here, can be migrated, and that our own people can be developed in the meantime, otherwise we will be in trouble. I don't think we have been able to do this very well. I was most disappointed with IT; this challenge is still ongoing. MIS works with a lot of data in many sectors. So if they cannot do this small part for us, then how will they do such big work? The challenge now is identical to the challenge in health services: it is still difficult to retain providers there. And a unique challenge in our country is person-dependency—if the person who is doing the work leaves, the work stops. That same thing has remained here. It's in the Health Economics Unit, it's at the upazila level, and it's in the district health administration as well. The people who worked at that time, the way they understood things and worked, those who have been transferred in later are not doing it that way. This is a major cause for our concern. There are almost fights. Because everyone wants a posting there. Because even the peon and others, all the primary staff, want a posting there. Because of the incentive. Because of lobbying for that posting, they cannot do any other work. And after getting the posting, there is trouble over how much of a share they got, for their share. There are lawsuits, quarrels over this. As a result, whether the patient's diagnosis was done or not is not important; whether the incentive was received, whether I got my fair share, becomes important. Especially in our developing country where financial governance is not very good and is even weaker, we forget everything when we see money. Alright? You have to motivate them a little. There was motivation; the motivation we have in our regular programs, monitoring, is there. But the challenge is that we are working in a specific place, and their argument is also correct that others are not working in other upazilas but are getting the same benefits as me, so what's the use of me working here? It is difficult to work with motivation alone. The person who was the Civil Surgeon there or the DD of Tangail hospital, he used to visit regularly and work well. He has left, he has retired. The person who has come now is not that interested. Similarly, UH&FPO Belayet, who worked from the beginning, tried to understand and worked hard; the person who came after him does not have that sense of belonging that "I have to work here." As a result, this is not just for SSK, not just for the health sector; this is a characteristic of our entire society that we are very person-dependent. We cannot be institution-dependent. Claim management is actually new for the government. The government usually gives money and things in advance. In this case, it is new. That is why we appointed a third party or a scheme operator. The scheme operator's job is to look at the claims. The one who got the job before this managed small programs. There is no health insurance in our country's health sector. In light of that, they are also learning; it was a learning experience for them on how they will dispose of claims. What has happened in claim management is that the main parties are the hospital, the scheme operator, and the one who is paying, the SSK cell. Coordination among these three would sometimes be a problem. It was often seen that the doctor made a mistake or did something that was not necessary, and it couldn't be reconciled, the cost became too high. Again, the ones who were making the claims, the scheme operator, initially did not have medical personnel, so they did not understand. They would look in a book and find

that this is what is written, but this is not happening, but healthcare does not always follow the book. For example, paracetamol might not work for everyone. So, this is a new thing. Similarly, what happened for them is that ultimately, it often gets delayed to pass the claim bill, and that is the problem.

Recommendation:

There is no trick for this. If there were a trick, we would not have this problem. This is not just for SSK; this is for the entire state, the entire government. To say there is no trick would be wrong; there is a trick, but its implementation depends on wider governance. Yes? If my job performance were well-linked to my promotion and salary, I would work well. But I will get my salary anyway, I will get my promotion anyway, so why should I work? I will pursue other side hustles. This has become a problem. So the fundamental principles of this employment system need to be implemented well. And for this, very good, concerned leadership needs to be established. This is not a difficult task; we just need to agree on some disciplines. Motivation is an everyday task. Motivation is a daily task in our personal, family, and professional lives. I have been motivating my child at home, saying, "Get up, have breakfast, sit down to study, if you do this, this will happen." Similarly, I will motivate here; this is not a one-day job, not a one-time job. This has to be a part of our regular behavior. If you motivate someone, give them some money, send them abroad, and after they come back from abroad, the motivation is gone. Then it won't work. So, along with this motivation, there must be some regulatory measures. I will motivate you, but there will also be a stick, that if you don't do it, this is what will happen. So these are some principles of job management or what we call human resource management; those need to be implemented. Those are part of governance. These have to be done. Many have said that no one wants to take a posting there. I am always against incentives. From what I have researched, incentives have not worked well in our country or abroad; rather, the opposite has happened. Because of the incentive, all other work stopped; the focus became "I have to get that incentive." Other things aside—I am entitled to my salary anyway, I will get the incentive. And managing the incentive, especially the financial part, preventing corruption, and making people happy is very difficult. Political leadership must be there for the work, especially for a sensitive service like health services. So those of us working in this program have the responsibility to engage the political side very constructively. Because a political person knows, just like any other person, that if they don't lobby at the hospital, there will be no treatment. That "my worker has been admitted, I have to tell them, otherwise they won't look after him." But they don't know that the worker's arm is broken and there is no facility there to set it. Or the anesthesia machine is not working there, or there is no anesthetist. As a result, if they too can be involved and constructively engaged in the work, then they will also know, they will also try. This needs to be explained to them very well, and they need to be engaged, then it will be useful. Claim management is actually new for the government. The government usually gives money and things in advance. In this case, it is new. That is why we appointed a third party or a scheme operator. The scheme operator's job is to look at the claims. The one who got the job before this managed small programs. There is no health insurance in our country's health sector. In light of that, they are also learning; it was a learning experience for them on how they will dispose of claims. What has happened in claim management is that the main parties are the hospital, the scheme operator, and the one who is paying, the SSK cell. Coordination among these three would sometimes be a problem. It was often seen that the doctor made a mistake or did something that was not necessary, and it couldn't be reconciled, the cost became too high. Again, the ones who were making the claims, the scheme operator, initially did not have medical personnel, so they did not understand. They would look in a book and find that this is what is written, but this is not happening, but healthcare does not always follow the book. For example, paracetamol might not work for everyone. So, this is a new thing. Similarly, what happened for them is that ultimately, it often gets delayed to pass the claim bill, and that is the problem. But this is a very good learning process; this way we can make these things practical, and this way we can start this process. This has a good listening for the SSK cell. We used to work with the support of that committee, the steering committee, the one headed by the honorable minister. But the problem was that, like other committees, the inter-ministerial members were not the same person coming each time. Different

representatives would come on different days. As a result, it took a long time to explain things to you all; consequently, SSK had to be explained to them regularly. It becomes quite difficult to make a decision after explaining SSK anew. That was a problem. It would have been very good if we had the same membership, if we got the same person. A suggestion regarding SSK is that, since our sector program started, if the practical learnings from programs like SSK work in a support function, for example, we have an OP for governance, an OP for human resources, which includes training, visits, research—if these real issues are dealt with there, then some work will be done. Because after those happen, we are training, what motivation, what will happen?. But if we take a real program and increase the coordination between the two, if one can support the other, then... and overall, the problem we have has been identified by everyone long ago. As a result, health system engineering, human resources, these are the main problems. Everyone is working on them, but nothing is happening. GAVI is working on this, WHO is working on this, work is being done in the sector program, everyone is working, but it seems the problem is becoming more complex. So these things need to be looked at carefully: why, after so many years of work with so many people, are we still not interested, why are we having these kinds of problems? We need to work on these things very well. Another thing is, you mentioned analysis. The analyses must be very, very pragmatic. Analyses of different issues at different levels need to be done, and these need to be presented. Then it will be possible to get closer to a solution. Not everything can be solved.