Key Informant Interview 9

A: First, we heard from one of our colleagues that a tender like this has been issued for a health plan. We did not have any idea what kind of plan it was. When we saw the tender paper, we realized that as a strategic partner, we would have to submit a tender including any IT partner or joint venture that was part of the process. It was an open tender, and everyone who would participate was to be called on the same day. They had these requirements, and how much to quote, what to do—nothing was clearly laid out. It was only mentioned that there would be a project like this, a one-year pilot project in the Kalihati area. So, after we learned about it, since we had some background working with micro health insurance from 2012—we started this in Mymensingh, where our project named 'Niramoy' was running. While working on this project, we saw that the micro health system... ultimately, we also did some research, and it showed that micro health insurance is basically the key product for non-life insurance if we look at the future of Bangladesh. For a non-life insurance company, the biggest thing is the health insurance portfolio, which becomes quite large. It's a global practice. Q: You mentioned the Niramoy program in Mymensingh, whose was that? A: That was ours. Green Delta Insurance Company's. Q: It was a pilot? A: It was a pilot; it was our own pilot project. Q: With this background..... A: We started with this. When we saw that the government had also issued such a tender, we thought, why not us? We should participate, let's see, eventually... Q: That was a competitive tender? A: That was a competitive, very competitive tender. When we spoke with them, we went and submitted the papers. We had no... so we went to where the tender would be opened. We arrived there that day, and after arriving, it was revealed who had quoted what. So the first thing that was done was, one part was operational, and the other was your financial quote. Since all insurance companies work in some way or another, or besides insurance companies, some who were in micro-financing also came to participate. So we submitted our bid there, and we came out the lowest. There was an intentional effort here, which was that we would work with the government on such a project. Definitely, it would give us a huge mileage in future. How so? We considered it as a PPP, that if we treat it like a Public-Private Partnership, the government has expertise in managing these finances, and we have expertise working in health. So if we can join these together, for us, this should be a learning platform. So we treated it this way, that it's fine even if we incur some extra cost, but the learning here would be more effective than the money. Q: So your business calculation is more..... A: The business calculation was not there. What was there was hands-on learning, to see a bigger picture of how we can work in a more integrated way. We saw that almost 32 to 33 percent of Bangladesh's population is BPL, which comes to around 5.5 to 6 crore people under BPL. If we can cover them, if we can gain the learning from just this one pilot project, then we can eventually spread it to the remote regions of Bangladesh. And we went into it this way, that Green Delta did it, but it was Green Delta's initiative. What we always do, as the leading non-life insurance company in the country, Bangladesh, we always have an initiative to work for the sector. We don't work alone. Meaning, what we learn, we will share with our other industry colleagues, so that they can also come into this. We work with that kind of mindset. Q: Meaning, you were prioritizing the public-private partnership, the learning platform. A: Absolutely. Q: You were not being commercial. A: If it were about commercial liability, we would have focused on that in the very first initiative. Q: I see. A: And eventually, when we were added to the process, we started working with them on how things could be done, what the approach would be. In our TOR (Terms of Reference), it was written what our duties or tasks as a scheme operator were. We did those, and our first initial stage, as I shared a little earlier, was that we received a list, which was prepared by the government, a list of BPL people in the Kalihati area whom we would cover under this project. So, what was happening was that this list was actually incomplete. In some places, there was no household data, in some places, no address, and in some places, dual reporting had also occurred, there was duplication of data. At that time, although it was outside our TOR, still, we took approval from the Health Economics Unit that we want to completely re-verify it because if we want to work in the field, we cannot complete the registration process with this data. Then eventually we went; we had a data collection force of almost 35 to 40 people there. They used to go every day, area-wise, take the data, re-verify it, and after bringing that data to us, we made a final list and gave it to the Health Economics Unit. We brought

this data against the data we had received, because this is revised data. Until HEU gives permission for the revised data, I cannot start the work. So you have to take the approval from the Health Economics Unit. So we gathered it back, analyzed it their way, and they checked and verified that, yes, it is correct, now you work on this new data that you have prepared. You can start working on this. Q: I will consider this one of the challenges that you faced initially, right at the beginning. May I ask you, what were your responsibilities given by them? A: Our responsibilities were what was in the TOR. What was in the TOR was, first with the data, was the registration process. To complete the registration process. Because those who fall under this, their registration had to be completed. After the registration, we had to establish a kiosk here; a kiosk had to be kept at the hospital. Through the kiosk, those who registered, when they come for treatment, they will be admitted through that kiosk, take treatment, what will happen—we had to take responsibility for all that, the responsibility of admission. Q: But the clinical assessment would be done by the doctor, right? A: The doctor will do the clinical assessment. Here, when we come, as you said, the first thing they do is, after registration, when they come to the kiosk with the card, they give the card at the kiosk. We verify the card, that this person is a real person, and after verifying that, we transfer them to the hospital. The hospital's doctor decides whether their treatment is IPD or OPD or if it falls under this scheme. Because there is a specific list here; it started with 10 diseases, and eventually, it has been taken to 80 diseases. And what was here is that from the very beginning, we only had IPD; there was no OPD. Q: It wasn't there at first? A: No, there is still no OPD. It is still only IPD. OPD has not been started yet. 3 diseases have been added. Q: So you do registration and the facility does..... A: The facility does the treatment. After that, what happens is, if there is an admission, if the patient has to be admitted against that, after admission, they take treatment. When the patient is leaving again, meaning when they are being discharged, at the time of discharge, this claim process, like which disease this falls under—this is our job. To collect all the claim papers from the hospital, we have an area-wise doctor assigned who verifies it again. After doing all this, we send the report with payment details to the Health Economics Unit for final approval for claim settlement. Q: You process the claim and send it to HEU? A: The Health Economics Unit, what it does is, it processes it, gives the final approval, and the payment goes directly to the hospital's account. Q: So in short, it is registration, and then you process for claim, process the claim, and you send it to HEU. A: Absolutely, Health Economics Unit for final payment and approval. Q: Does the Health Economics Unit control that? A: Yes, because we cannot approve it. We verify the thing, and after verifying, we send it to the Health Economics Unit. The Health Economics Unit has a team that sits with these claims. They finalize it, and the amount they approve goes to the payment section, and the payment section sends it to the hospital's account. So we have no financial involvement here. Q: You mentioned a challenge to us a little while ago, that the BPL list they had was problematic, and you had to revise that, it was incomplete. A: That impacted our total financial proposal. Q: That was an additional... A: Not only additional, it was a big problem. What they had told us at first was that they would give us completely ready data, and we would just have to go to the field and do the registration. But actually, that data, you know, was not collected properly. Q: So far we know that it comes from the Social Welfare Department; was this done by the Social Welfare Department? A: No, it came to us, but from the Health Economics Unit. The information we have is that this data was actually prepared by the health workers, different level health workers. Q: Recent? A: No, it was started in 2012, completed in 2014 or 15. And interestingly, this data was like, when a field-level staff works with data, there is a problem. Another thing is that the field worker is known as a "doctor babu" in the village, because they are the doctors. The access they have, I don't have. So what he has done is, for example, he went to this brother's house, registered this brother as the head of the family. Now his father is also there. Here, our registration was household-based. Later, he was transferred, another person came, then maybe he registered you. So there was a repetition of work, and in some places, non-existent registrations also happened. In the Tangail area, there are lots of BPL who move around. Especially, they go to Mymensingh and Dhaka for work. We found many such non-existent families. It was a challenge, because, as I told you, we do hard work. The list we had then only had a telephone number, not a para (neighborhood) name, and one person's name. But when you are going to start the data entry, at that time you need the family members' names, their biometric system, identification method, all the information as

quickly as you can get it. That was a challenge. For that, we had to create a form. Almost 100 people, on and off, worked for nine months to collect this data. What happened while doing that was that we lost time, but we got to know the area of each union. Because if you think about it, Kalihati has 13 or 15 unions. Each of the 15 unions has 9 wards. Our boys have traveled all over them. We had the opportunity to travel. And the other part is on the other side of the river; we have been to that side as well. I don't think we have left any place. While doing this registration, there were lots of challenges. As I was saying a little while ago, among our challenges, the first was political pressure from different aspects. I mean, there are area-wise leaders, then there are the chairmen, and they have many things, you know, each has some favorable candidates or persons who were not incorporated into this list. They do not fall under BPL, and they gave us a lot of pressure. But what happened was that as a scheme operator, the inclusion or exclusion from this list was not in our hands. So any inclusion, any exclusion has to be approved by the Health Economics Unit. So we could never do it, and it was not within our authority. I mean, at that time, you had a registration, a survey was going on at that time. icddr,b also had a survey work at that time, which was done in '12/'13, that was MIS's. And some of the boys and girls who worked there in that team also worked with us. What happened then was, for some reason, they got a message that a health insurance card would be made from here, a health card or something of that sort would be given. And the identification of households, weren't you talking about the challenges? The biggest challenge of registration was to attract people to come to the book, and to identify the house, because the tagging was not done in a proper way. A barcode that was put on at one time, we found no existence of it at another time. We never saw it. Those were challenges in terms of registration. After registration, the challenge is how to make them come to the hospital when doctors were not there. You are not finding a doctor after 2 PM. Q: I have one question. How did you manage the previous registration data? Was it included with the new one, or did you cross-match this for the included ones? A: It was a process for that. We re-identified the household by the help of the local government authority. Now it's the councilors, so we collaborated with those names, identified them, then we went to their house. We had a form, a big form including all their family information, telephone number, age, and everything. Then we came back to our office, entered the data into our database, and we went there again to distribute the slip. They came to the center fielder, registration, and we went to their house to distribute the card. So it took nine months to end the process. Q: So you just depend on the previously completed list? A: Yes, because this was actually outside our responsibility. We couldn't do anything about who was included and who was not. Because one thing is that the data of those who are included is there, but including those they want to include is not within our authority. So we have to get the approval from the Health Economics Unit. So we worked on this here. And while doing these processes, I must say that the support we were supposed to get from the government, especially from the Health Economics Unit... I'm sure you have met Asad sir before, so sir... it was quite a passion for Asad sir, and he worked that way. And to implement this, however many times we requested him for any support, he ensured that on the spot. In fact, it has happened that at 11 o'clock at night, he has called us to give a clearance. The minister was going abroad; he went to the airport to see the minister off, and after hearing a verbal instruction from him, he called us and informed us to do it. So this passion, this working with responsibility, the support we received, I would say that is why we have been able to come here today. A major reason for this is the support we received from the Health Economics Unit. Dr. Amin bhai was very supportive; their whole team worked wholeheartedly. Even another person who is now a consultant there, Azmol bhai, he also supported us greatly, whenever needed. Even at 7 in the morning, I have called from the field level, and he has immediately worked it out and informed us that it is possible or to go ahead and do it. A: Sir was saying that, on the first day of the meeting in September, in September 2015, when I and an officer went to the field, how the treatment will be in the hospital here... I mean, the hospital was... if there is a picture, let me see if there is one, if it can be shown. Q: You have worked with the government since 2015? A: The first rollout started from September, but the agreement was done in December 2015. And we started the project; the official launching was on March 23, and registration started on March 17, 2016. Q: Why do you appreciate Mr. Asadul Islam? His commitment to the program was very useful. What happened after he left? A: After he left, in fact, when he left, our second phase of work had already started. And meanwhile, one thing that

happened was the advantage we got here, which was that initially, the local leaders, like the chairmen of these local areas, they were quite negative about the entire program. They initially said that the list here... many chairmen came and told us that they took our signatures by force. We did not give this list. I mean, quite informally in a meeting, they were saying things like, "We didn't give these, they brought them and told us we have to sign, so we signed. We don't even know what's in it." So now, we have to sort these out. What happened then was that we used to talk to them on a regular basis. We started giving them hope that, see, if such a work is done in your area, who will benefit? The people of your area? If the people of your area benefit today, eventually they will support you. I mean, what was happening then, we tried to politicize the thing a bit, because we wanted to show them that if you ensure this, you are ensuring your own vote. Because if they benefit, they will tell you that, "Okay, this happened during this chairman's or this leader's time, and we appreciate this and they have provided us with facilities." But eventually, when they felt it, and when we started the second phase, Asad saheb was also there then. In the second phase, when we started in Ghatail and Madhupur, the main person there was Thandu sir, the chairman of that place, I mean, the chairman of Kalihati. He is very influential, very senior, everyone respects him a lot. He was so positive about the entire program in Kalihati. Q: Is he the Upazila Chairman? A: Yes, the Upazila Chairman, Kalihati Upazila Chairman. So he so positively presented the matter in front of the minister, deputy minister, Asad sir, other local leaders, and Razzak sir, who is now the MP of Madhupur. He was there. He so positively highlighted what benefits his area has received from this. So this was a big help for us in working in Madhupur and Ghatail. Because within the same Tangail area, when one chairman speaks so positively about the development of his area's health, then the others, in Madhupur and Ghatail, they were also quite impressed, they were very hopeful that such a beautiful health plan is being taken in our area too. So this did a lot of work for us. So when sir first left, in the middle, Zaman bhai came; he was one of his deputies, a director, his name was Nuruzzaman saheb. So Zaman bhai gave us enough support. What happened was that when sir did the work, he involved everyone in such a way, like Dr. Amin, Nuruzzaman bhai, then Dr. Rafiq, he involved them in such a way that each one of them developed a soft corner for this Health Protection Program. As we also had regular interactions, it happened that sometimes we would even joke that it's been a week since we've seen you, it feels like we haven't talked in a long time. There was such a rapport that a strong team was built, and by the grace of God, it is still there. But in the middle, what happened was that after sir left, Nuruzzaman bhai, and another person came in between him. So what happened here was that when an ongoing project is established, it's a bit difficult for another person to come and drive it in the same way, because they don't really know from the root level what ways it has come through. So what happened was that at that time, we were slightly... how we would move things forward. Were we getting any involvement from HEU, since there was no DG then, an acting DG sir was working. What was happening was that he was not giving us any guidelines on the spot. What was happening was that he would talk to the secretary, then if the secretary gave a green signal, he would inform us. So it would get a bit delayed. Q: So changing the DG for work... A: It did hinder the work a bit. Because in the gaps in between, many decisions which were previously made on the spot, over the phone, message, or an email would get an immediate decision, there was some hindrance. But I will say that even after the change, sir gave us enough moral support. From his new ministry, he controlled a lot remotely, saying, "See how far this can be taken." You have access to Asad sir for anything, from us bosses to our field-level kiosk operators, they even... "Sir, this is the requirement," and he used to call them to know the situation on the ground. So that's called motivation. Serious motivation, absolutely. I mean, a government secretary level, which is the highest position in a government job. There, he even on a Friday, I still remember, on a Friday he was repeatedly calling me, "Wafi, what will happen to this? Bring this. Okay, what will be the solution? I have to brief the minister now." I mean, he was so supportive. Q: Meaning, he was so supportive? A: He was so supportive. Even I can remember one day, we were having some sort of problem regarding the operational thing. It was a Friday, and we had no other option. And he was in this area. I got a call from my colleague at three o'clock, and he said, "We need to see sir within 10 minutes." And that was the weekend. And he gave us two hours of time. Sir had come to a seminar in this area. I told sir, then sir said, "Okay, I am leaving the seminar after lunch, I will talk to you then." Sir came, sat, had tea with us,

understood the whole thing from us again, and then said, "Okay, I will look into this." This support, if you think about it morally, I feel that he was a moral boost for us. Because we got a lot of support in this; we were able to move these things forward very easily. We never found him to disagree. I mean, the kind of attitude a secretary might have, he had nothing of that sort. Whenever needed, we went to his room, worked, and came back. This kind of a role model is actually needed to run such a project. At every point, the leadership and the support that he is with you... another big thing we got from his leadership was his ownership. Many might be in leadership, but they might not have the ownership, that "this is mine." "I own this. So I have to win this." So this thing cannot be achieved unless it works as a passion. A: The day the tender was opened, he opened the file. When he saw our quoted price, he said, "You won't be able to do business here." That's the first thing he said. "You cannot do business for this price." So he knows. He understood our struggle right then. But he found the real passion, that we are there to do, your team can do. Even when we started working in one ward initially, then this registration process, because this is totally a digital platform, our registration to claim, the whole thing is running on a digital platform. And to go to an outstanding remote area and provide a completely cashless health benefit to people using a digital platform, this was, from SSK, I mean, it was a big learning for us. A: When we were talking to him at the beginning, there was a big negotiation going on about the software, that a software would be bought. The one who quoted for the software was from an Indian company, so there was a lot of back and forth about that. They were not lowering the price at all; it couldn't be negotiated. We got involved; we also started negotiating with them. At one stage, it was getting to a point where we had to start the project's work, we had already come close to the deadline, from where we had a few days left to start the registration work. Then at one stage, sir, one day the team from the software company came from India. We sat with them. We sat in the big meeting room next to sir's office. Sir came out from there, and he was very upset. He called me and said, "Wafi, on your way out, you and Shuvashis please see me." So we went. We saw that sir was very morally upset that if the negotiation is not fully completed, because KfW is financing it, and KfW is saying that they will not give more than this for the software. What to do now? Then one day he called us and said, "Wafi, suppose there is nothing. We don't have the software. Can't we start the work manually?". "This has to be done, Wafi." So that day, his eyes and body language told us that he owns this. I mean, in any way, he is handling this thing as if it's his own, without any benefit or anything. That he must do this, something like that. Seeing this, we then thought that we will do it, and then we literally took a flight to India from HEU. We went there, and our group CEO knows the people from that software company. He called them, directly to the MD, to the chairman. They were kept online, we sat in their office and negotiated and made the final decision that by any means, today we have to negotiate the price and come out. There is no other option. One day we went to see the project, another day was totally for negotiation, that this must be done. And finally, we came to a solution, where they agreed to give us the software within the limit. And then finally we came out of there, and then it felt to us when we came out, I remember everyone, I was there, Shuvashish was there, Dr. Amin bhai was there, your Azmol bhai was there, Rafiq bhai was there, each of them, from looking at our eyes, we could all say that we won something, I mean, we won the match. It was then that we were saying that half of our project's success is already achieved because the entire backbone of our project is technology. The moment, if my server connectivity is off for one day, a serious revolt will start there. And today what I feel is that..... Q: Which Indian company is this? A: This is Heritage, Heritage Knowledge. They basically do the work for RSBY, and RSBY works with their software. So here, when we did it, initially, from the local leaders, the first thing was, why is a private company doing this work?. Why is the government not doing it itself? Q: They raised this question? A: Yes, I mean, why will a private insurance company like Green Delta come and do this work? Have we run out of resources here that we have to do this work?. Sir went to that meeting, Asad sir was also there. He told them, "Look, this has come through a tender. Everyone has their expertise; we don't have expertise in everything. The government has one expertise, they have another—coordinating the two, we have decided. So we will not talk about the process." He said this very boldly, "Why they got the work, what they got, that is not the issue. We have to do the work. And everyone must be brought under the Health Protection Program for all. This is our main objective." So let's stick to this. Don't disrupt our work by bringing up external issues. Q: So it was a

challenge, a sort of threatening environment? A: A threatening environment, non-cooperation. When we went, it happened that they called us because the local leaders who are there, I mean the chairmen who are there, they are also members of the hospital committee. So they decide on things like what kind of service is being provided at the hospital or if there are any complaints, whatever, they decide everything, or even if something needs to be purchased, it has to be done through that committee. So when we were talking to them, it happened to us that, as I was saying, we went, and in the middle of a full assembly, they told us, "We have nothing to talk to you about, you can leave.". This was one time. Another time, after setting the meeting schedule, we went from Dhaka to the Upazila Parishad, and then they said, "Only Dr. Amin can stay there, and we have to come out." So now, what is happening, what feels good is that when we go to their door, they tell us, "Please sit down first. You have come, the work you are doing in the area..." I mean, this is a big achievement. Where they were totally negative, to come to this point... and regarding these matters, I would say that Asad sir, the HEU team, Amin bhai, when they used to go regularly, if there was any problem, they would physically go there, highlight the issues, and sit with them to provide a solution. So this Kalihati was an eye-opening project for us. I mean, how to do things, whom to approach where and how, with whom to talk and how, how to manage the local government authority, how to bring a critical environment to your side—all these we learned from Kalihati. Q: A great deal of learning? A: And that's what, when we are doing it in Dhaka and Madhupur, we sometimes say that we don't have those challenges now. I mean, now Shuvashis has gone to the field, Jahangir has gone to the field, he is calling, we are going to the field, we are calling—what is happening is that now, as I was saying a little while ago, we don't need to physically go there to check even once a month. We are able to manage the thing so well. Even our team who are there, who are kiosk operators, then there is a zonal head for each hospital area, so everyone was so into it and everyone has taken it that it was a massive learning, and everyone, after learning this, I would say that they are well-experienced. It was like, during our first phase, we had a ninety-day on-field stay, almost ninety days. In the second phase, it was almost sixty days. We stayed on a regular basis. We wanted to do the thing in one way. A: Our learning was the main thing. Now the capacity we have, you tell us any area of Bangladesh, except the Hill Tracts, we can start any project within thirty days or sixty days. We have that capacity. Because we know where to adjust, where to develop capacity. What material to give in training, what speech to give in training to motivate the boys and girls to work at the field level, from that point onwards, you tell us anything, we can go there and say that we are ready. I mean, it's more like, what we call plug and play. You just tell us that the work will be done in this area, we have funds or whatever, you work as a scheme operator, we can do the work. I was saying a little while ago that with a subsidiary fund, you cannot cover such a large population of Bangladesh. So if we want to make it sustainable, then what we need is, we as a sector, I mean the insurance sector, we should come with micro health insurance products. And I was saying a little while ago that micro health products should be different; it should vary from area to area. Because if I am to provide micro health in Mymensingh, what does the demand there, the research there say, what kind of diseases are more needed? Again, in another place, what diseases are more common, the variation is area-wise, and it is not possible for Green Delta alone. We own the entire sector because this is, if you look at India's RSBY, there the tender is held area-wise by the government, which insurance company will get the work in this area. Through that tender, when they quote on what the premium will be, because the premium is being paid by the government, so what that premium will be, when they quote there in that tender, the premium that comes, that company will work here. The ultimate future of the process is micro health insurance. Only with micro health insurance is it possible to give it sustainable growth. Q: What do you think, if this, let's say, sustains and switches over to micro health insurance, and if you are involved then, will you have any benefit? A: Of course, here..... Q: I mean that benefit, I am talking about commercial benefit, business benefit. A: I am talking about business benefit. There is a matter of business benefit here. But one thing we need to understand here is that if you look at health insurance globally, if it is only health insurance, then it's a loss project. Globally, it becomes negative because the amount of money you are receiving, the settlements, I mean the claims, which is much higher than whatever you are getting as premium. So what happens here is, we call this health insurance a health portfolio. It is a portfolio. The portfolio has to run awareness programs area-wise. They have to be informed about fitness.

Recently, a month or a month and a half ago, the honorable Prime Minister went to an area where, I mean, I saw it in the paper and also on TV, she went there and asked the elderly people, "What do you need here?". What they said was, "We don't have a physiotherapy center here.". Then she asked the women, the women said, "Give us a gym." To stay healthy. Now if you go to a remote area, I mean, a place at the upazila level, and if you get this kind of feedback, then you need a ladies' gym. That means you have to think that awareness is being created. With this awareness, you can reduce the health claims. If you provide a gym there, if they keep their health good, then automatically the claims are reduced. If you give them a physiotherapy center there, then automatically their claim is being reduced. So there is a risk, and the risk factors fall under a portfolio. It is not a health insurance; it is a comprehensive product. Where you must have a gym, health, awareness programs will run. For example, our breast cancer awareness program is starting this November. So these, if you take these overall initiatives, for example, here population growth is, of course, the NGOs have to be credited for working very strongly, but still, there are health hazards. For example, after having one child, what kind of hazards can occur in a second issue, these also fall under this portfolio where we have these events. So if you only talk about health insurance, if we reach there with only micro health insurance, then commercially it is not viable. A: Actually, we are thinking about the commercial aspect. Obviously, it can be a viable project. But you see the RSBY, RSBY is backed up by the state government or the central government. Until or unless we redesign a product, or how do you say, a product, it should be a project, where the government has to give cross-subsidiary in terms of any product like cost, premium, or facility, whatever it is. I am telling you that unless that is ensured, it will not have viability. Like in India today, 22 crore people are being supported by your private organizations. The premium has come down from 1000 rupees to 700 rupees in many places due to quoting, but the third-party management and insurance companies are surviving, and they are making money and profit of ten to twenty percent, ten percent profit they are keeping. Why?. Because of cross-subsidiary. The software that is needed is being provided by the state government, the device that is needed is being provided by the state government. Until our government ensures these things, for a private company, if a company like Grameenphone or Unilever is punching their money with this, thousands of crores will be spent, nothing will happen. So we are talking about the ultimate work, the universal health package. If you are trying to address the universal health coverage, you need to design the essential package first. Then after the essential package, you need to design who will cater to the thing and the other steps like IT platform and the services of the hospital. If those are ensured, definitely this is going to be a final project. And another thing is unique payment, I mean, unique charges. This, across the country, somewhere the delivery charge is forty thousand taka, somewhere it is twelve thousand taka. So this has to be brought under a unique system, a unique rate. That across the country, in these hospitals, be it a government hospital, be it a private hospital, it has to be fixed. The doctor's fees, that also has to be fixed, that a doctor cannot take more than this. So otherwise, if you have to put this into a mechanism, an insurance mechanism, these things have to be identified. Q: You addressed another partner in this, which is the Upazila Health Complex, the UH&FPO and his team of doctors. This is one group. And another is probably Oxford Policy Management or OPM, working in support of the project. What is your cooperation with OPM and your cooperation with the Upazila Health Complex like?. Or what kind of support are you getting from them? A: Well, if I talk about the initial stage at the Upazila Health Complex, they were also quite negative on this. They assumed that we were probably a new boss. I mean, we came into the picture with a bossing system, from the private sector to boss over the government sector. Which is absolutely not the case. We went as their supporting hand. It is not our job to interfere in their day-to-day activities. Our job is to ensure that their day-to-day activities are smoothed out. So this is our major job. Eventually, when they first sat with us, they would tell us, "What are you doing? You are doing these things, giving these reports, these reports are not correct. You are saying that patients don't come, there are no doctors.". So ultimately, here, I would say, the Health Economics Unit played a big role. They came, gave support, sat down, sat repeatedly many times. The person in charge of the hospital also sat down. He has recently been transferred, Belayet saheb. He called us and said, "Keep me here, I want to stay here with you.". This achievement is not of one day. Today he is saying, "I want to stay with you," because you have arranged things so beautifully now, it is tough for me to go somewhere new and

organize this thing. Although his posting is now in Madhupur. He has been posted in Madhupur, because he... no, sorry, Sirajganj. So what happened at first was, when he was told, he was told that if his posting is in Madhupur, at least he will understand the thing. Because he worked in the pilot project in Kalihati from the beginning, and I would say that from what I have seen, he worked with us as an outstanding partner. I mean, now I feel that from the gatekeeper to even the cleaner, they know how beautifully the hospital can be kept. And the state of the hospital on day one when we went to see it in September 2015, I had said, "Will we take patients there?". If we take patients, they will die there. The condition was that bad. Dirty, what do you mean? One is moss, there is no plaster to speak of, moss has accumulated in the washroom, a terrible smell, the hospital beds are in a mess, people are lying on the floor. I mean, the first day we went there for a meeting, it was literally very difficult for us. We had to repeatedly press a handkerchief to our face. How long can you keep a handkerchief pressed? At one stage, we got used to it, okay. But after this, the infrastructure development that happened, the picture of the hospital today, whether you say the interior, the operation theater, the ward—every single one is fully tiled, clean, the cleaner is working. An environment changes people. For example, how will a cleaner clean such a dirty place?. It also works in their mind, "How will I clean this? I don't feel like it.". But when a clean environment is given, automatically, they actually change. Q: I see, these were done later? A: Yes. It's all about actually the mindset, because the team that will work here, especially the UH&FPO and the RMO, other doctors and nurses, they need to be... until or unless they are convinced with that project. Now that Belayet bhai has left, the person who has come, we are not getting that flavor. One UH&FPO our.... Q: Meaning, it was a, if we think of a gestational period, from a political aspect, from a static aspect, and the partners you were working with, like all the stakeholders except HEU, Health Economics Unit, those you were working with in the field, it took some time, quite a long time? A: Quite a long time, if I say, the initial one year. Q: To get them on board, it took an initial one year. That was challenging? Getting the political drive right, motivating people, and the environment when you went to work, improving that environment and getting them on board, the UH&FPO and other doctors, it took a year. A: But in those years, we have had our learning. After that, it is seen that..... Q: There is a benefit to it as well? A: After that, in Ghatail and Madhupur, we did not have to do that amount of work. Because we have the learning. We did those works at the beginning. Q: A similar incident did not happen in the other two upazilas, clearly because they are working... if you could say from experience. A: In the other two upazilas, if I say now, what are the challenges in the other two upazilas? For example, in Ghatail, in fact, there are no challenges at all. Ghatail hospital is there, RMO is there, UHFPO is there, and it is clean. Ghatail is the cleanest. Q: You did not find it in a bad state when you went? A: No, because Ghatail was newly built. The work of the 3 hospitals started at the same time. We first took charge of Kalihati, then Ghatail, then Madhupur. The work is still ongoing in Madhupur. But if you think in terms of patient traffic, Madhupur is the largest. And Madhupur has the potential to become the largest in Bangladesh because it will become a 200-bed hospital in a few days. And the challenge in Madhupur was access to the locality. Because, didn't you say that the biggest challenge is access from your place to the hospital?. Because according to our Kalihati example, the nearest union to us is 4 kilometers. And the farthest is 15 kilometers. The first was Elenga. Elenga was like the center, around twenty-two kilometers from Kalihati. So patients from Elenga never came to Kalihati. They went to the district. But I had to spend the most time for Elenga. Elenga had the most household registrations. So area-wise, actually sir, if you can break it down, what were the challenges? Political economy was one, second was the service delivery, third was the distance from the hospital, access to the hospital, fourth is the technology. Why the technology? We, from the city guys, as a city guy or tech-savvy, we know what is technology. It took some effort to explain a tab app to a boy from the village who has passed intermediate or is a graduate. And thanks to Facebook, thanks to IMO, thanks to Viber. That made them habituated with all those things. A girl worked with us during data collection from day one, her name is Nazma. She was a housewife. She had never used anything other than a basic phone. We trained her. How to use the smartphone, how to use the tab. Those are the things, actually, if we say, in two years, we have almost made a boy pass matriculation from class one to ten. Q: But the initial time, the first year, was really challenging. A: That was challenging because... Q: Motivating people, the upazila parishad, the chairman, getting this group on

your side. A: Actually, there is an advantage in Tangail. Tangail is the fertile ground for all the pilots. Of all the pilots that happen in Bangladesh, 90% happen in Tangail in different upazilas. So the Upazila Chairman of Tangail or the various local government authorities, they know how projects can be done. The problem is if you are having a list and that list is not up to the mark in terms of politics, then it's a challenge. If you don't have that... we didn't have to do anything of that sort, and so far, don't quote anywhere, we didn't spend any single additional money and other things. So that shows the commitment from the local government authority was also there. Because one MP, he is a previous food minister, chairman of the parliamentary standing committee, he got directly involved in this, although it is not under his jurisdiction. He said, "50 thousand people means, 50 thousand households mean almost three and a half lakh, four lakh people, I cannot take the challenge for them. They are my people. I need to provide them service." Now if you visit Madhupur Upazila Hospital, you will be surprised, where once cows used to graze...