Shasthyo Surokhsha Karmasuchi (SSK)
Concept Paper

স্বাস্থ্য
সুরক্ষা
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ABBREVIATIONS

APL	Above-poverty line population
BDT	Bangladesh Taka
BPL	Below-poverty line population
CDBP	Case- and Diagnosis Based Payment
DGHS	Directorate General of Health Services
DH	District Hospital
DMIS	Data Management Information System
DP	Development Partner
DRG	Diagnosis Related Groups (case payment mechanism)
FWA	Family Welfare Assistant
GFA	GFA Consulting Group
GoB	Government of Bangladesh
HEU	Health Economics Unit
HISP	Health Information System Program
HPNSDP	Health Population and Nutrition Sector Development Program 2011-2016
HQ	Head Quarter
IPD	Inpatient Department
KfW	German Development Bank
MoF	Ministry of Finance
MoHFW	Ministry of Health and Family Welfare
MRS	Medical Record System Platform
MSR	Surgical Medical Equipment
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHSO	National Health Security Office
OPD	Outpatient Department
OOP	Out of pocket payment
SO	Scheme Operator
SSK	Shasthyo Shuroskha Karmasuchi
UHC	Upazila Health Complex

Preface

Bangladesh has made an admirable success in the health and population sector over the last decade owing to its overall strategic development efforts including economic growth, consistent investment in the social sector and programs and initiatives in the health sector. It has been lauded throughout the world for its attainment of health related MDGs. However, taking the successes further forward to build a health system that can render necessary and affordable services to all the citizens has been challenged by certain realities like the demographic transition, changes in the disease pattern and escalation of the health care cost etc. Many of these challenges have their roots in sectoral financing scenario, which is featured with relatively low level of spending, inefficiency in management and huge amount of out-of-pocket (OOP) expenditure for the people which generates impoverishment or refrains them from using health care.

Health Care Financing Strategy has been developed to address these difficult challenges and to ensure the universal health coverage. The strategy targeted to cover the whole population through a range of interventions has adopted an approach by dividing them into three major categories:

- Population living at below poverty level
- Population working in the formal sector
- Population in the informal sector

As protecting the poor is the policy priority of the government, a health protection scheme has been developed for the population at below poverty level (BPL) name "Sastha Suraksa Karmosuchi (SSK) – which will be piloted in several upazilas. The poor families in pilot areas will be selected through evidence based 'poor selection' criteria and get a health card upon registration. The card will enable them to avail a package of treatment facilities for 50 diseases free of cost at the Upazila Health Complex and in case of necessity, at the district general hospital (including drugs, diagnosis and transport cost for referral to the district).

SSK is the first among the set of interventions to be implemented as part of the Health Care Financing Strategy which is designed to ensure universal health care through introducing social health insurance, increasing the fund available in health care financing and enhancing equity and efficiency in spending.

The SSK scheme and its concept, methodology and implementation manuals have been developed through broad based consultations, discussions and experience sharing. This document describes the concepts and processes of the scheme and we hope that the scheme will be further developed and be made more realistic through incorporating the practical information and experiences during the pilot implementation.

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EXECUTIVE SUMMARY

SSK (Shasthyo Surokhsha Karmasuchi) is the social health protection scheme developed by the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MoHFW). SSK is designed to improve access of the poor population to hospital services, to reduce out of pocket payments (OOP), and to improve efficiency of hospital care.

Under the supervision of MoHFW, SSK will be managed by SSK Cell and operated by Scheme Operator, which will be selected through competitive bidding.

SSK will charge flat rate contributions per household. For poor households fulfilling the poverty criteria contributions will be paid by the Government of Bangladesh (GoB).

SSK members will receive necessary health care through Upazila Health Complexes (UHC), and on a structured referral basis from District Hospitals (DH). Non-government health facilities will be included into the SSK system in due course based on the need and availability of accredited health care providers. The Scheme Operator will pay hospitals for inpatient services on a per case basis following a simplified DRG (Diagnosis Related Groups) system of about 50 positions. The prices for these payments will be set by SSK cell in the beginning of SSK implementation. However, once all partners (SSK Cell, Scheme Operator and providers) have become acquainted with costing, accounting and pricing, payments shall be negotiated between hospitals and Scheme Operator. Inclusion of outpatient services (OPD) in SSK scheme will be considered during SSK pilot implementation and then should be remunerated on a per capita basis.

Hospitals will receive the public budget plus the extra payment from SSK. With the extra funds they will have room to improve and expand services so they can meet the quality criteria and avoid complaints.

SSK will be supported by an IT based information and management system in order to generate more efficiency and transparency as well as to avoid fraud and misuse.

Implementation will start with a 4-year pilot phase. and it is expected that a nation-wide implementation of SSK will require a period of 10 years.

1 INTRODUCTION

SSK (Shasthyo Surokhsha Karmasuchi) is the social health protection[1] scheme developed by the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MoHFW).

In October 2011 the Health Economics Unit (HEU) organised a workshop to mark the start of a new process for designing a National Health Care Financing Strategy. During this workshop the draft concept note for the SSK scheme was discussed with and distributed to development partners and experts for feedback. The development partners took the effort to examine the proposal and provided comments, which have been incorporated into the revised concept note.

Justifications for the SSK scheme have been manifold:

1. It will pilot an innovative way to improve access to inpatient care for the poor.
2. SSK is designed to improve quality hospital care.
3. It has been developed to improve efficiency and effectiveness of health financing through risk pooling and innovative payment mechanisms.
4. As tax-based funding for the health sector is insufficient in Bangladesh the approach allows to pool taxpayer's money with health insurance contributions , which might improve the financial situation.

The scheme is designed to address the weaknesses of the current system in the area of access and quality caused by scarcity of funds, lack of incentives, transparency, and efficiency.

It was decided that it would be implemented as a pilot scheme initially at upazila level and be gradually scaled up in all districts of Bangladesh based on the evaluation and the lessons learned , aiming towards Universal Coverage (UC).

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[1] Social Health Protection (SHP) is a way to organize health financing and health provision in an equitable way. WHO defines SHP as : "A system – based on prepayment and financial risk pooling – that ensures equitable access to essential quality health services at affordable prices, with contributions to the system based on capacity to pay and benefits based on need" and "A series of measures against ill health related cost of treatment, social distress, loss of productivity, and loss of earnings due to inability to work". See http://www.WHO.int/providingforhealth/topics/shp_p4h/en/index.html

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SSK Scheme reflects the direction of the following documents:

The Sixth Five Year Plan (2011 – 2015): In rural areas HPN sector's financing will be raised through cost sharing by well-to-do patients when they are treated in public hospitals. Moreover, the Govt. will encourage promotion of Health Insurance Pilots at different levels (P: 366, Part 2).

The National Health Policy-2011: Solving the problem of financing in the health sector, it is needed to introduce health insurance in the formal sector. But in phases, the insurance program can be extended to other sections of population. It is necessary to ensure free health care for the very poor and disadvantaged population. GoB will provide health cards for the poor in a recognized and appropriate way.

Health Care Financing Strategy : The Goal is to strengthen the financial risk protection, and extend health services and population coverage, with the aim to achieve universal coverage. The poor will be covered by the scheme and subsized by the govt.

Vision 2021: Modern and adequate social health insurance could mitigate the health care costs to the individual, and society.

Health, Population, and Nutrition Sector Development Program, 2011 – 2016 (**HPNSDP**)

The long-term vision is a scheme combining risk pooling, purchaser-provider split, and autonomous providers with a supervision function for MoHFW. This ultimate goal should be reached through a step-wise implementation plan. Towards that end, the SSK scheme has the following short- and medium term objectives:

1. Universal coverage;[2]
2. Affordable health care.

In order to reach these objectives, the following measures have to be taken:

- Improve access of the poor to hospital inpatient care by reducing financial barriers;
- Decentralized autonomous hospital activities for functional improvement in the health sector in phases as a part of Local Level Planning (LLP) and development (⇒ partial financial autonomy);
- Introduce performance based financing models (⇒ simplified DRG type of remuneration for hospital services;
- Contracting out of the management function (⇒ Scheme Operator);

2 Universal coverage means that every citizen of Bangladesh is covered by any soft of health protection scheme.

- Introduce modern Information and Communication Technologies for increased efficiency and transparency in the health sector (e. g. claims processing, accounting, controlling, and electronic patient records).

There are some assumptions associated with the scheme:

- User fees for inpatient care will be introduced and covered by SSK, or other ways must be found to give SSK the possibility to provide extra services to members and cover costs that non-members will have to pay out of pocket;
- Hospitals will be authorized to manage and make their own budget decisions at local levels for expenses that support a better service;
- Effective financial control and audit mechanisms will be established;
- An appropriate system with defined standards of quality of care will be established;
- The legal framework for the establishment of SSK as a health protection scheme, with SSK Cell and Scheme Operator, will be developed further accordingly and approved by the Government of Bangladesh (GoB);
- All sanctioned posts will be filled-up.
- The health facilities will be fully functional regarding equipment and infrastructure.

It is expected that the following effects will be achieved:

1. Reduced out-of-pocket payment (OOP) of the poor;
2. Increased access by the poor to hospital in-patient services;
3. Experience with a third party payer agency to manage the insurance fund;
4. Defined quality standards;
5. Improved efficiency and transparency in hospital management.

The following part of the document outlines the key elements of the proposed system as well as a plan to implement the pilot project, which is supposed to precede a countrywide implementation of the new health insurance scheme (SSK). The SSK scheme represents a new model for Health Care Financing in Bangladesh, which will introduce a third party payer. The model is open for contributions from different sources: employer-employee contributions, social protection schemes, and voluntary contributions (e.g.through remittances). SSK will be piloted in a number of Upazilas. The SSK pilot can be further developed to serve as a national social health insurance, including compulsory membership.

2 SALIENT FEATURES OF SSK

The scheme will have the following features:

- Under the supervision of MoHFW, SSK will be managed by SSK Cell and operated by a Scheme Operator (SO). The Scheme Operator will be selected through international competitive bidding. This Scheme Operator will have the main task to register members, to issue health cards, and to handle the claims of the hospitals.
- SSK cell will have its office in Dhaka. The Scheme Operator will be located at Upazila level in UHCs. Each UHC will have a SSK-Kiosk staffed with at least one officer.
- SSK Cell will contract, monitor, and coordinatethe Scheme Operator and will reimburse the money to the contracted Scheme Operator, which then will pay the hospitals based on the claims processed.
- SSK will charge flat rate contributions per household. For poor households fulfilling the poverty criteria, contributions will be paid by the GoB. The contribution and the Benefit Package will be determined by SSK.
- SSK members will receive necessary inpatient care through Upazila Health Complexes (UHC), and on a referral basis from District Hospitals (DH). At a later stage private and NGO facilities as well as outpatient services will be included gradually following specific measure.
- SSK will consider the services as per benefit package only and will pay for the required drugs, diagnostics, and travel expenses in case of referral to DH. Costs for salaries, infrastructure, and equipment in the Upazila Health complex and district would be covered by GoB.
- Membership in SSK will have several advantages for members:
    1. No co-payments at Upazila or in District Hospitals;
    2. Access to grievance authority, where it is possible to complain about quality of services;
    3. Guaranteed free access to essential drugs at UHC and DH. These advantages are not guaranteed for non-members.
- Hospitals (UHC, DH) will be partly funded from GoB budget and partly from SSK contributions. The funding responsibilities will be split according to cost categories: (i) Investment and salaries by the GoB,
  (ii) The rest (especially drugs and diagnostics) by SSK contribution.
- Hospitals (UHC and DH) will need an accreditation and will have to be included in the SSK hospital plan in order to receive SSK Contribution and to treat SSK

patients. For the pilot phase the selected UHCs in Kalihati, Ghatail, and Modhupur as well as the DH in Tangail will be contracted without accreditation. Private and NGO Health care facilities in the three selected areas will be empanelled under accreditation criteria.

- SSK will pay contracted hospitals through the Scheme Operator for inpatient services on a per-case basis, following a simplified DRG type (Diagnosis Related Groups) case based remuneration system with about 50 positions. The initial payment was calculated and together with the expected utilization rate allows for the calculation of the initial contribution[3].
- The Scheme Operator will obtain a fixed administration fee.
- Members of SSK during the pilot phase will be poor households only, which will be identified through community-based poverty targeting. At a later stage above-poverty-line (APL) households will be included.
- The members will receive one health card per household, which will enable them to request services from Upazila Health Complexes and, on a referral basis, from District Hospitals. These services are based on quality standards and a list of available services.
- A grievance procedure will be established based on which members will have the right to complain, if they do not obtain the guaranteed services free of charge, which will be made known to all members. The grievance authority will have the mandate to initiate sanctions and inspections, and will be operated by SSK.
- Contracted health care providers will receive the regular public budget plus the extra payment from the SSK. With the extra funds they will have to finance drug supply, maintenance, performance incentives, and other running costs (all except 'regular' salaries and investment), and will have room to improve and expand services so they can meet the quality criteria and avoid complaints. Main control mechanisms are the grievance procedure and the quality monitoring through SSK.
- Cost containment will play a pivotal role in SSK in order to keep the contribution low. Main elements are: monitoring and evaluation, introduction of co-payments, it necessary functioning provider payment, incentives, and information.

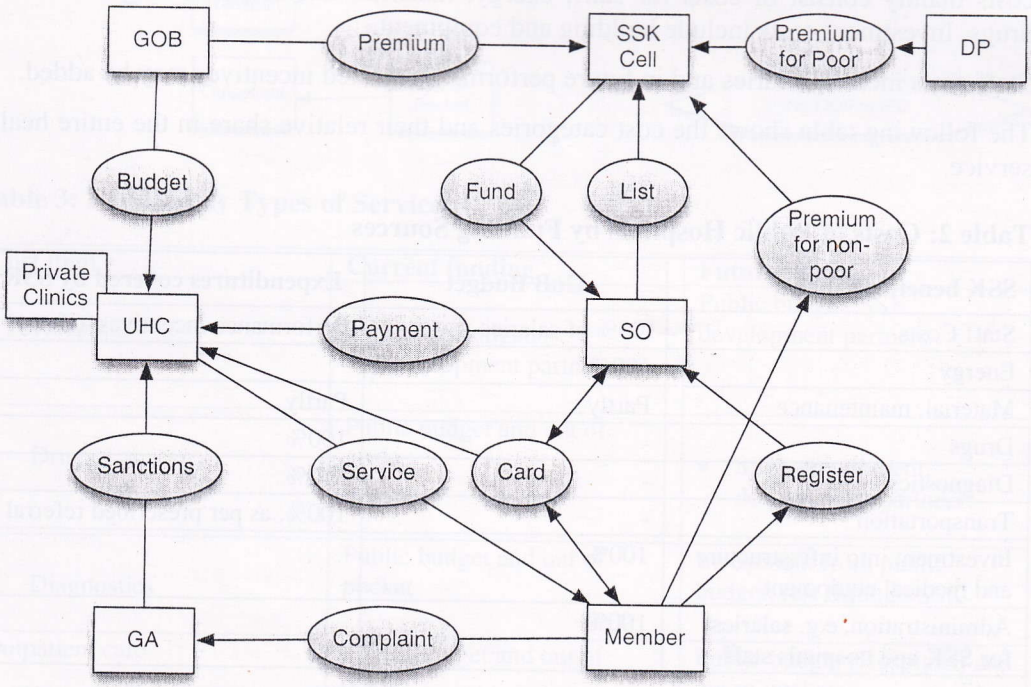
[3]The initial contribution of 1.000 TK would leave room for the inclusion of outpatient care.

Table 1: Institutional Overview

Institution	Functions	Legal Status	Activities
Development Partner	Technical and financial assistance	Bilateral or multilateral institutions	To provide seed funding to SSK and to give technical inputs
GoB	Supervision, funding, legal framework and enabling environment	Government	Supervision of SSK, provision of fund payment of contributions for the poor, legislation
Independent Grievance Mechanism	Address of complaints	Procedure under SSK	Receiving complaints from members, investigating and initiating sanctions on and inspection of providers.
Members	Card holder, and beneficiary : payer (APL only in the later phase)	Registered member of SSK	To hold health card, to ask for care, to contribute to monitor quality and to give feedback, to pay contributions (non-poor)
Scheme Operator	Local operations of SSK and link between both hospitals and the insured with SSK	Independent body, e.g. insurance company or NGO.	To register members, to issue health cards, to provide other customer service, including claims management of and payments to the contracted hospitals.
SSK	Health care financing and managing scheme	It is a denomination of the scheme of the government.	None
SSK Cell	Coordinating and supervising body of SSK, registration of providers and quality control	Institution set by govt. order	To maintain central register of members, selecting and monitoring Scheme Operator, managing funds, grievance management
UHC/DH	To provide health care	Government Institutions	Providing care, checking membership, contract with Scheme Operator, billing Scheme Operator

For the proposed pilot phase, the Scheme Operator will be recruited through an international competitive bidding procedure.

Figure 1: Functional structure of SSK



GOB=Government of Bangldesh
UHC=Upazilla Health Complex
GA=Grievance Authority

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3 ELEMENTS OF SSK

3.1 Costs

The main costs related to services emerge in inpatient care, which is offered by Upazila Health Complexes (UHC) and District Hospitals (DH). At the beginning of the pilot implementation, outpatient care and services provided by Tertiary Hospitals and Private Hospitals are not part of the SSK benefit package, but both elements could be integrated upon policy decision of GoB for providing more comprehensive health care to the poor and thus help poverty allevation.

The major cost categories in public hospitals are running costs and investment. Running costs mainly consist of costs for staff, energy, material, maintenance, diagnostics, and drugs. Investment costs include building and equipment.

Staff costs include salaries and in future performance related incentives may be added.

The following table shows the cost categories and their relative share in the entire health service.

Table 2: Costs of Public Hospitals by Funding Sources

SSK benefit package	GoB Budget	Expenditures covered by SSK
Staff Costs	100% of salaries	Performance incentives (if any)
Energy	100%	-
Material, maintenance	Partly	Partly
Drugs	-	100%
Diagnostics	-	100%
Transportation	-	100%, as per prescribed referral
Investment into infrastructure and medical equipment	100%	
Administration, e.g. salaries for SSK and hospitals staff	100%	

The cost structure may not change significantly under SSK, except that there might be incentive payments and better provision of drugs. However, the level of costs may increase due to a boost in demand, from providers as well as patients.

3.2 Financing

The financial resources available under SKK are public budget and SSK contributions. SSK is supposed to change the existing pattern of health care financing, which is dominated by out-of-pocket payment (about 64% of the total health expenditure).

In future, hospitals will receive funding from public budget and from SSK. However, both areas of funding will be separate according to types of costs.

The following chart and table show the financing structure under SSK.

Figure 2: Financing Structure under SSK

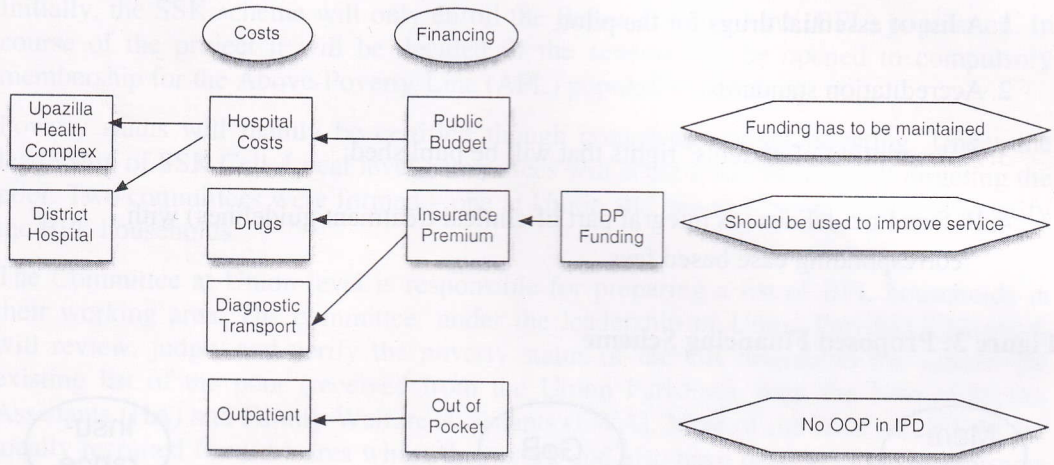

Table 3: Funding by Types of Service

Cost item	Current funding	Future funding
• Hospitals	• Public budget, development partners	Public budget, SSK, development partners
• Drugs	Public budget and out of pocket	• SSK, government, development partners
• Diagnostics	Public budget and out of pocket	Investment from public budget, rest through SSK
Outpatient care	Public budget and out of pocket	Public budget (Hospitals) and out of pocket

Main and most important feature for the patients (in IPD) in the future system will be that their out of pocket spending will be reduced close to zero, through:

- Coverage of official co-payment in UHC and DH by SSK;
- Coverage of essential drugs and diagnostics by SSK for the defined benefit package.

Especially the coverage of essential drug will make a difference, as currently often patients are sent to external pharmacies to purchase their drugs on their own account.

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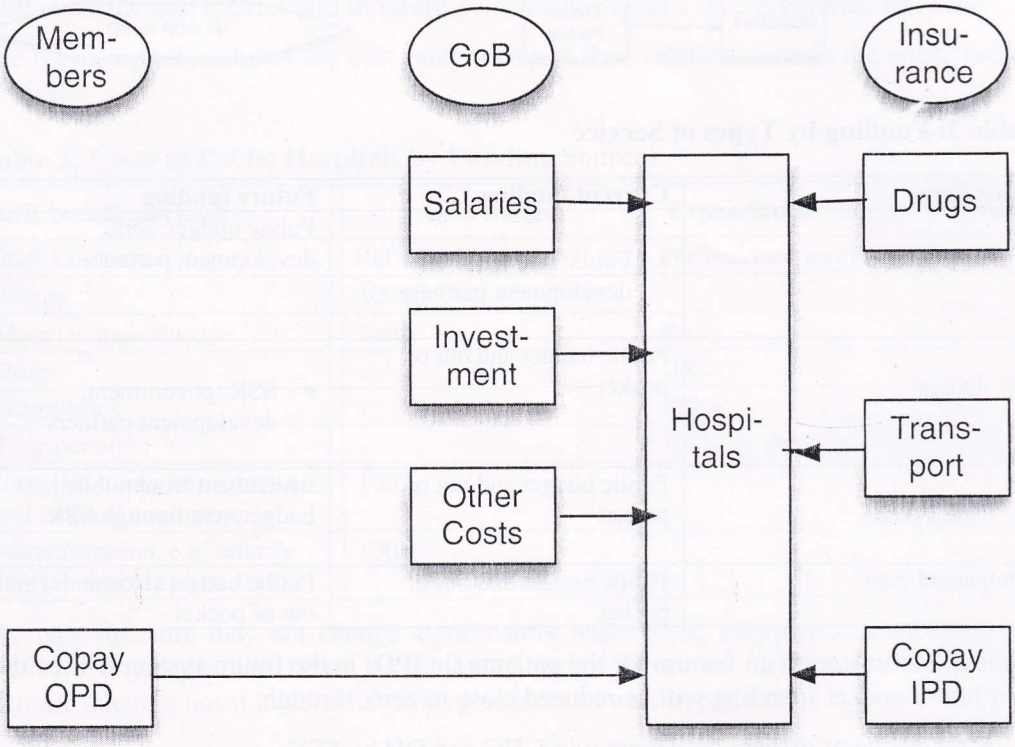
For this purpose several instruments should be elaborated:

1. A list of essential drugs for the pilot;
2. Accreditation standards;
3. A description of patients' rights that will be published;
4. Referral guidelines (as integral part of clinical treatment guidelines) with corresponding case based fees.

Figure 3: Proposed Financing Scheme



Concerning the contribution financing, a flat rate of initially BDT 1,000 per year per household has been discussed, which corresponds roughly with the public hospital costs for a household (MoHFW share 2011 estimate). This rate will vary in line with the price movements of the medical costs in the facilities.

Once the scheme is in place and reimbursement for health care begins (less OOP), co-payments for selected services may be introduced.

3.3 SSK Membership

Initially, the SSK scheme will only enroll the Below-Poverty-Line (BPL) population. In course of the project it will be decided, if the scheme can be opened to compulsory membership for the Above-Poverty-Line (APL) population.

Poverty status will mainly be certified though community based targeting. Under the leadership of SSK Cell, Local level committees will accomplish the tasks of targeting the poor. Two committees were formed – one at Union and one at Upazila level – to identify the BPL households.

The Committee at Union level is responsible for preparing a list of BPL households in their working area. The committee, under the leadership of Union Parishad Chairman, will review, judge, and verify the poverty status of the GR household list against the existing list of the poor (received from the Union Parishad), with the help of Health Assistants (HA) and Family Welfare Assistants (FWA). Most of the HAs and FWAs are locally recruited from the area where they work and also have been working in the same area for a long period. In addition, they do daily domiciliary visits at the households in the community. HAs and FWAs therefore have knowledge about the poverty status of the people in their area. With their help, the Union Committee will identify and prepare a list of BPL households.

The Union Committee will submit the list of BPL households to the Upazila Committee. The list of the BPL households will be reviewed by the Upazila level Committee. The Committee will make necessary corrections, if required, and will finalise and approve the list. Upazila Committee will submit the list to SSK cell for including into the database.

The poverty targeting will be closely monitored in order to avoid inclusion and exclusion errors. Information thus collected by the HA and FWA about the poor will be compared with and endorsed later by Union Parishad in the established structures and procedures at local level.

Once the list of beneficiaries has been identified according to the socioeconomic category in the pilot area, a Health Card will be processed and distributed to the beneficiaries by the Scheme Operator. The mid-term and long-term perspective is that the card will be a smart card with the following major information:

- The card holder's name (the head of the household) :
- The name of the dependants, average household size:
- Digital fingerprints or photos of all entitled members of the household .

For kicking-off SSK in the fast-track mode a simple health card will be sufficient.

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The validity of the card will be for 1 year and will be renewed every year. In order to build up ownership of the system, a nominal card-fee shall be charged.

The Health Card will serve to identify SSK members by their individual insurance number in line with the Health Information System.

3.4 Benefit Package

It was the intention not to include outpatient benefits under SSK. Initial costing exercises showed that the planned BDT 1.000 per household per year may have room for covering additional services:

(i) Outpatient care, which mostly would be drug costs, or

(ii) Increasing the target population or

(iii) Contracting NGOs and private health providers.

The costing showed that based on estimated prices for each position of the 50 case based payments (simplified DRG system) and recorded frequencies of the diagnosis countrywide average costs will amount to BDT 118 per household per year. This would be for inpatient treatment in UHC, only. Supposing an increase of utilization of 200%, an increase of costs though referral of 100%, and 20% of the total administration costs, we would end at about BDT 600. This would leave BDT 400 for covering outpatient care. Including outpatient care to the SSK benefit package would reflect a significantly more comprehensive benefit package for the poor population. However, considering a defined financial envelope, much of future potential developments of SSK services depend on the increase in utilization and whether the estimated costs of each diagnosis prove to be realistic.

The benefit package is limited to BDT 50,000 per health card per year. The list of reimbursable benefits will be basic in the beginning and will evolve over time. It shall be updated regularly. Ultimately, the benefit package will include:

- Free drugs and diagnostic facilities for inpatient care in UHCs and in DH upon referral;
- Structured referral to the secondary level hospitals, including transportation costs.

Hospitalized SSK members will be treated according to defined medical treatment guidelines. The treatment guidelines will support to calculate and standardize the reimbursement to the hospital. HEU made an attempt to price the 50 diagnosis using elements like diagnostics, drugs, and referral expenses.

As it was documented in Bangladesh National Health Accounts (NHA), the OOP cost of the patient is 64% and the major outlet is for drugs (around 67%), SSK has been designed to ensure all drugs for the poor are covered if admitted in hospitals. A mechanism for improved drug supply for SSK members at health providers in terms of quantity and quality during the project phase will be implemented. It is to note that:

- Under SSK, drugs will be provided to SSK members for inpatient care only;
- Drugs will be supplied to SSK members free of charge (cashless health care provision under SSK);
- Drugs will be provided through SSK for 50 diagnoses as per agreed clinical protocol.

In general, additional income from contributions should be sufficient to cover the drug costs. The treatment costs are limited by the case based payments (simplified DRG system) (see later in this paper).

The costs of these treatment elements are limited by the following:

- Only structured referrals to DH, no self-referral;
- Only those servicesincluded in the 50 diagnoses (benefit package)are covered;
- Only essential and basic services, no luxury and extra services will be included.

As there exists shortage of MSR (Surgical Medical Equipment) supply, implementation of SSK would require bridging the shortage in supplies of MSR for the 50 diagnoses in the pilot UHCs.

Concerning the prices of the treatment, please see the chapter about provider payment. It is essential to monitor the cost development and to adjust the benefit package in line with the experiences with the demand and supply development. Currently, it is not known how the costs will develop, though international experiences show that the introduction of free of charge treatment leads to a boost of costs up to 300%. Decision makers must be prepared to take the following measures in a flexible way:

- Exclusion of certain services;
- Introduction of co-payments;
- Increase of contribution.

The contribution of BDT 1,000 per household, which has been inititially fixed, is the upper limit for expected costs of care. This contribution is based on the calculation above and also on following assumptions and experiences:

- An admission rate of less than 1% of the catchment population of UHCs;
- Average case costs according to NHA of BDT 11,000 in district hospitals and 2,000 BDT in UHCs;
- A referral rate of 10% to district hospitals;
- A margin for increase of demand and supply of up to 20%.

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3.5 Provider Management and Performance

The following elements will constitute the provider system for SSK:

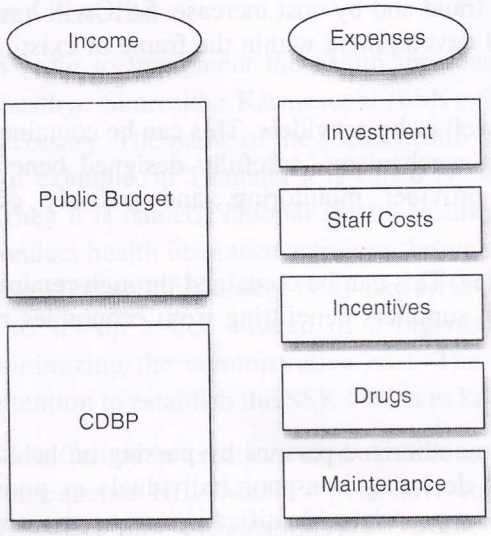
- Upazila Health Complex (UHC) will act as a focal point for service delivery and will enjoy a certain degree of autonomy (contractual, financial, and administrative) which may require waiver from the existing provisions.
- District Hospital will act as secondary referral point with the UHC as gatekeeper.
- Patients will be registered in a database and will identify themselves through a Health Card in UHCs.
- Enlisted providers (UHCs) will be required to register all clinical data and to preserve it in the database for further analysis.
- Providers will use a structured referral system (gatekeeping) to manage the access to district facilities. The gatekeeping function of UHCs will be strictly maintained (patients will not be able to approach district hospitals directly (except for emergency cases)).
- All facilities and providers will provide services as per structured guidelines.
- Supplies of drugs will be assured by SSK supply mechanisms.
- SSK will be expanded by contracting not only with public sector facilities, but also with private and non-governmental providers as soon as necessary preparations will be made.
- Providers will be trained on administrative and financial procedures.

Facilities in the SSK scheme will claim reimbursement for providing free services to SSK members based on a full and verifiable patient record, which will be maintained in the facility.

Reimbursement will follow a case- and-diagnosis based payment system (CDBP = limited simplified DRG based on 50 diseases), which will be gradually refined. Claims will be submitted to Scheme Operator monthly in a detailed format. The Scheme Operator will reimburse the hospital within 30 days. The hospital will be obliged to keep full hard copy records for each claim. The claims and supporting documents will be audited on a regular basis (at least 10% of claims annually).

The CDBP revenue will be used to increase performance and to ensure quality care, to improve the facility and to meet other revolving cost, especially for drugs. Some portion of CDBP may be used to provide performance-based incentives to staff. Exact allocation and management of hospital earnings will be decided at local level following the guidance of the SSK Steering committee and shall be determined during the pilot implementation.

Figure 4: UHC Budget



3.6 Health Card

It is planned by MoHFW to provide one card per household. The head of the household will be the card holder; and entitled members of the household would be identified through the card (either through the card number in combination with National ID card or through pictures stored on the card).

The health card has several functions in the system:

- It identifies the patient as a member of SSK when he or she is admitted.
- It stores data about received health care services to facilitate the payment process.
- It may be used to store patient data (diagnostics).

The advantage for the member holding a health card would be to get better service (less waiting time, no co-payment, guaranteed free drugs), and no out-of-pocket payment. The card is also an integral part of the security concept. It also gives access to the SSK grievance mechanism.

ICT implementation in fast track mode would start with a simple health card, which would have fewer functions as a smart card, i.e. less protection against fraud and less information on the patients.

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3.7 Cost Control and Anti-Fraud

Any health insurance scheme is threatened by fraud and by cost increase. SSK will have the task to limit costs and to keep the financial development within the frame of existing incomes. Major sources for cost escalation are:

- Expansion of demand by members as well as by providers. This can be contained through appropriate provider payment mechanisms, carefully designed benefit schemes and referral mechanisms, provider monitoring, and possibly co-payments.
- Increases of prices of drugs and supplies. This can be contained through retainer contracts and careful negotiations with suppliers benefitting from economies of scale.
- Fraud can happen in many areas like
    - Utilization of SSK through non-authorized persons by-passing on health cards, faking means tests and declaring non-poor individuals as poor. This can be avoided through appropriate identification measures and through good targeting.
    - Billing for items that have not been provided. This can be avoided through regular sample checks.
    - Over-practicing, means to provide health services that are not necessary just in order to maximize income. This can be avoided through monitoring by sample checks.
    - Under the table payments, charging of extra fees that are not officially foreseen. This can be avoided through grievance procedures and sanctions.

All these sources of fraud and cost escalation can be prevented through appropriate system design (provider payment, claim processing, monitoring, IT support for increasing transparency, exit interviews of patients, and grievance procedure).

International experience shows that often the risk of fraud and increasing costs is limited through annual or case-based caps on reimbursements. This places the risk on the members. The Ministry considers introducing an annual benefit maximum of BDT 50,000 per household. In case a household is burdened by a catastrophic case exceeding this limit, it is proposed that sources for additional funds may be explored, for example the Prime Minister's relief Fund etc.

3.8 Administration

3.8.1 SSK Cell

In order to implement the health insurance activities laid down in the concept note of Shasthyo Shuroskha Karmasuchi (SSK), the existence of an independent organization is necessary. The name of the social health insurance body differs from country to country. For example, in Thailand it is called National Health Security Office (NHSO), in South Korea it is named National Health Insurance Corporation (NHIC). However, in order to conduct health insurance activities through insurance companies in Bangladesh, too, there should be an independent body like NHSO. But HEU prefers for the pilot – as a first step - to set up a Cell instead of a big organization for sufficient reasons including the minimizing the administrative cost. The name of the proposed cell is SSK Cell. The intention to establish the SSK Cell is to kick-off the SSK scheme on a pilot basis.

SSK Cell is a creation of executive order and thus cannot be a legal body. As a consequence HEU/MoHFW will have strong influence on SSK and the SSK Cell bears the risk of little sustainability.

In order to establish a more sustainable and politically independent statuary body, HEU/MoHFW plan for the future a National Health Security Office (NHSO). Thus, HEU/MoHFW will develop a Roadmap "From SSK Cell toward NHSO". NHSO would be developed as soon as possible and operationalized after the decision for a fully fledged SSK implementation after the pilot phase.

In the SSK model the SSK Cell will be in the centre of entire scheme. On the one hand, the SSK Cell will formulate policy decisions in consultation with the 'SSK Working Committee', on the other hand, it will be responsible for implementation of the SSK at facility level through engaging a 'Scheme Operator' (SO). It is important to note here that the Health Economics Unit (HEU) will provide the SSK Cell with policy guidance. A consulting company (implementing consultant) to be tendered by international competitive bidding provide with Technical Assistance to HEU and SSK.

SSK Cell will be responsible for conducting the following major tasks:

i. General policy and Administrative tasks

- Call for tender as prerequisite for contracting Scheme Operator, as and when required;
- Procure services related to the benefit package from the health facilities through Scheme Operator (SO);
- Drug cost surveillance and supplier management for drug procurement;
- Support Procurement Activities of Hospitals (spend the amount received from SSK Scheme).

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ii. Finance management:

- Ensure funding of SSK;
- Payments to the Scheme Operator;
- Ensure proper accounting at hospitals;
- Monitoring of SSK related financial activities of hospitals and Scheme Operator;
- Coordination of auditing.

iii. Targeting:

- Prepare list of BPL households with support from the local level committees (see targeting manual);
- Maintain centralized member database;
- Review the list of target population every two years.

iv. Clinical and Facility management:

- Prepare and update benefit package for card holders;
- Facility preparation.
- Supervise Quality Management;
- Update treatment guidelines.

v. Grievance :

- Establish grievance procedure;
- Define appropriate channels of incoming complaints;
- Establish efficient distribution of the incoming complaints to responsible persons at SSK;
- Establish grievance software;
- Follow-up of grievances, including feedback mechanisms to complainer.

vi. Expansion of the scheme:

- Provide required training and orientation to the relevant officials and committee members;
- Organize workshops and seminars at national and local level.
- Provide feedback and policy input to the Working Committee and Interministerial Steering Committee through HEU;
- Implementation though outsourced provider.

vii. Program coordination:

- Link with HEU, DGHS, and other government offices and units;
- Disseminate program information;
- The health facilities will receive some liberty of using the contributions to their needs. However, SSK should support them, ensure that best practises are developed and shared between UHCs and DH. Especially for the area of procurement, specific legal know-how may be required; also a coordinated approach may help to get good prices.

viii. Accreditation of health facilities:

- SSK will develop both criteria for and a plan of accreditation of hospitals and execute its implementation;
- SSK will approve contracts between hospitals and SO;
- SSK will be responsible to assure medical quality (including accreditation) and will ensure that payments are only made for treatments which satisfy approved standards of care;
- SSK can issue a contract for technical and financial audits of hospitals to keep the SSK structure small and efficient at the beginning. As the volume of claims grows, SSK can employ additional staff and take over.

ix. Information Technology:

- Data management support;
- Software and data base support;
- Testing;
- Training;
- Others.

x. Monitoring and Evaluation

- Routine controls:
  - Monitoring of SO;
  - Collect monthly reports from SO;
  - Monitoring of enlisted health facilities.

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- Regular sample checks:
  - Examine 10% of all Claims. Reports from the data warehouse will help to identify claims to be examined in detail;
  - These will then be examined during visits to the facilities. Special focus could be, for example, to:
    - Avoid over-billing: Billing for items that have not been provided;
    - Avoid over-practicing: Unnecessary health services to maximize income.

3.8.2 Scheme Operator

The scheme operator of the SSK can be an insurance company or an eligible NGO to which the task to administer SSK will be outsourced. The main goal to which the SO will be bound is to the SSK objective "to reduce OOP payment and to improve access for the poor through a new financing mechanism". The purpose of the Scheme Operator is to support smooth, corruption free, and client oriented service throughout the pilot areas.

The Scheme Operator will professionally conduct core SSK operations in the following areas:

1. SSK membership and health card management;
2. SSK claims and financing management;
3. Provider management and contracting.

Scheme Operator will have the following tasks:

- Register the beneficiaries and issue the health card using corresponding hard-and software. The cards will be provided and designed by SSK and the SO will :
  - Follow the list of Target Population provided by SSK;
  - Structure the list, prepare Mobile Team activities;
  - Register SSK members, issue cards to members;
  - Send Members data to SSK database / Hospital database;
  - Update Membership data (through Permanent Scheme Operator Desk at hospital or is its office in town) Database & Cards.
- Target for registration and management of SSK members, and this number should be used for calculating the financial offer (increasing numbers may be possible):
  - Year 1: 20.000 households;
  - Year 2: 60.000 households;
  - Year 3: 95.000 households;
  - Year 4: 95.000 households.

- Renewal of SSK membership;
- Process claims form UHC and DH in a standard format. The billing will be based on case payments (cases of inpatient care) based on approx. 50 diagnoses :
    - Receive Claims data from Hospital (hard copies);
    - Make plausibility checks and consolidate data;
    - Create monthly invoices (soft- and hardcopies) and forward to SSK;
    - Calculate invoice amount based on member numbers / claiming;
    - Invoice to SSK;
    - Receive SSK payment;
    - Pay the providers;
    - Perform Financial Accounting.
- Monthly reports to SSK management including a list of beneficiaries, a claims report as well as a narrative report about experiences made;
- Provide personal service to beneficiaries in terms of giving support, collecting complaints;
- Provide support to providers in terms of billing procedures;
- Run information campaigns in the pilot areas in order to boost registration;
- Support SSK with Data Quality Management;
- Support SSK with Fraud detection activities;
- Report to SSK.

The Scheme Operator has to cooperate closely with SSK, and providers in the field, which in practice means to have a representative in the UHC and/or DH.

3.9 IT

The SSK scheme will support implementation of information technology in the following areas:

- Health card;
- Individual electronic medical record;
- Claims processing and accounting;
- Monitoring systems.

The project will equip the participating hospitals and the Scheme Operator with the necessary soft and hardware. Information technology will facilitate access to GoB-subsidized health care, monitoring quality of care, and efficient financial and patient management.

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SSK needs an IT system that responds to the requirements of different users and stake holders:

- The system should provide a reliable and stable coverage of basic patient-flow centred Hospital Management functions;
- The system should produce operational and analytical reports, including performance reports, that should contribute to a continuous process of improvement, thus helping to prevent fraud and misuse;
- The system should be scalable from an initial simple system into a fully integrated system as part of the established Health Information Infrastructure, namely the existing DHIS2 Data Warehouse.

Conceptually and at the central level, the Bangladeshi Health MIS (DGHS MIS) was greatly improved over the last years. However, at hospital level basic PCs and Internet are not always available and data entry discipline is not yet sufficient at all levels. The Government strategy for the Health MIS is focusing on open source and web-based technology.

Within MoHFW, the DGHS-MIS unit is responsible for most of the information systems. In the context of the SSK scheme, DGHS-MIS is offering its services to DG HEU to support future system set-up. Also, in order to adequately support the ambitious HMIS initiatives in a sustainable way, MoHFW and GIZ have teamed up to create a proper non-profit company called HISP Bangladesh (Health Information System Program). Involving HISP Bangladesh into the SSK programme would be highly beneficial for providing reliable technical and HR support.

DGHS MIS offers general support to the project, e.g. the possibility to host the SSK server free of charge in the DGHS MIS server room. In addition, DGHS has recently defined a hospital software strategy, which also covers UHCs and DHs. SSK can benefit from their approach, if it aligns its initiative into a joint approach.

The consultants suggest a two-phase approach for the implementation of a system to support the SSK operations. The system architecture will have three main components, the Health card, the SSK Cell head office software, and the hospital management systems.

Regarding **card management**, a baseline survey team will collect beneficiary data; on this basis the SSK Cell will prepare membership cards. Details of card distribution to the beneficiaries are defined in the Socio-economic Study. The project should introduce a household smart card that serves two purposes: Identification of beneficiaries and verification of available budget for treatment. All participants will therefore be equipped with devices that can both read and write on the smart cards. Under fast-track implementation no smart cards would be needed.

This **hospital management** software approach should be in line with other Hospital Management Initiatives of MoHFW, which are based on a customized openMRS configuration, covering the areas of patient registration, discharge, claims invoicing, and automated reporting to the DMIS. Regarding hospital management, in a first step, the UHCs should receive one or two PCs, focusing on member management and IPD.

In a later step, more PCs would be installed at one UHC, covering Registration/SSK Help desk (including Emergency, Referral), the OPD Dispensary, and the MIS room (Claiming). Hospital statistics (aggregated patient data) will be exported electronically to DHIS2. Claims are sent electronically to the SSK Cell software. Patient flow procedures and related forms and formats should be standardized and it should be ensured that electricity supply and technical support of devices and network are available at all times. The training plan foresees month 12-30.

The implementation of the second step of the hospital management step will be coordinated with the roll-out plans of DGHS-MIS. It should be built on the experiences from the first phase.

Referrals will be supported on the basis of print-outs and treatment data written to the card. The referral Hospital will have the same set-up of one or two PCs and card reading devices.

For the SSK Cell head offices, a centralized SSK data warehouse should be established, which could be hosted in the DGHS-MIS server room but would be under control of the SSK Cell.

This centralized system **(Data Warehouse and Reporting System)** serves to provide benefit cost codes and values to the different hospital and card systems. Also, this data warehouse receives electronic copies of all member and claims data from hospitals. The main function of the data warehouse is to provide reports based on this data, both automated standard reports and ad-hoc analytical reports. For monitoring purposes, the SSK software will have automatic routines for claims verification, monitoring of the hospitals efficiently, disease patterns, and of possible fraudulent activities.

Suggestions for the procurement of hardware and software as well as a training plan and training cost estimations have been created and are annexed to the IT study in order to provide MoHFW with the necessary basis for the successful implementation.

Finally, it should be mentioned that the IT system has to pay attention to issues of protection of personal data.

3.10 Quality Improvement & Patient Safety

It is intended to establish an appropriate system for quality of care & patient safety during the pilot period of the project. Total Quality Management (TQM) approach witll be introduced in SSK pilot facilities step wise (5S-CQI-TQM) Incentives for following the quality Improvement procedures will have to be defined. If incentive payments are part of the SSK scheme, these should only start after ensuring the standard of quality services in the facility. The participating facilities should be guided through quality standard operating producere (SOP) and clinical management protocol.

Quality Assurance is not a task for SSK (alone). Quality Assurance is a general task for the health system. HEU is working on this issue and Quality Management in general is reflected in the SSK concept. The clinical treatment guidelines and protocols are one tool of Quality Assurance supported by HEU and to be implemented by SSK Cell. For details we kindly refer to annexes 2 SSK Cell manual and 12 Clinical Guidelines.

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3.11 Long Term Perspective

As a medium-term goal it is expected that the SSK scheme will be successful in increasing access to care for the poor and in raising utilization rates, which are low in Bangladesh in comparison to other countries. It is likely that better health care for the poor will increase health expenditures, which only can be financed with resources from public budget and from SSK.

In the first phase only the poor will be covered. In the long run paying members need to be included. However, the combination of the SSK with voluntary health insurance is not sustainable, because it must be expected that only the "bad risks" will be interested to register for SSK membership (adverse risk selection). So, the preferred option is to introduce compulsory health insurance (firstly for the formal sector) during the pilot to overcome the problem of adverse risk selection. Additional revenue will be generated including above-poverty-line members (APL) in the scheme. The combination with compulsory health insurance appears much more promising in terms of risk pooling, cross-subsidizing, and also in revenue generation for future scale up and sustainability.

SSK has a high responsibility of using all possible measures for cost containment. Main instrument of cost containment will be:

- A list of essential drugs,
- Prescription and treatment guidelines;
- Regular audits;
- Co-payments for patients.

The SSK scheme, as mentioned above, in the long run will operate through an autonomous and independent public corporation, the NHSO, under the oversight of the Government. This will ensure efficiency in the system, which is needed to split the functions of purchaser-provider mechanism. The proposed setup of the NHSO is to be determined.

The extension of the SSK scheme to lower levels of health care is desirable to provide a comprehensive benefit package and strengthen referral systems. As long as outpatient services are free, it does not make sense to introduce claims reimbursement systems at lower levels. If user fees for outpatient care are introduced during the course of the project, the SSK scheme can be expanded to cover those fees in lower level health facilities, although the logistic challenges of installing reimbursement mechanisms in hundreds of facilities, some of which may not have electricity, are considerable. Also introduction of the electronic patient record could be considered in those facilities at a later stage of the scheme.

4 IMPLEMENTATION

4.1 Establishment of SSK Cell and Scheme Operator

During the kick-off of the pilot phase there will be a temporary shape of SSK and the following steps will be implemented:

- The institutional setup for SSK Cell and later on NHSO must be created;
- Procedures and structures must be developed;
- Personnel must be nominated, which should be comprised of experienced members of GoB and Civil Society;
- Capacity building is needed;
- A legal and/or contractual and statutory framework must be created and approved by GoB.

The roles of SSK and the Scheme Operator will include the followings:

- SSK Cell:
  - Act as fund-holder for contributions and manage the health insurance fund;
  - Selection and accreditation of appropriate service providers;
  - Monitoring and Evaluation;
  - Finance and administration.
- Scheme Operator:
  - Enrolment of beneficiaries – mainly poor; issuance Health Cards with local administrative support.
  - Contracting with approved providers;
  - Claims processing and provider payment;
  - Revenue (contribution) collection;
  - Creation of data base and receiving electronic reporting from Scheme Operator of insurance services for monitoring purposes;
- Scaling-up by GoB:
  - Development of tools/ mechanism for implementation and scale-up;
  - Setting-up the insurance fund country-wide within 5 years;
  - Implementation and operationalization of Capacity building;
  - Monitoring and evaluation of the implementation;
  - Contract private hospitals at some stages under PPP.

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4.2 Inter-ministerial Steering Committee (IMSC)

It is important to ensure that the project has a forum for raising and resolving issues that will inevitably arise during the long process of implementation. For better coordination of pilot activities, an Inter-ministerial Steering Committee under the Chairmanship of the Honourable Minister, MoHFW was established as per 4 January 2012.

This Inter-ministerial Committee should meet at 3-month intervals to guide and inform pilot activities. It is intended that this Committee will provide directions and advice to the Working Committee as well as feedback to the Honourable Minister to keep him informed about progress of this very important initiative.

4.3 Working Committee (WC)

The Working Committee was established as per 3 January 2012, and is headed by the Secretary, MoHFW. This Committee shall provide some advisory service to the both the HEU and the SSK Cell for implementing the project.

4.4 Participating Hospitals

Hospitals in the pilot areas will be contracted by SSK and later on by NHSO. These hospitals must:

- Sign a contract with SSK Cell, which lays down the services to be provided and the payments due;
- Ensure availability of medicines and medical consumables for the target group either from the MoHFW and DGHS supply chain or by local purchase;
- Ensure a women and child friendly environment;
- Introduce separate auditable bank accounts for receiving SSK payments;
- Introduce computerized accounting systems allowing to trace SSK revenues;
- Introduce (electronic) claiming and invoicing;
- Follow medical treatment guidelines, which will be stipulated by MoHFW and/or Medical Associations;
- Maintain full patient records, both in hard copy and as electronic patient record for auditing purposes;
- Produce electronic activity reports, which shall be linked with SSK systems as needed.

5. Monitoring & Evaluation

Monitoring will shows us how the SSK is doing on an ongoing basis by tracking inputs and outputs to assess whether the scheme is performing according to plan. A functional MIS is essential to do effective monitoring. It is used on a day-to-day basis and facilitates regular follow-up of activities and finances during implementation. The MIS data can also be used to evaluate the performance of the SSK by the management team as well as through internal and external audits.

Key Monitoring indicators can be classified into three categories:

- SSK Targeting / BPL identification/ Claim related performance
- Financial performance,
- Facility Management

5.1 SSK Monitoring and Evaluation framework

A well thought out monitoring and evaluation framework for SSK can assist greatly with thinking through SSK programmatic strategies, objectives and planned activities, and whether they are indeed the most appropriate ones to implement.

Monitoring and evaluation frameworks:

- Assist in understanding and analysing a programme
- Help to develop sound monitoring and evaluation plans and implementation of monitoring and evaluation activities
- Define relationships among inputs, activities, outputs, outcomes and impacts
- Clarify the relationship between programme activities and external factors.
- Demonstrate how activities will lead to desired outcomes and impacts, especially when resources are not available to conduct rigorous impact evaluations. They often display relationships graphically.

Developing a corresponding monitoring and evaluation plan that acts as a monitoring tool by defining how information from the programme will be tracked. Developing the framework and plan before activities are implemented.

5.2 Steps in Developing Monitoring and Evaluation Frameworks

1. Determine the purposes of the monitoring and evaluation mechanisms and assess the information needs of each actor.
2. Ensure prevention and response interventions have clearly defined objectives, outputs and indicators;
3. Establish coordinated and common reporting tools;
   Determine methods for obtaining information on indicators;

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4. Assign responsibilities for information gathering, determine time frame and frequency of data collection, and allocate resources; and
5. Establish mechanisms for sharing information and incorporating results into prevention and response planning.

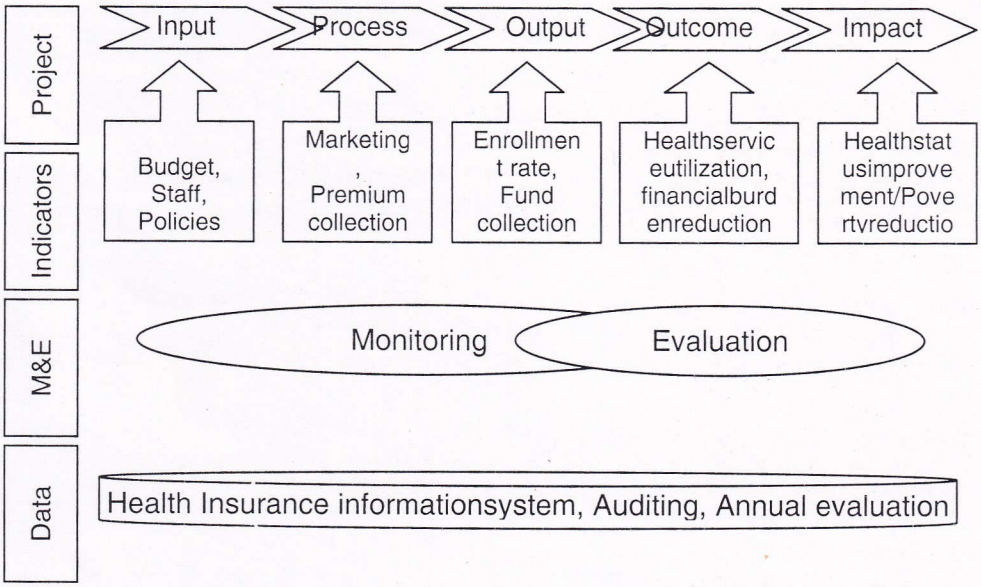
Evaluating impacts of SSK in terms of equity, efficiency, and effectiveness requires the use of analytical methodology that cannot be fully summarized in this brief document. Briefly, a complete picture of the scheme's impact can be obtained through measurement of changes in health status, financial risk protection, access to health care, service delivery efficiency, and quality of care.

Public satisfaction is another important dimension. A comprehensive evaluation of SSK cannot be conducted in a short time frame because some impacts, such as changes in health status, will only be observed in the long term.

List of indicators by type of impact are listed below

1. Health status change
2. Financial risk protection
3. Client satisfaction
4. Change in access barriers
5. Efficiency gains or losses in service delivery
6. Non Health Areas

Figure 5: Conceptual framework



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