Evaluation of the Pilot Shasthyo Shurokhsha Karmasuchi (SSK) of the Government

Dissemination of Findings

Principal Investigator:
Dr. Mahbub Elahi Chowdhury
Scientist, icddr,b

Date: 26 August 2020

Study team members

- Dr. Mahbub Elahi Chowdhury, Scientist and PI, icddr,b
- Dr. Shams El Arifeen, Senior Director and Co-PI, icddr,b
- Prof. Syed A Hamid, Professor, Health Economics Unit, DU
- Mr. Sayem Ahmed, Assistant Scientist and Co-PI, icddr,b
- Dr. Ziaul Islam, Associate Scientist and Co-Inv, icddr,b
- Md. Zahid Hasan, Res. Investigator and Co-Inv, icddr,b
- Mr. Mohammed Wahid Ahmed, Sr. Res Officer and Co-Inv
- Mr. Gazi Golam Mehdi, Research Officer, icddr,b
- Ms. Rashida Akter, Qualitative Researcher, icddr,b
- Ms. Aklima Chowdhury, Sr. Res. Officer, icddr,b
- Ms. Orin Khan, Research Assistant, icddr,b
- Dr. Anadil Alam, Asstt. Scientist, icddr,b
- Dr. Shamima Akhter, Dep. Project Co-Ordinator (Ex icddr,b)
- Dr. Zeenat Islam, Research Officer (Ex icddr,b)

Background

- In Bangladesh the share of households' out-of-pocket (OOP) payments for healthcare has increased from 63% in 2012 to 67% in 2015. (BNHA 1997 – 2015)
- Around 17% of the households face catastrophic health expenditure (CHE) due to OOP payment for healthcare (Khan et.al, 2017) which push around 5 million people into poverty annually
- In 2015 the Government of Bangladesh had adopted a Health Care Financing Strategy (HCFS) with a view to bringing all the citizens under financial protection for healthcare by 2032.
- *Shashtyo Surokhsha Karmasuchi* (SSK) scheme is being piloted from 2016 by Health Economics Unit (HEU) for the financial risk protection for the below poverty line (BPL) population.

USAID FROM THE AMERICAN PEOPLE
icddr,b

Key entities of the SSK scheme

Name of the entity	Role in the SSK scheme
SSK Steering Committee	Policy decision makers on SSK
SSK Cell at the HEU	Management body for plan, implement, claim verification of SSK scheme
Local SSK implementing committee	Decision making body for operating SSK
Scheme operator (Green-Delta Insurance Company Ltd)	Enlist BPL population Provide health-card to BPL population Assist cardholders in receiving healthcare Facilitate UHCs in claim reimbursement Monitoring the scheme activities
Upazila Health Complexes (Kalihati, Modhupur, and Ghatail)	Provide healthcare services
Tangail District Hospital	Provide healthcare to the referral patients
Contractors for pharmacies and diagnostic centres, and supplier of guards and cleaners	Supplies medicines and selected diagnostic services to the SSK patients and provide guards and cleaners to SSK facilities

USAID FROM THE AMERICAN PEOPLE
icddr,b

SSK benefits package

- Inpatient care for 78 types of diseases or health conditions for the BPL populations
- Premium 1,000 BDT per household per year paid by the Government
- Maximum celling 50,000 BDT per BPL household per year
- Benefit includes-
  - ✓ Free required drugs and diagnostics for inpatient care at UHC and district hospital
  - ✓ Structured referral to district hospital including transportation cost

Expected effects of the SSK scheme according to SSK concept paper

- Reduced OOP expenditure for health care of the poor
- Increased access by the poor to in-patient services
- Defined quality standards in place
- Improved efficiency and transparency in hospital management.
- Experience with a third party payer agency to manage the insurance fund

Overall objective of the study

To evaluate the SSK scheme in terms of financial and non-financial factors from both demand and supply side perspectives

USAID FROM THE AMERICAN PEOPLE
icddr,b

Specific objectives – demand side

To assess

1) Effectiveness of SSK in service utilization by BPL population
2) Effectiveness of SSK intervention in reduction of
    i. OOP payments for healthcare among the BPL population
    ii. CHE among the enrolled BPL household
    iii. Economic impoverishment among the enrolled household
3) Knowledge of SSK cardholders about the scheme
4) Patients' experience with SSK service process

USAID FROM THE AMERICAN PEOPLE

icddr,b

Specific objectives – supply side

To assess

1) Facility readiness (HR, workload at facility, drug, equipment, logistics availability) for providing SSK services
2) Referral system of the SSK scheme
3) Record keeping system of SSK
4) Financial management system of the scheme (revenue generation, fund allocation, fund utilization etc. and related barriers)
5) Authority and autonomy of the managers in fund allocation and utilization
6) Claim management process of SSK
7) Community engagement process by the scheme operator
8) Compliance with SSK treatment protocol for service provision
9) Monitoring and supervision of SSK services
10) Experience of third party engagement in SSK (scheme operators, pharmacies, diagnostic centres, suppliers of guards/cleaners)

USAID FROM THE AMERICAN PEOPLE
icddr,b

Methodology

Mixed method study

Quantitative assessment:

- ✓ Community survey (SSK and non-SSK upazilas)
- ✓ Patient exit interview at SSK facilities
- ✓ Facility readiness and service availability assessment

Qualitative methods:

- ✓ Key Informant Interviews (KIIs) of Members of SSK Steering Committee (SC), Cell, Local Committee and Facility Managers
- ✓ In-depth Interviews of Service Providers, Scheme Operators, Contractors of services
- ✓ Focus Group Discussions (FGDs) of SSK members
- ✓ Case studies of the beneficiaries

Record / document review:

- ✓ Patient management protocol of different diseases
- ✓ Patient records
- ✓ Claim documents
- ✓ Financial records

USAID FROM THE AMERICAN PEOPLE
icddr,b

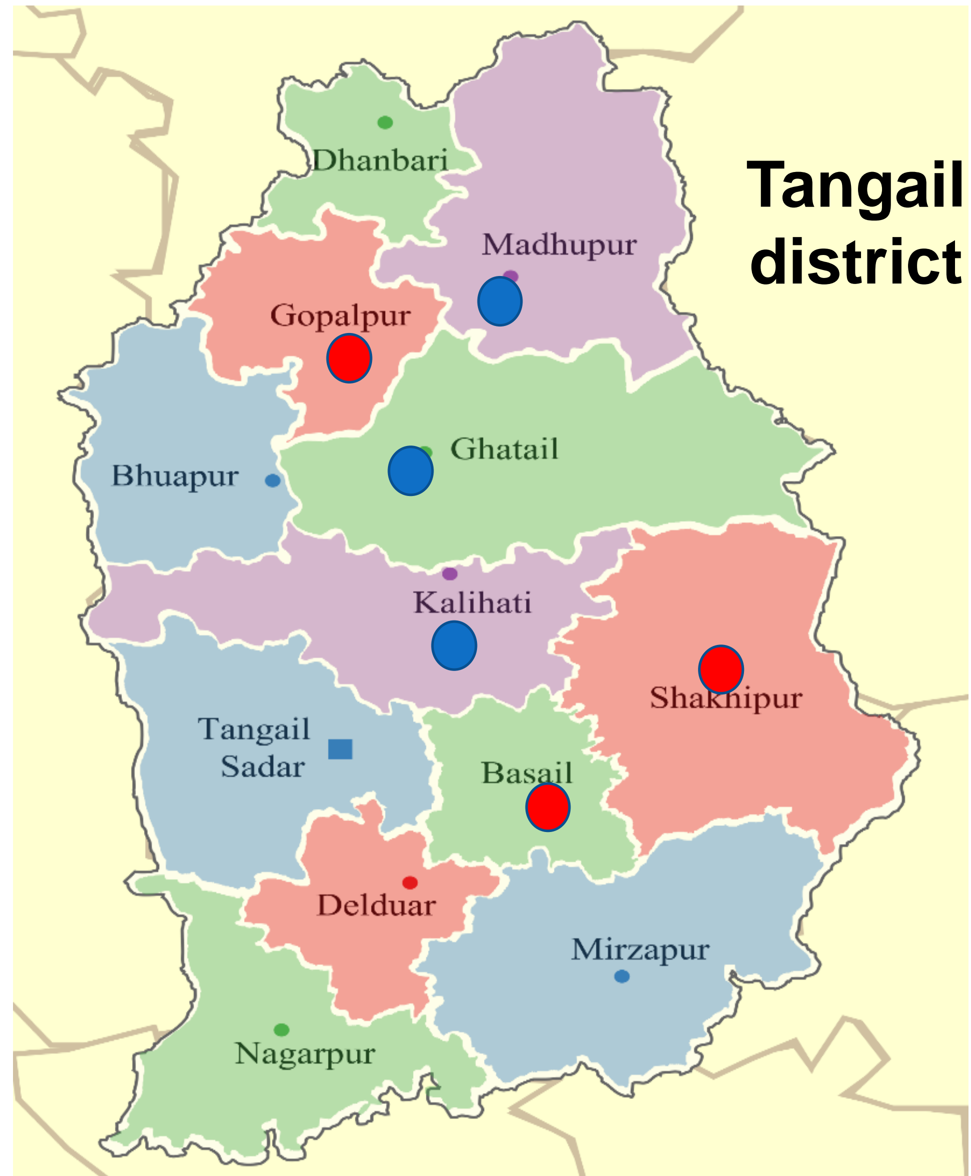
Methodology : Community Survey

USAID FROM THE AMERICAN PEOPLE

icddr,b

Study design / sites / facilities / agencies / bodies

- **Cross-sectional post intervention comparative study**
- Three SSK intervention upazilas of Tangail district (Kalihati, Modhupur and Ghatail)
- Three comparison upazilas were selected based-on based-on distance to Tangail District Hospitals
- Three Upazilla Health Complexes (UHCs) in the SSK pilot upazilla and Tangail District Hospitals
- SSK SC, Cell and Upazila Committees
- Scheme operators (Green Delta), contracted pharmacies, diagnostic centres, suppliers of support staff



Intervention upazila

Comparison upazila

USAID FROM THE AMERICAN PEOPLE

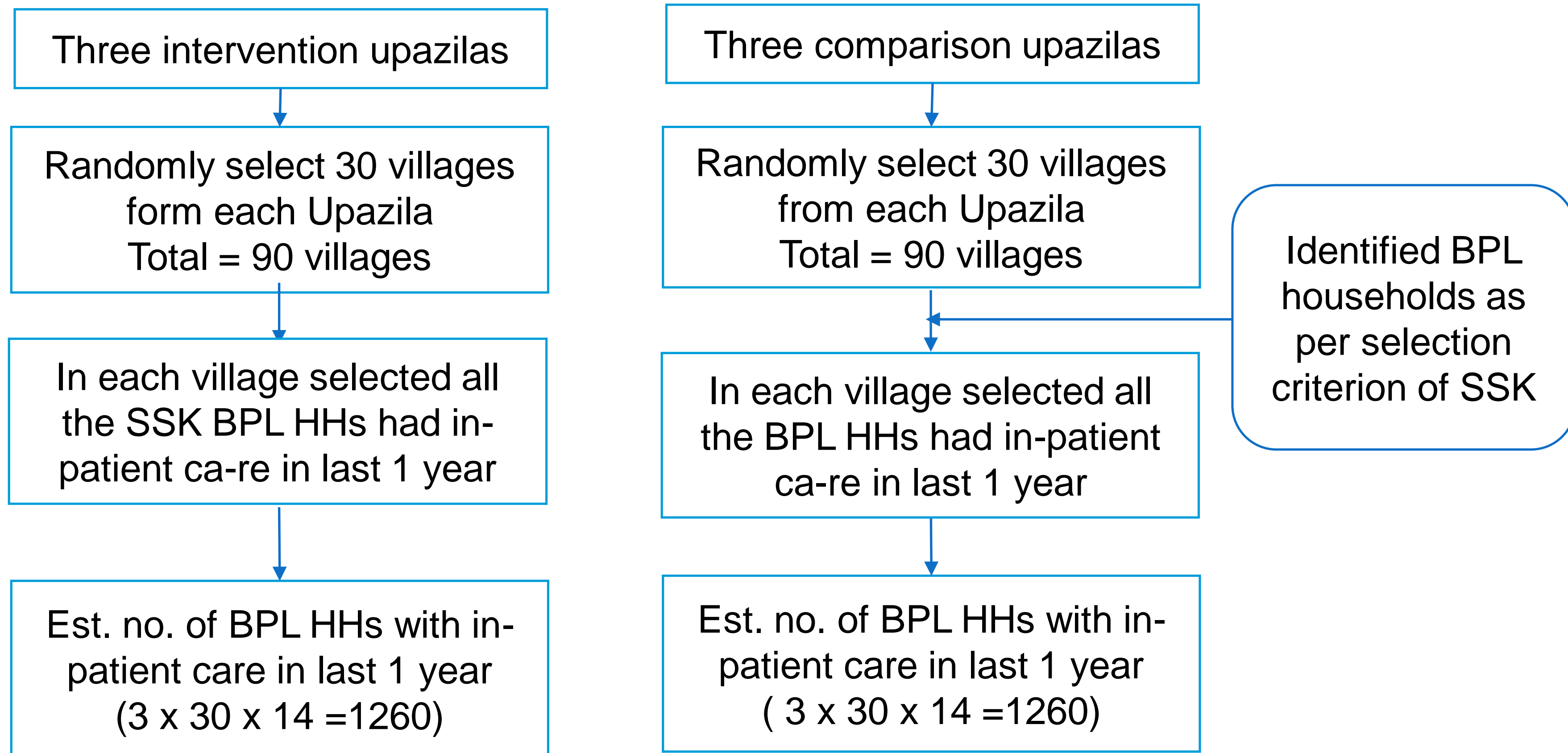
icddr,b

Sample sizes for community survey

- Assumed 30% less incidence of CHE from 16.5% (Khan et al, 2017) among the poor in the SSK upazilas than those in non-SSK upazilas
- Needed an estimated 795 SSK households (HHs) from each SSK intervention and comparison areas
- Assumed 1.4 design effect and 10% non-response
- Thus total minimum required sample sizes for community survey -
  - 1236 HHs from intervention areas
  - 1236 HHs from comparison areas

USAID FROM THE AMERICAN PEOPLE
icddr,b

Multi-stage Cluster Sampling Technique for Community Survey

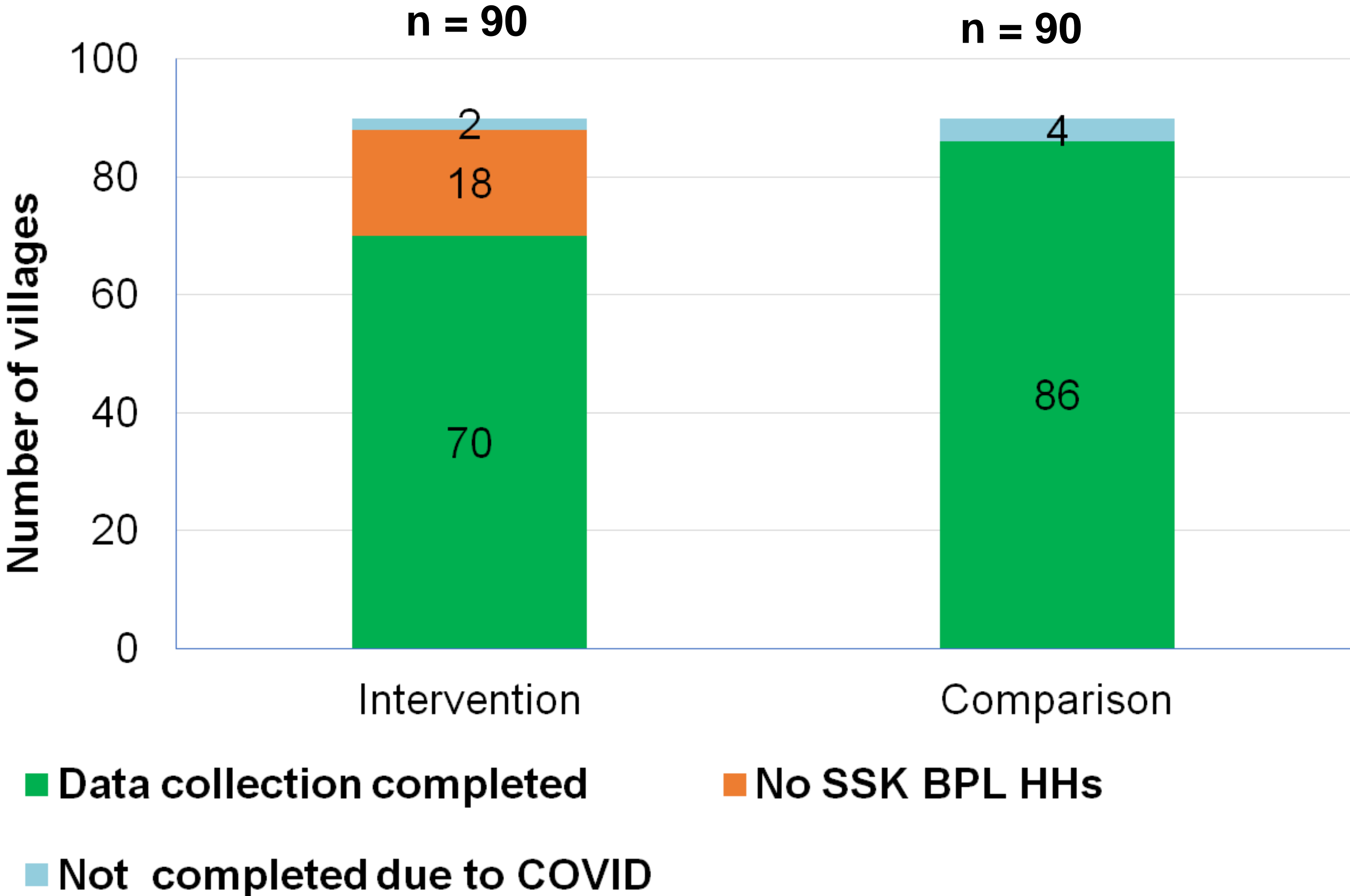


USAID FROM THE AMERICAN PEOPLE
icddr,b

Findings from Community Survey: Coverage and Service Utilization

USAID
FROM THE AMERICAN PEOPLE
icddr,b

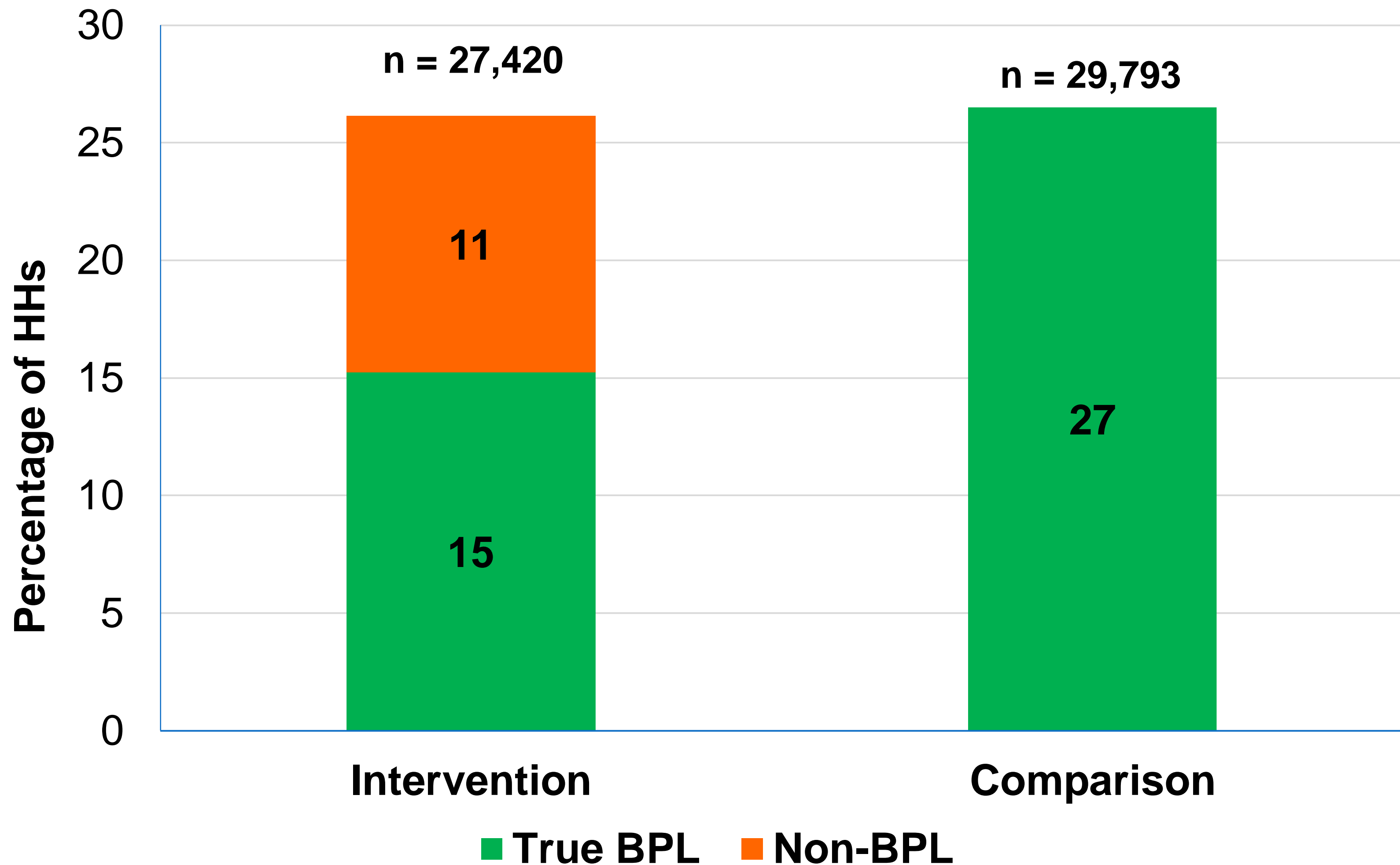
Coverage of sampled villages by study areas



USAID
FROM THE AMERICAN PEOPLE

icddr,b

Proportion of BPL HHs by their actual BPL status by the study areas



USAID FROM THE AMERICAN PEOPLE

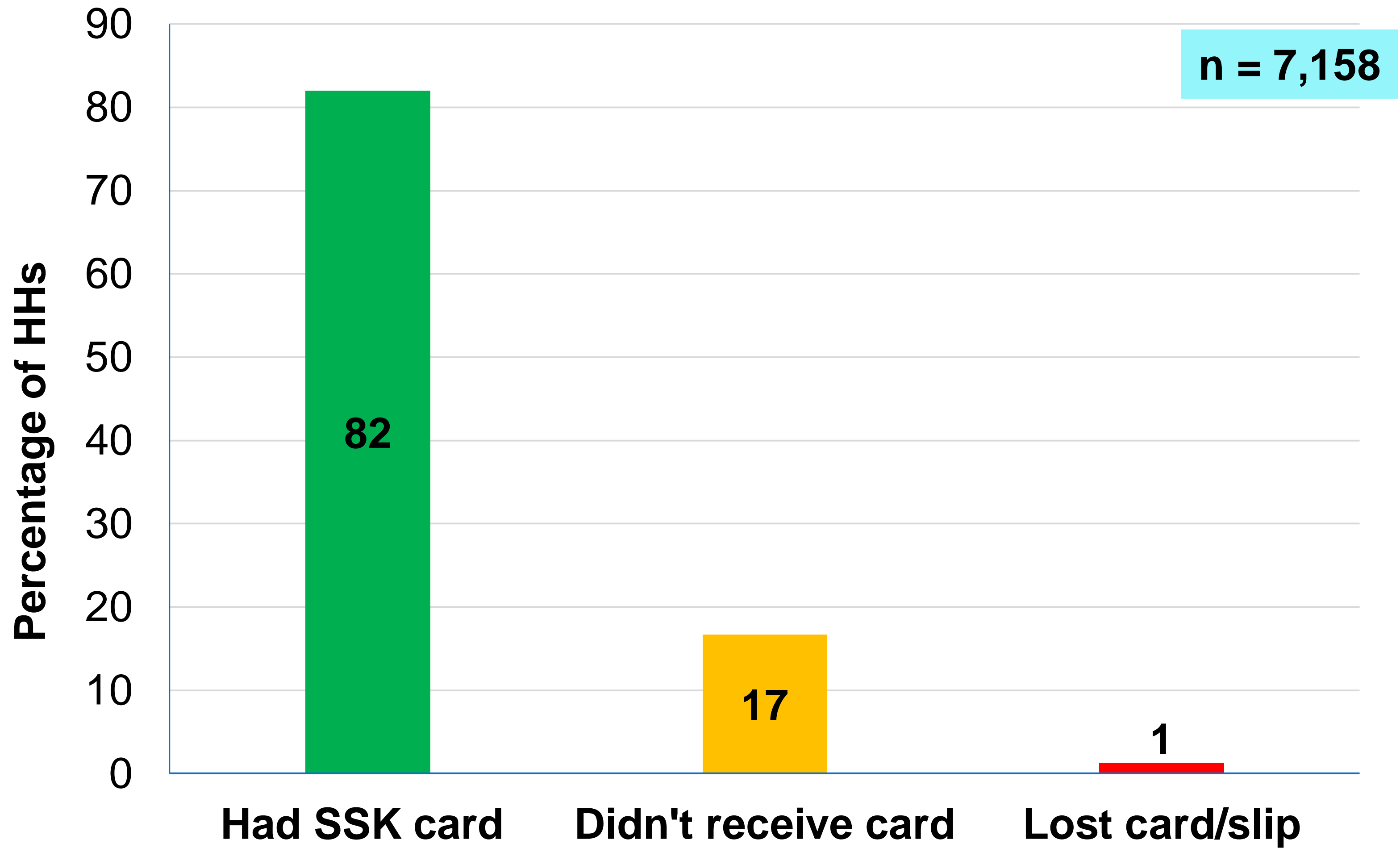
icddr,b

Reasons for inclusion of non-BPL HHs in the SSK BPL HH list

- No specific process was followed for identification of BPL-HHs
- Initially house to house visit was not made for identification of BPL HHs by verifying the set criteria.
- Community dwellers were asked to assemble at a specific point for enlistment for SSK health cards
- In addition, political and local power structure influenced contamination of the BPL list

USAID FROM THE AMERICAN PEOPLE
icddr,b

SSK card ownership status among the SSK BPL HHs in the intervention area



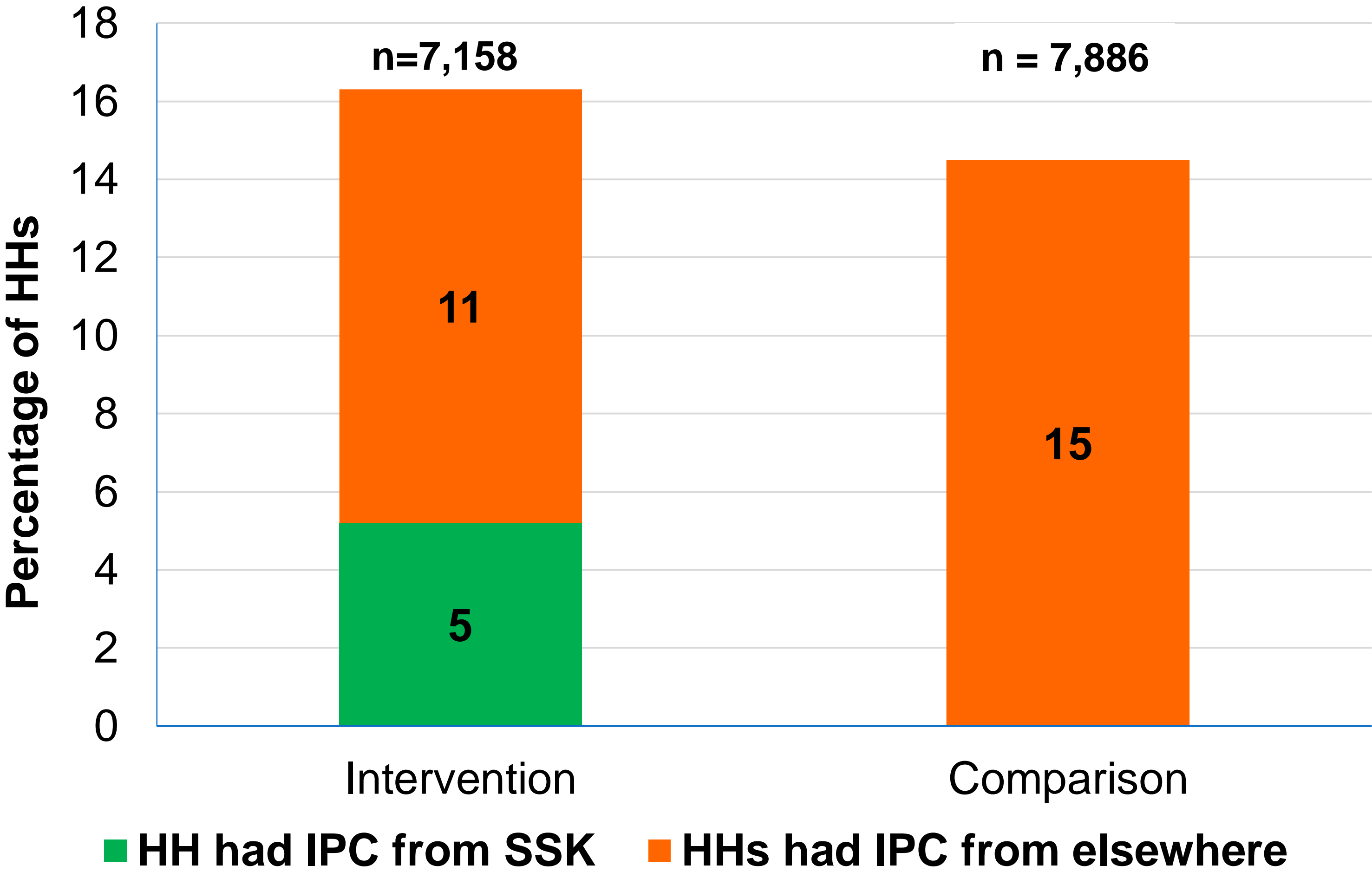
USAID
FROM THE AMERICAN PEOPLE
icddr,b

Reasons for delay in or not getting BPL cards by the SSK BPL-HHs

- Within 7 days of collection of identification the card was supposed to be delivered whereas some had to wait until 6 months or more to get the card
- In some areas, people with different political views did not get the cards when distributed through local elected leaders
- Some HHs reported of not being able to use the cards due to mismatch between name and pictures in printed cards
- Rectification of the cards was also time consuming due to dependency on a foreign company

USAID
FROM THE AMERICAN PEOPLE
icddr,b

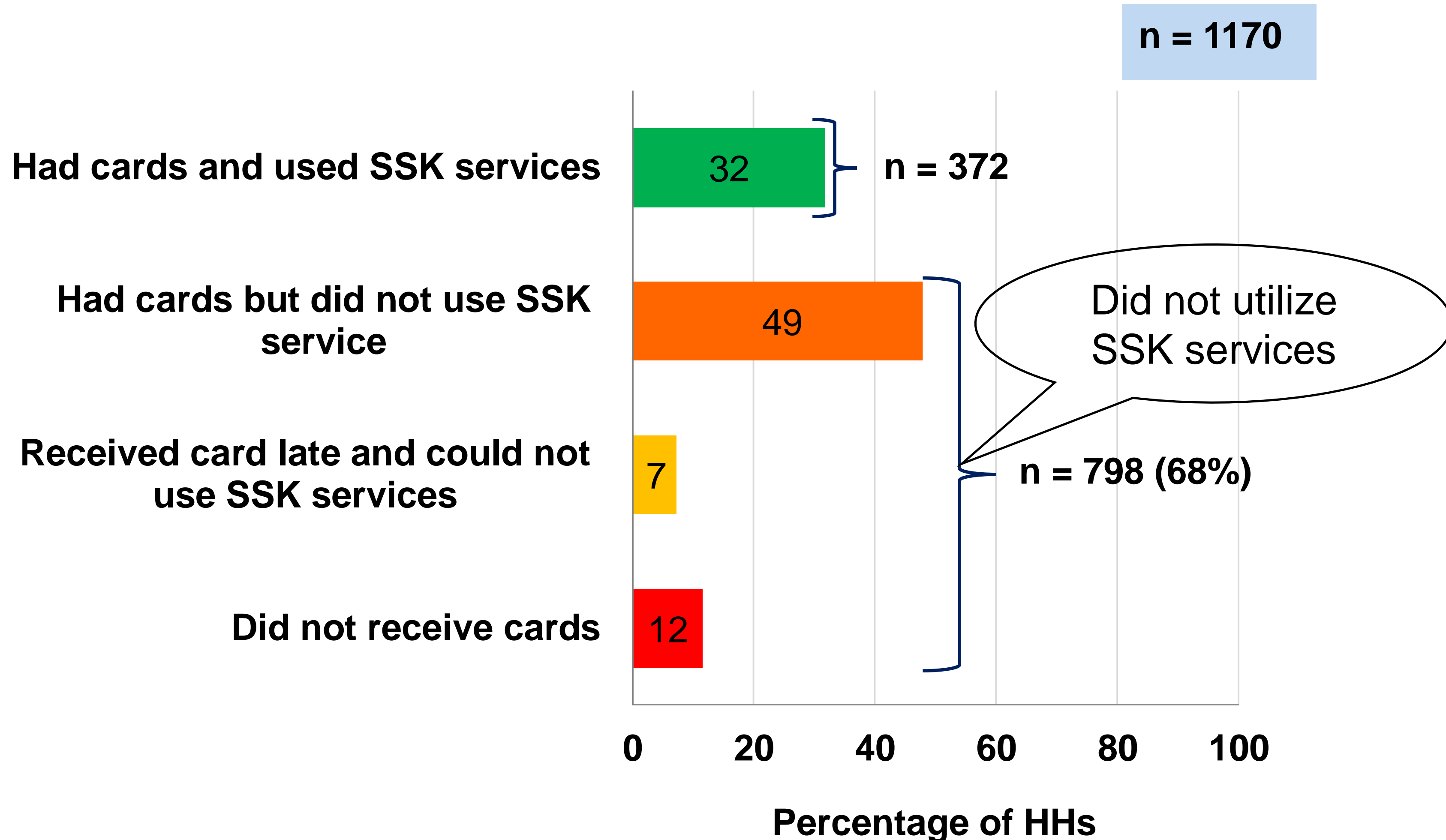
Source of In Patient Care (IPC) utilization by study areas



USAID FROM THE AMERICAN PEOPLE

icddr,b

Utilization of SSK services by status of having SSK cards



USAID FROM THE AMERICAN PEOPLE
icddr,b

Summary findings

- ✓ Overall about one-fifth (18/90) of the sampled villages were not covered by the SSK intervention.
- ✓ About 42% of SSK card-holders were actually non-BPL
- ✓ Not using an appropriate process and influence of local power structure contaminated SSK BPL-HH list
- ✓ Around 17% of the SSK BPL-HHs did not get SSK cards
- ✓ Key reasons for not having BPL cards are the delay in card preparation and distribution
- ✓ About 16% of the SSK BPL-HHs had IPC in the last one year of which only one-third actually utilized SSK services
- ✓ About half (49%) of the SSK BPL-HHs did not utilize SSK IPC (had elsewhere) despite having the SSK cards

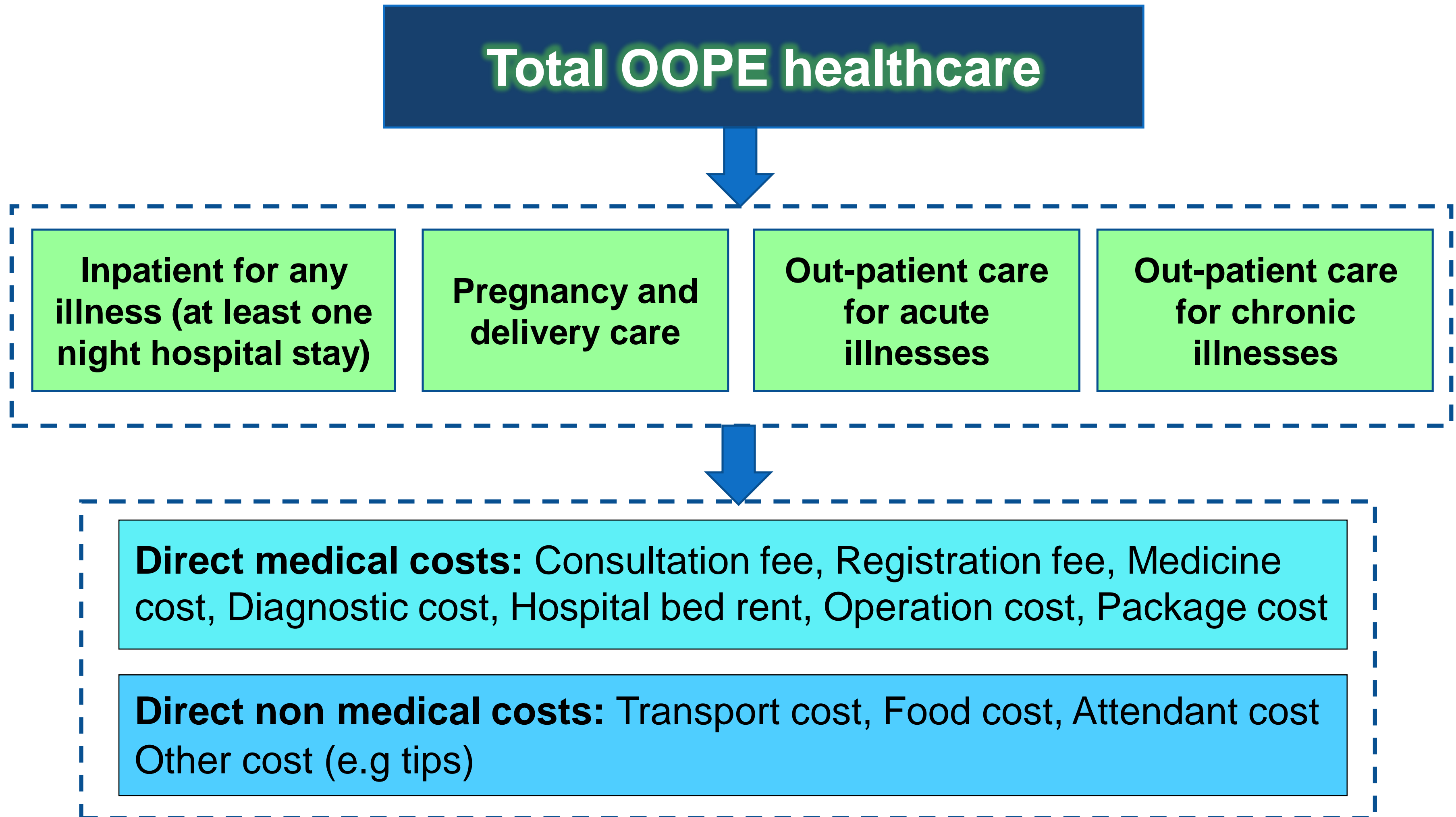
USAID FROM THE AMERICAN PEOPLE
icddr,b

Findings on

- Out-of-pocket Expenditure (OOPE)
- Catastrophic health expenditure (CHE)
- Impoverishment due to OOPE for healthcare

USAID FROM THE AMERICAN PEOPLE
icddr,b

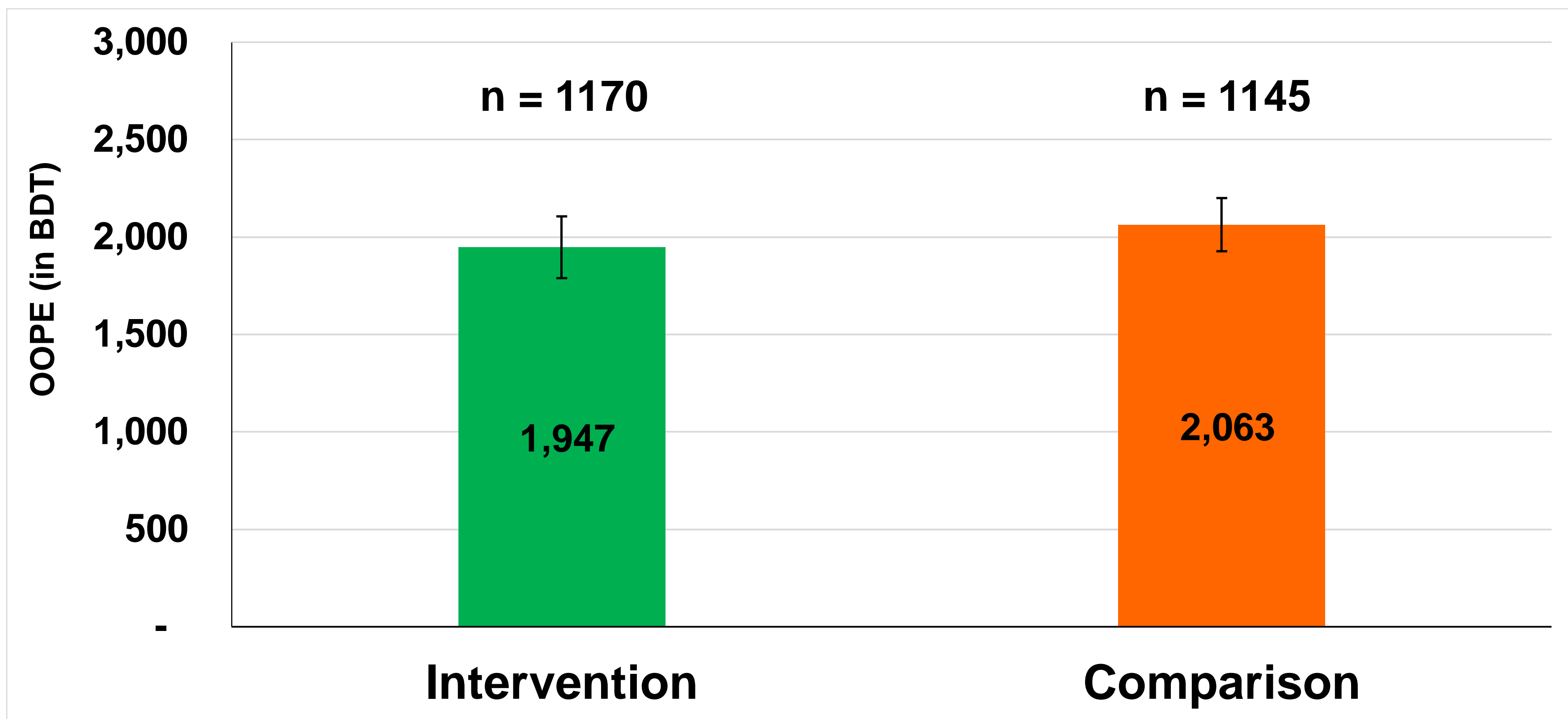
Estimation of OOPE for healthcare for HHs in the last 1 year



USAID FROM THE AMERICAN PEOPLE

icddr,b

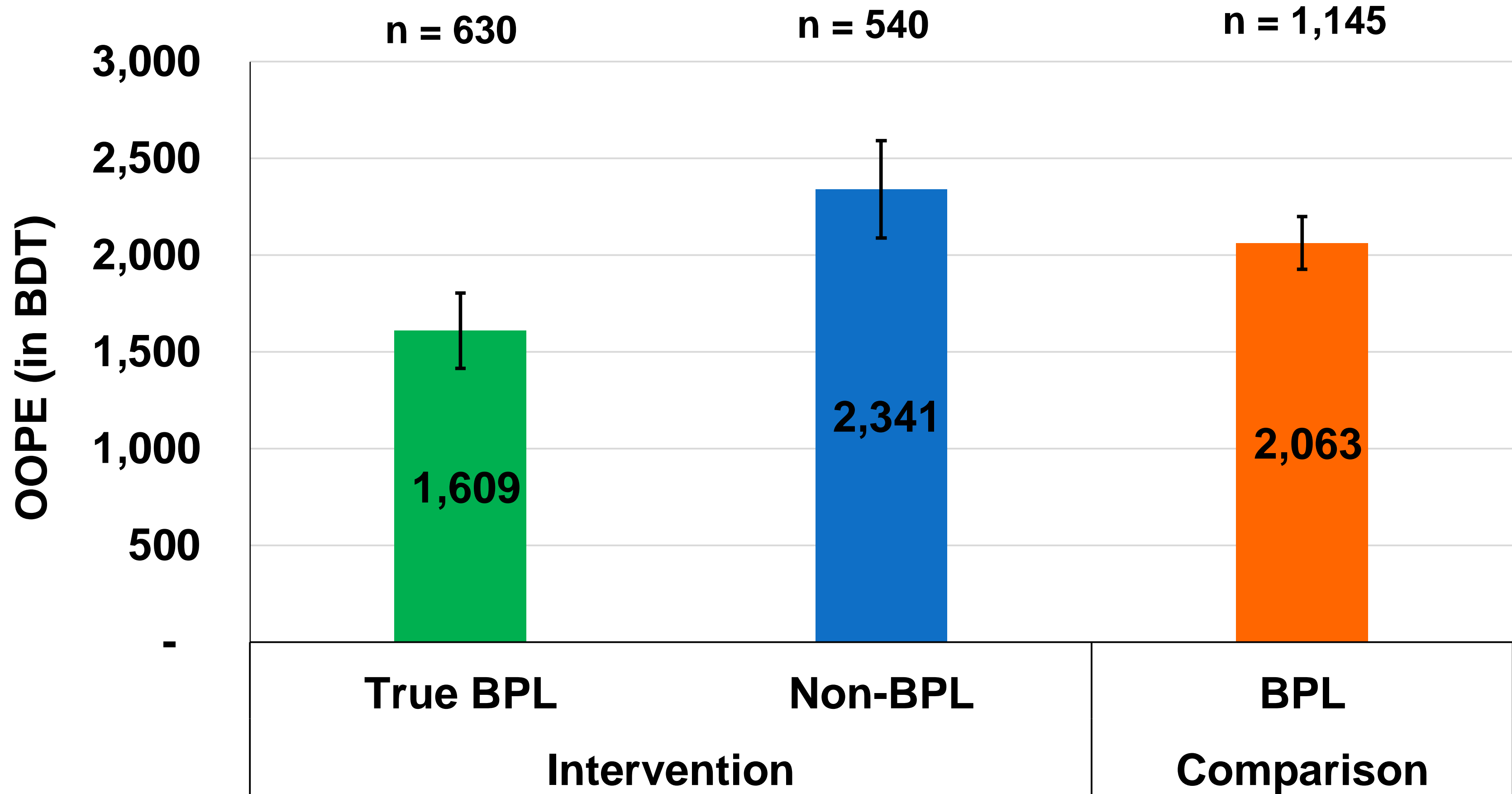
Monthly OOPE (with 95% CI) for health care among the BPL HHs by study areas



USAID
FROM THE AMERICAN PEOPLE

icddr,b

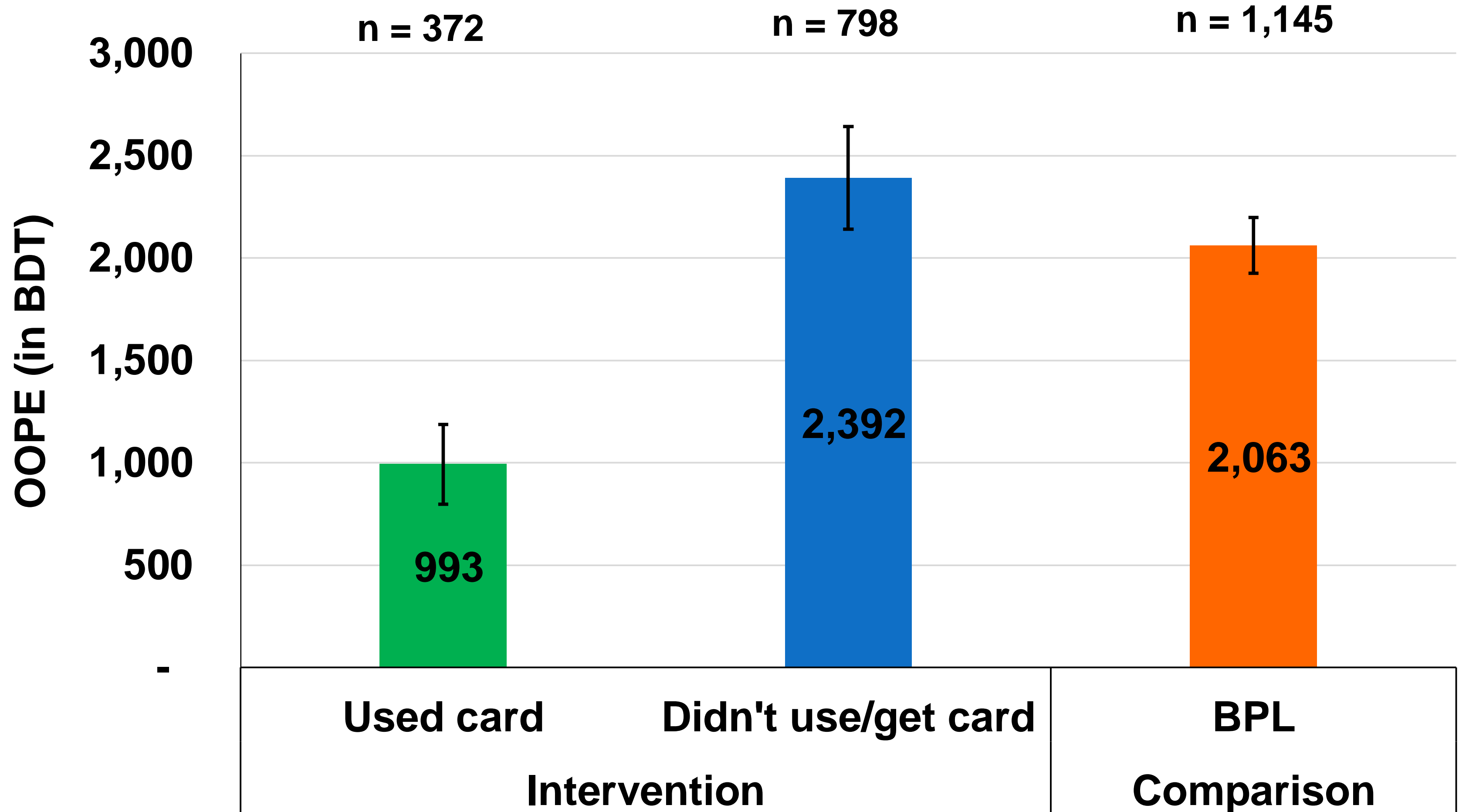
Monthly OOPE (with 95% CI) for health care by BPL status by study areas



USAID FROM THE AMERICAN PEOPLE

icddr,b

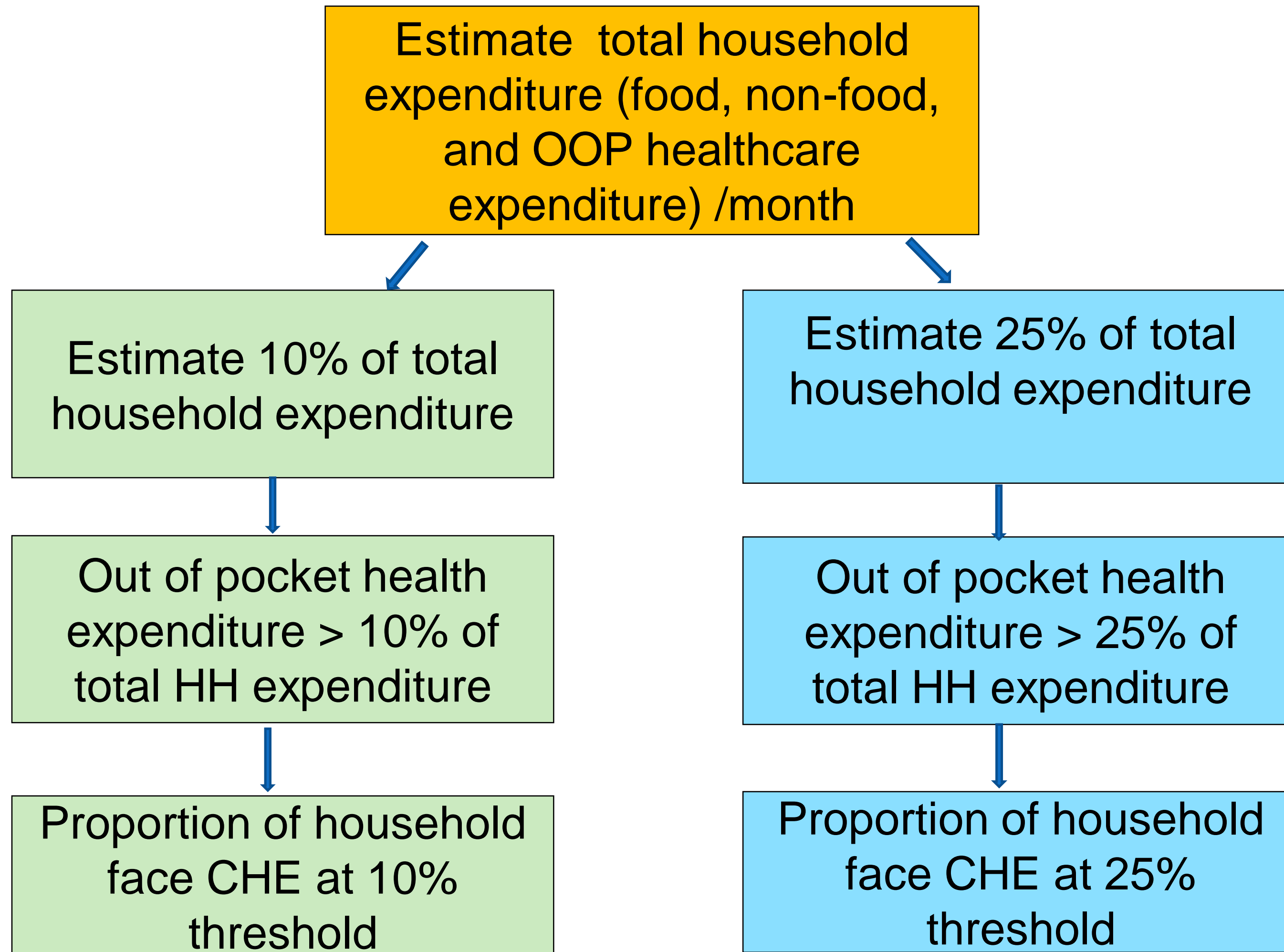
Monthly OOPE (with 95% CI) for health care by use of the SSK cards by study areas



USAID FROM THE AMERICAN PEOPLE

icddr,b

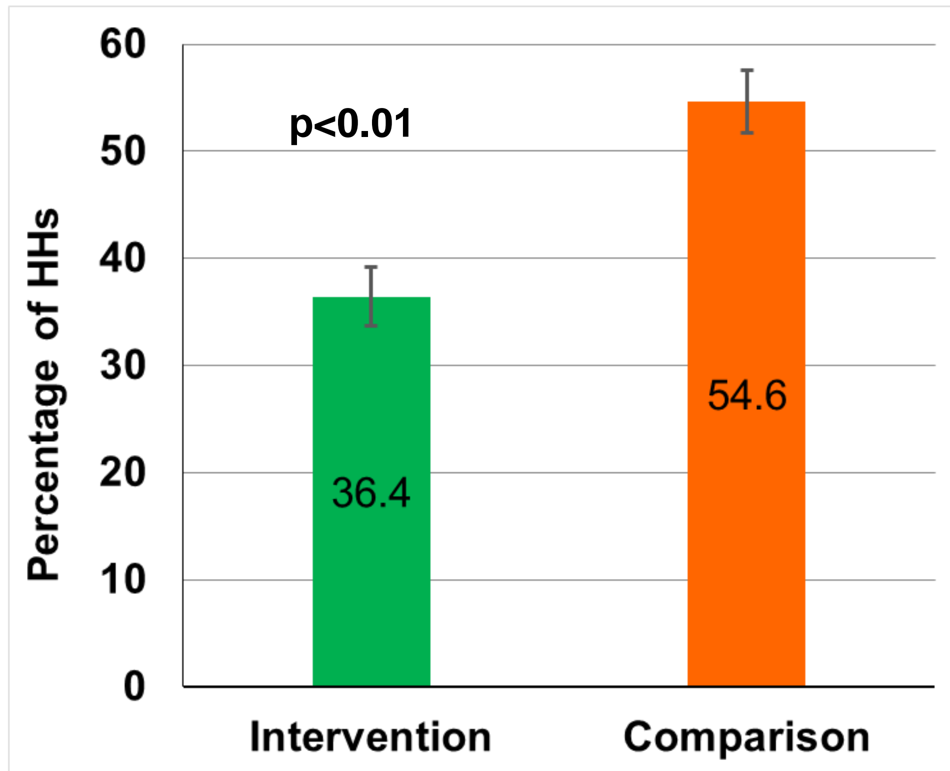
Methods of estimation of CHE at 10% and 25% threshold levels



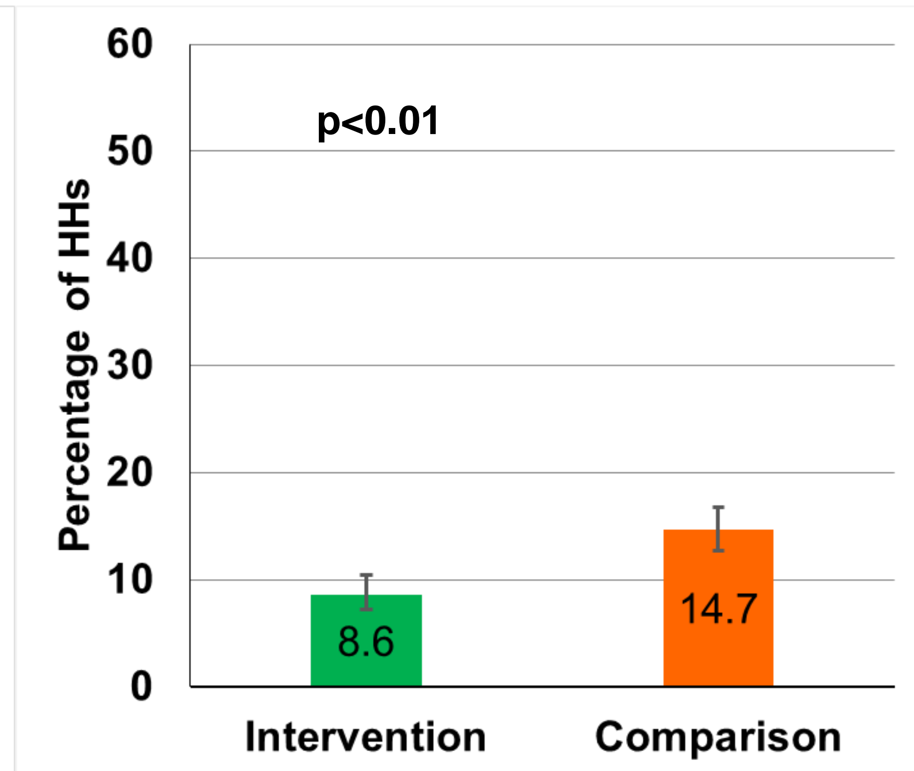
USAID FROM THE AMERICAN PEOPLE
icddr,b

Incidence of CHE among the BPL HHs by study areas

CHE at 10% threshold level



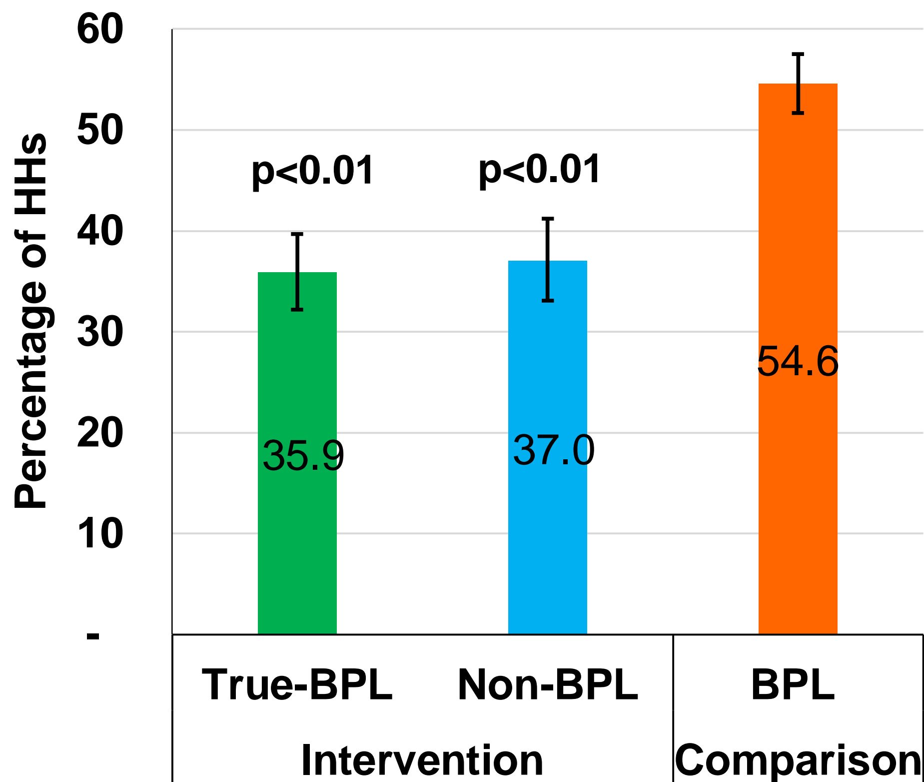
CHE at 25% threshold level



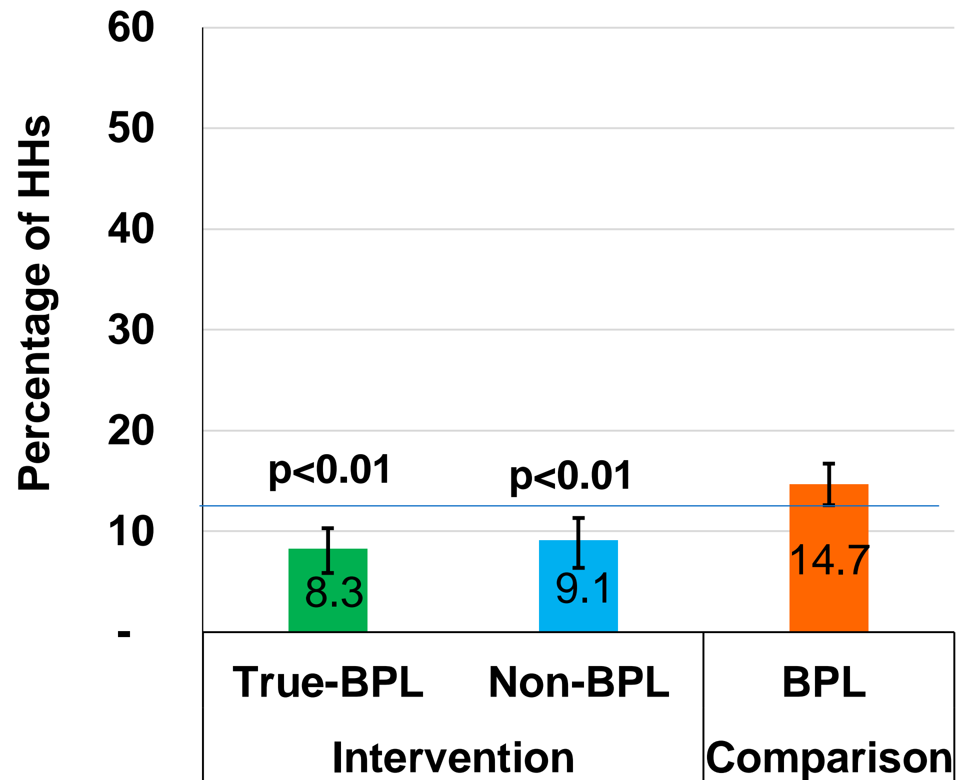
USAID FROM THE AMERICAN PEOPLE
icddr,b

CHE by BPL status of HHs by study areas

CHE at 10% threshold level

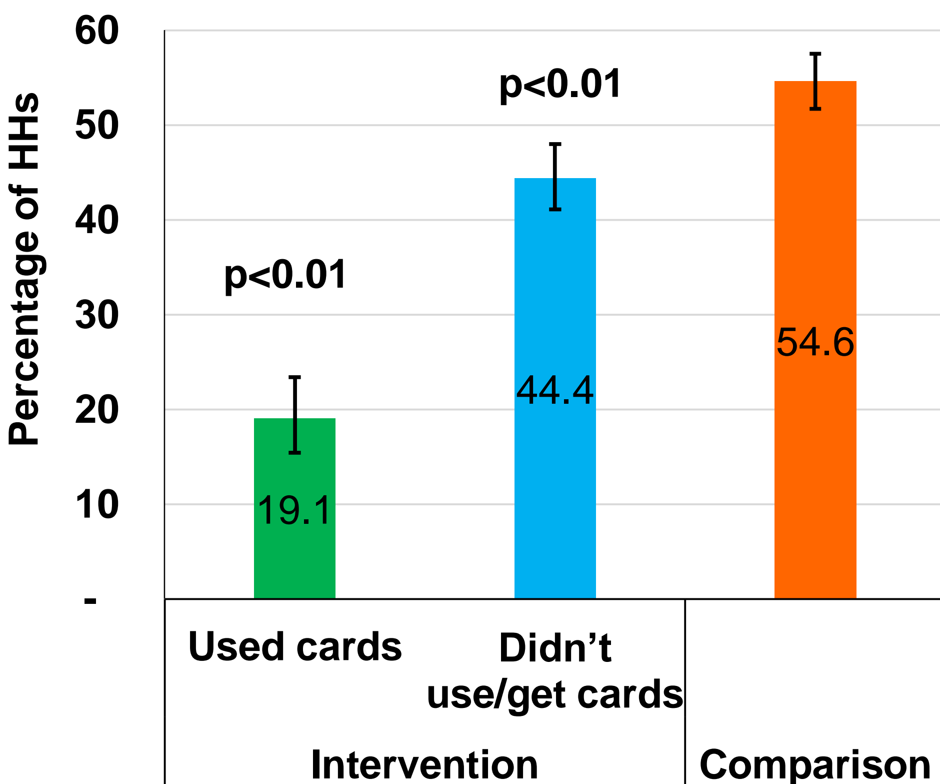


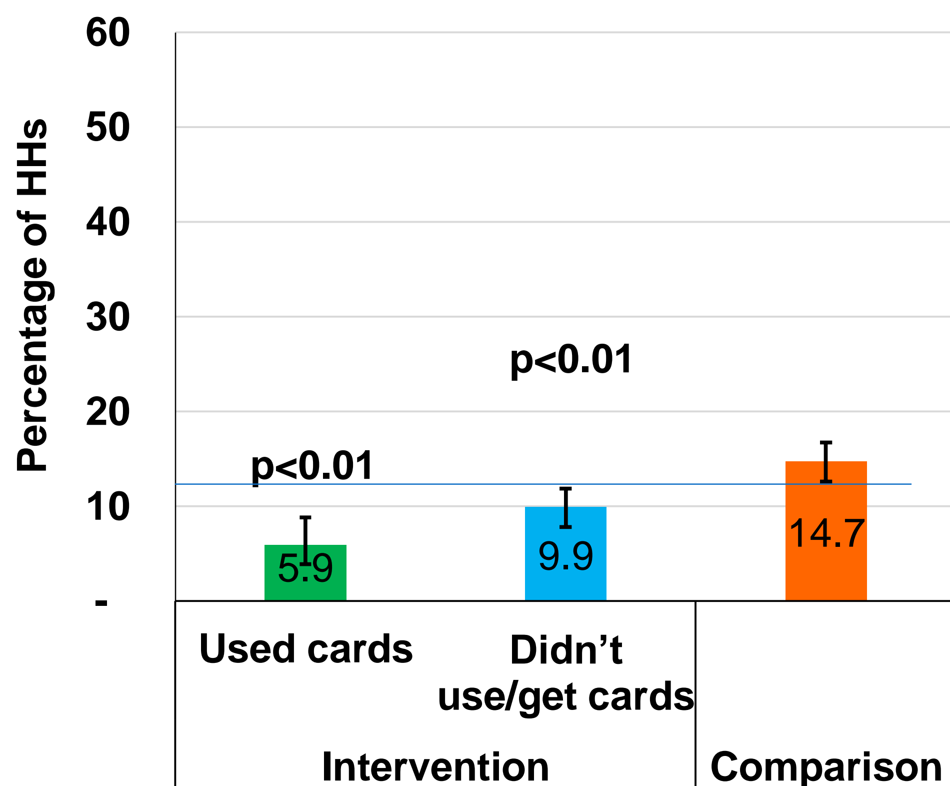
CHE at 25% threshold level



USAID FROM THE AMERICAN PEOPLE
icddr,b

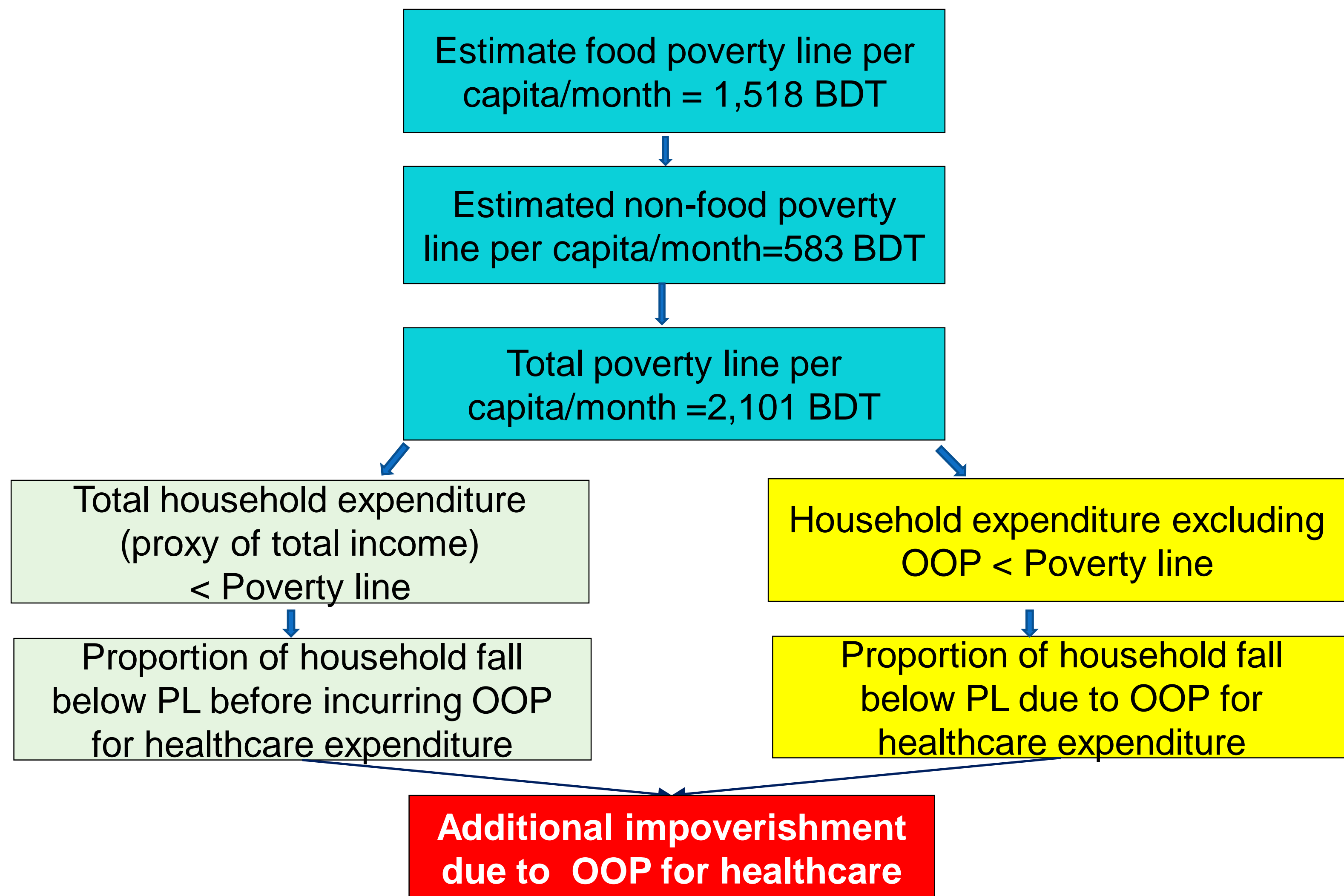
CHE by utilization of SSK cards by study areas





USAID FROM THE AMERICAN PEOPLE
icddr,b

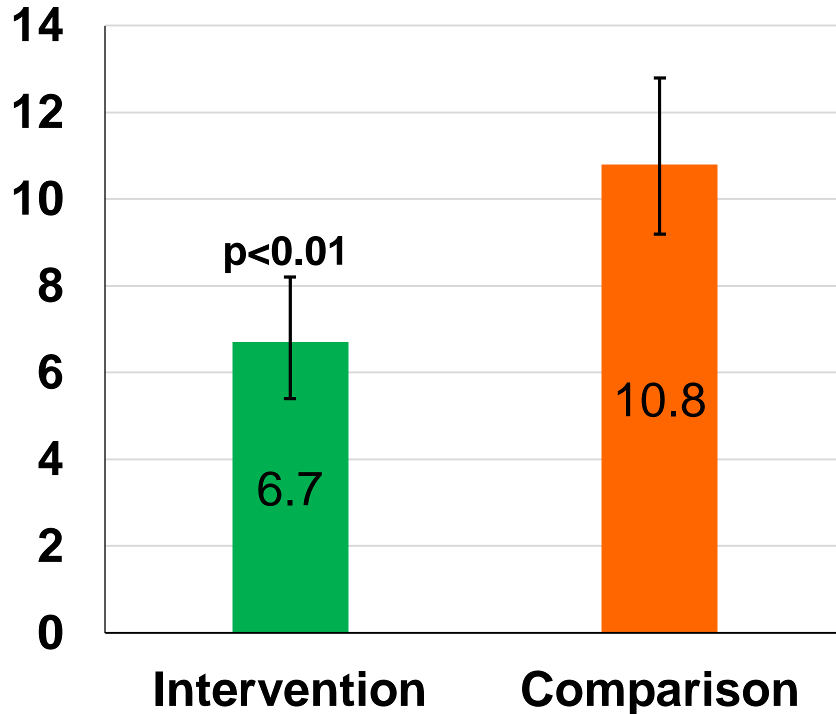
Methods of estimating impoverishment

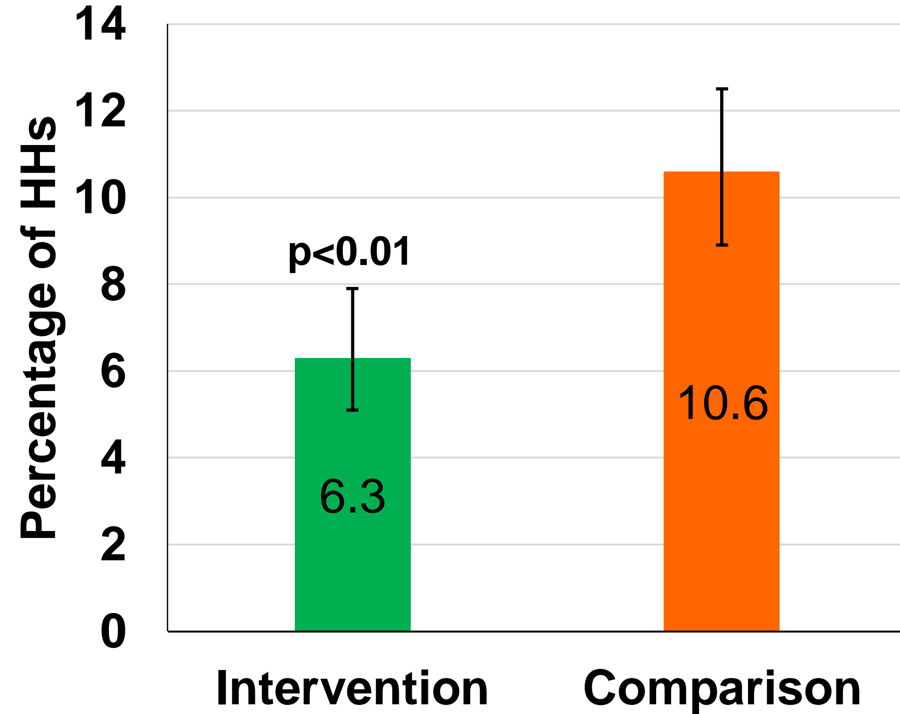


USAID FROM THE AMERICAN PEOPLE

icddr,b

Impoverishment by study areas and type of scale





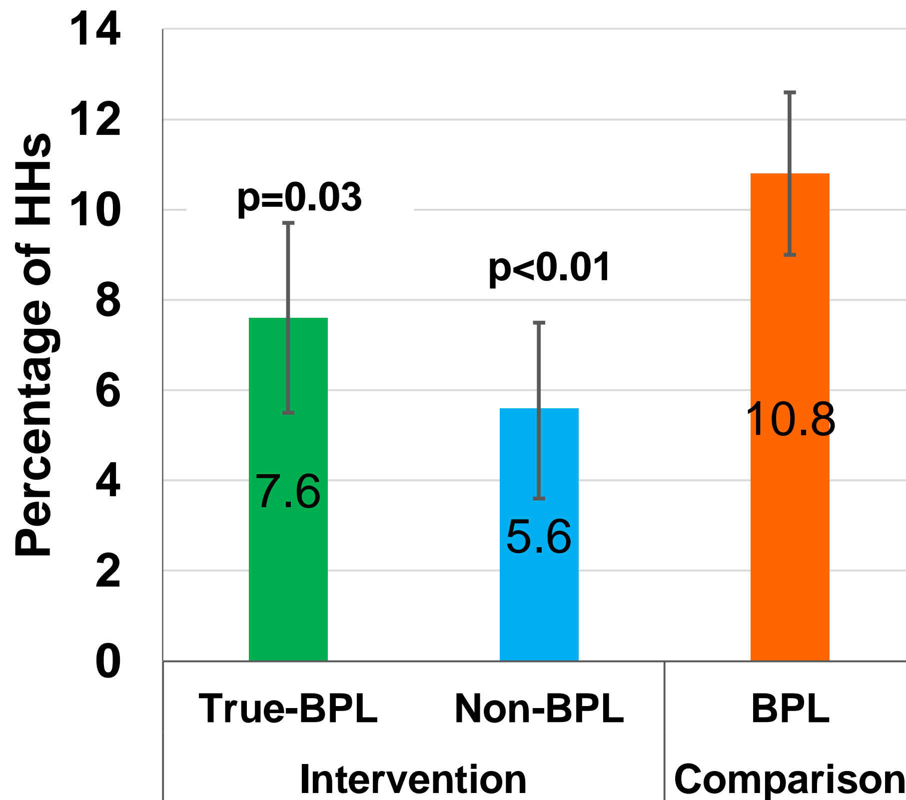
- *Estimated poverty line- 9,028 BDT /hh/month or 2,101 per capita/month*
- *National (Dhaka rural) poverty line 9,305 BDT /hh/month or 2,152 per capita/month (HIES 2016)*

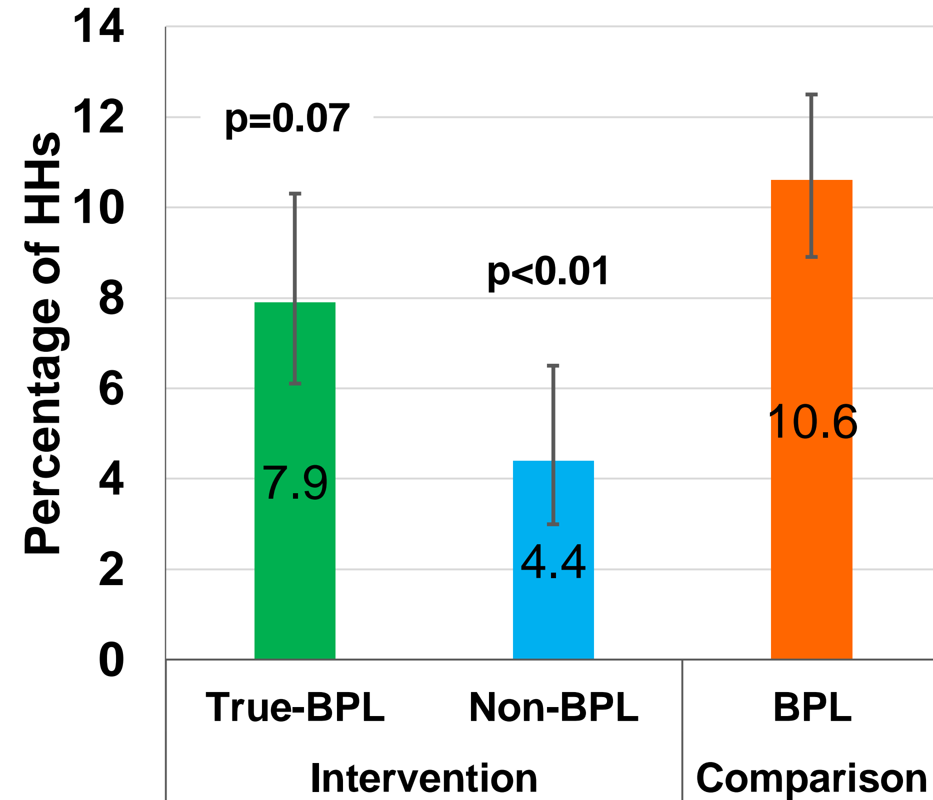
USAID FROM THE AMERICAN PEOPLE
icddr,b

Impoverishment by BPL status by study area

Compared to EPL

Compared to NPL

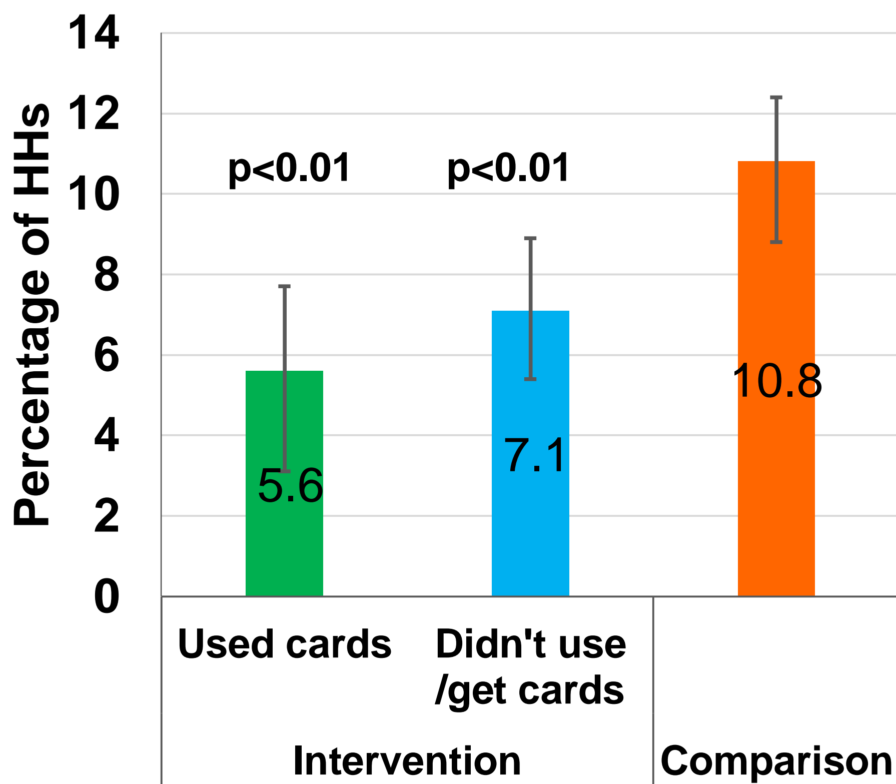




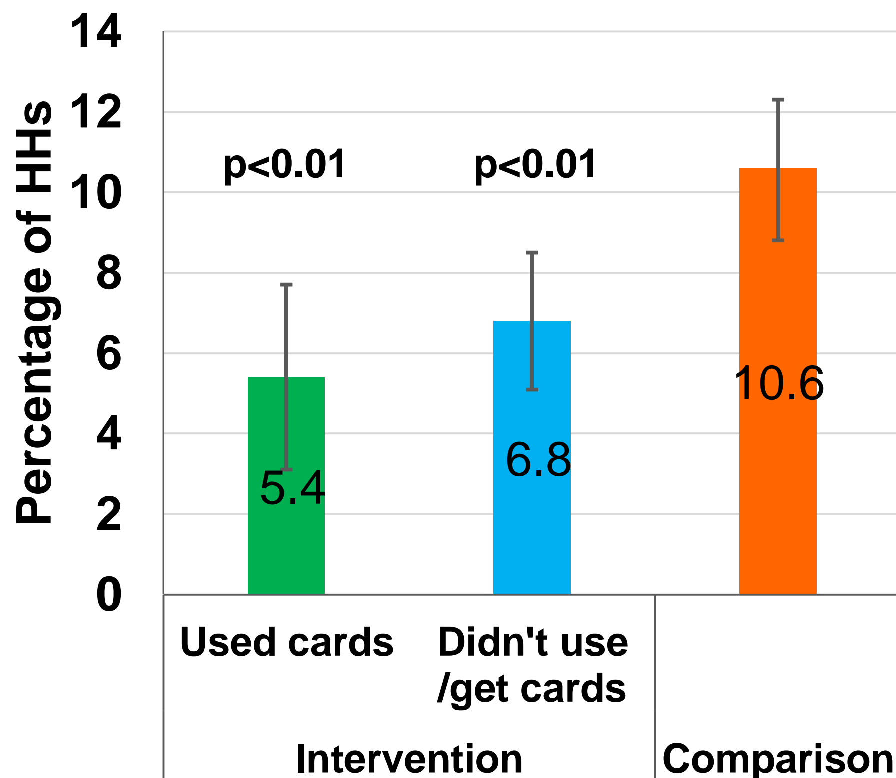
USAID FROM THE AMERICAN PEOPLE
icddr,b

Impoverishment compared to scales by SSK utilization and by area

Compared to EPL



Compared to NPL



USAID FROM THE AMERICAN PEOPLE

icddr,b

CHE and Impoverishment after adjustment for other covariates*

**Adjusted for BPL status, card use status, education and occupation of household head, chronic illness of any member, private provider utilization, accessibility to UHC*

USAID
FROM THE AMERICAN PEOPLE
icddr,b

Effect of SSK
Overall (Intervention vs Comparison areas)

Indicators	Crude	Adjusted
OOPE for healthcare	NS	NS
CHE at 10% threshold	S	S
CHE at 25% threshold	S	NS
Impoverishment wrt. EPL	S	NS
Impoverishment wrt. NPL	S	NS

S = significant;   NS = Non-significant

USAID FROM THE AMERICAN PEOPLE
icddr,b

Effect of SSK by BPL status (True-BPL vs Comp.) and (Non-BPL vs Comp)

Indicators	Crude		Adjusted	
	True-BPL	Non-BPL	True-BPL	Non-BPL
OOPS for healthcare	S	NS	NS	NS
CHE at 10% threshold	S	S	S	S
CHE at 25% threshold	S	S	NS	NS
Impoverishment wrt. EPL	S	S	NS	S
Impoverishment wrt. NPL	S	S	NS	S

S = significant; NS = Non-significant

USAID
FROM THE AMERICAN PEOPLE
icddr,b

Effect of SSK by card use status (Used cards vs Comp.) and (Not used vs Comp.)

Indicators	Crude		Adjusted	
	Used cards	Not used	Card used	Not used
OOPS for healthcare	S	NS	S	NS
CHE at 10% threshold	S	S	S	S
CHE at 25% threshold	S	S	S	NS
Impoverishment wrt. EPL	S	S	NS	NS
Impoverishment wrt. NPL	S	S	NS	NS

S = significant; NS = Non-significant

USAID FROM THE AMERICAN PEOPLE

icddr,b

Summary
Effect of SSK on economic indicators

Characteristics	OOPE for healthcare (Tk)	CHE at 10% threshold	CHE at 25% threshold
Intervention area	1947	36.4 *	8.6
True BPL	1690	35.9*	8.3
Non-BPL	2341	37.0*	9.1
Used SSK cards	993*	19.1*	5.9*
Didn't use/get cards	2392	44.4*	9.9
Comparison area	2063	54.6	14.7

**Statistically significant* (marked with *)

USAID FROM THE AMERICAN PEOPLE
icddr,b

Review of treatment protocol and related findings

icddr,b

Findings from document review

- Overall compliance of the treatment protocol was around 70% and did not improve over time
- When we examine by component of disease protocol, the compliance for diagnostic tests and advice was below 50%

icddr,b

Limitation of the SSK 78 disease list

- Providers face difficulty in following the treatment protocol in the IT system for several reasons:
  - ✓ As each SSK patient to admit under a specific disease condition, the providers face difficulty to treat patients with co-morbidities
  - ✓ Due to unavailability of some disease conditions in the 78 disease list, providers are compelled to use a different (false) code
- There has been strong suggestion on updating the disease list along with provision of allocation of fund for treatment of co-morbidities in the system.

icddr,b

Findings from qualitative assessment: Challenges in implementation of SSK

Qualitative interviews by type

Respondent Type	KIIs	IDIs	FGDs	Case Studies
National level: • Policy Makers • Programme Managers • Academicians • Development Partners	09	-	-	-
Field level (3 Upazilas) : • Health Managers • Care Providers (doctors/nurses) • Scheme Operator's staff • Contracted Diagnostics Managers • Contracted Pharmacy Owner • Contracted Support Staff suppliers	08	30	-	-
Field level : • BPL HHs used SSK Services • BPL HHs did not use SSK Services	-	-	18	26
Total	16	30	18	26

USAID FROM THE AMERICAN PEOPLE

icddr,b

Reasons for not using SSK services: supply side factors

- SSK card holders were not well oriented about use/benefit of card
- Unwelcoming attitude of the staff/providers in SSK facilities
- Unavailable 24/7 SSK booth services (nights and weekends)
- Service interruption due to
  - ✓ Lack of providers (consultants) for in-patients care
  - ✓ Non-functional equipment

USAID FROM THE AMERICAN PEOPLE
icddr,b

Reasons for not using the SSK services: demand side factors

- Lack of trust on free services / or negative feedback on public facilities
- Fear of referral to district hospitals (wage loss, food cost)
- Lack of supporting hands at household acts as barrier for in-patient care
- Did not understand the benefit of SSK Cards
- Long distance to SSK facility / no travel cost reimbursement
- Non-BPL HHs felt ashamed of using free services

USAID FROM THE AMERICAN PEOPLE

icddr,b

Weaknesses in community awareness activities

- The community awareness activities (mikeing, leaflet, TV scroll, postering) of SSK programme were mostly one time activity.
- SSK did not have inter-personal communication strategy which was needed
- Card holders complained that they were not adequately informed about the benefit and use of the cards by the scheme operator

USAID FROM THE AMERICAN PEOPLE
icddr,b

About lack of inter personal communication, a beneficiary said,

"কার্ড তো দিয়া গেছে। কিন্তু কোথায় গেলে বা কিভাবে চিকিৎসা পাওয়া যাবে সে বিষয়ে কিছু বলে নাই । আমিও আর কিছু জিজ্ঞেস করিনাই। তারা শুধু বলছিল হাসপাতালে গেলে কার্ড দেখাইলেই আমি চিকিৎসা পাবো।"

USAID FROM THE AMERICAN PEOPLE
icddr,b

High referral from some SSK facilities

- Each month about 120 patients are referred to Tangail DH from the 3 SSK UHCs. Of them 60% are from one UHC (Modhupur)
- One major reason of high emergency/direct referral is unavailability of providers or services at the UHCs
- Influential non-BPL who received SSK cards pressurize the service providers to have them admitted even if their disease condition does not fall within the 78 disease list. These cases get referred to DH

USAID
FROM THE AMERICAN PEOPLE
icddr,b

Regarding high referral from Modhupur, a heath manager said,

- "কিছু মানুষকে *ডি- সোল্ডারিং করার জন্যও রেফার করা হয়েছে। যেমন অনেক স্থানীয় মানুষ চেয়ারম্যানের সহায়তায় কার্ড পেয়েছে কিন্তু তারা বিপিএল এর মধ্যে পরেনা। এরা কার্ড নিয়ে হাসপাতালে আসে ধমকি -ধামকি দেয় ডাক্তারদের , তখন কার্ডের আওতায় রোগ না থাকলেও অন্য একটা কোডে ফেলে রেফার করে দেই এদেরকে ।* "

USAID FROM THE AMERICAN PEOPLE

icddr,b

Irregularities in ambulance services for referral

- The referred patients are supposed to get free ambulance services (either govt. or private) from the SSK
- However, govt. ambulances are not always available for SSK and usually drivers of govt. ambulance claims forced tips from poor SSK patients
- Sometimes patients have to arrange ambulance at own cost
- Irregularities (multiple bills for single trip, bills for patients not using ambulance) noticed in claiming reimbursements

USAID
FROM THE AMERICAN PEOPLE
icddr,b

Lack of readiness of referral hospital –Tangail DH

- Referral hospital (Tangail DH) is not enough ready to treat SSK patients due to shortage of specialized doctors and no ICU services
- For ICU support patients need to refer to Mymensingh or Dhaka Medical College Hospitals from SSK UHCs
- Patients also have lack of confidence on Tangail DH and sometimes go to private hospitals instead of DH while referred

USAID FROM THE AMERICAN PEOPLE
icddr,b

Medicine supply related issues for SSK patients

- The contracted pharmacies not always supply drugs from the listed top 10 companies.
- Delay and partial supply of medicine is common.
- As per SSK protocol >7 days of medicine can not be provided at discharge. Patients needing medicine >7 days can not get so without re-admission.

USAID FROM THE AMERICAN PEOPLE
icddr,b

Diagnostic services and related issues for SSK patients

- For SSK patients diagnostic services can be provided from both SSK facility and private contracted diagnostic centres
- However, at SSK facilities many common tests not regularly performed due to problem of equipment, reagents and manpower
- From contracted diagnostic centres, there is no provision of collection of sample from patients' bed-side.
- In-patients need to reach the diagnostic centres on their own

USAID FROM THE AMERICAN PEOPLE
icddr,b

Shortage of doctors and consultants and related challenges in SSK facilities

- Effective co-ordination of the HEU with the DGHS and HSD at the MoHFW is a challenge in ensuring the availability of medical officers and consultants in the SSK facilities
- Very recently, the vacant posts of medical officers has been filled-up through recruitment of medical doctors by Govt.
- However, unavailability of consultants (80% post vacant) remains as a challenge for in-patient care of the patients

About lack of effective co-ordination, a key informant said,

"এসএসকে প্রোগ্রামের কনসেপ্ট-এর একটা বড় চ্যালেঞ্জ ছিল হিউম্যান রিসোর্স এর বিষয়টি। কিন্তু আমরা সেরকমই জানতাম যে, ডিজিএইচএস থেকে এসএসকে ফ্যাসিলিটিতে ভ্যাকেন্ট পোষ্টগুলো ফিলআপ করা হবে। ফ্যাসিলিটি রেডিনেস-এ আমাদের বড় দুইটা চ্যালেঞ্জ এরিয়া, একটা ইকুইপমেন্ট ম্যানেজমেন্ট -যেটাতে আমরা অতোটা চ্যালেঞ্জ এর সম্মুখীন হই নাই। কিন্তু আরেকটা হিউম্যান রিসোর্স শর্টেজ - যেটা আমরা বেশী ফেইস করেছি।"

USAID FROM THE AMERICAN PEOPLE

icddr,b

Additional workload of doctors and nurses and managers for SSK

- The providers and managers reported of additional workload they have to bear in serving the SSK patients
- Nurses have to maintain different registers and take approval of doctors in different documents
- Doctors need to fill-up a number of forms and check claims documents. Also need to counsel the SSK patients who do not qualify in getting SSK services
- Managers need to monitor and supervise the contractors, verify claim documents, organize monthly meeting with local committee and manage patients' complain about SSK services.

USAID FROM THE AMERICAN PEOPLE
icddr,b

About workload of doctors in the UHCs, a UH&FPO said,

"মেডিকেল অফিসার যারা আছেন তারা সার্ভিস দিচ্ছেন। জেনারেল পেসেন্ট এর পাশপাশি তাকে এসএসকের পেসেন্টও দেখতে হচ্ছে। ... এসএসকের বাড়তি কাজগুলো এই জনবল দিয়ে আসলে সম্ভব নয়। বিষয়টা আমরা বারবার উর্ধ্বতন কর্তৃপক্ষকে জানিয়েছি। কিন্তু কোন সমাধান হয়নি।"

Regarding additional workload, a nursing supervisor said,

"আমার জেনারেল পেশেন্ট আসলে এতগুলি খাতা হ্যান্ডেল করতে হয়না। এইজন্য আমাদের জেনারেল রোগী আর এসএসকে রোগী অনেক পার্থক্য। একটা এসএসকে রোগী আসলে অনেক সময় লাগে একটা পেশেন্টের জন্য , কারণ অনেকগুলি রেজিস্টার খাতায় তাদের চিকিৎসা ব্যবস্থা লিখতে হয়। "

USAID FROM THE AMERICAN PEOPLE
icddr,b

Demand for incentives for service providers

- Most of the managers and providers at the health facilities consider their SSK related activities as additional job
- They have strong expectation for incentives from SSK
- Incentive at institutional level (support for infrastructure, equipment) was implemented in all the facilities
- However, at personal level the provision of incentive could not been implemented due to policy barrier

USAID FROM THE AMERICAN PEOPLE

icddr,b

SSK Design Flaw - No referral linkage with the primary health care system

- Many common illness for which SSK card holders visit UHCs could be provided from primary heath care system
- Many card holders not requiring hospital admission get disappointed and develop negative impression about SSK
- Sometimes providers make unnecessary admissions being sympathetic to poor card holders
- Unnecessary bed occupancy (sometimes 70%) by SSK patients deprives non-SSK patients from required healthcare

Suggestions on future scale-up of SSK

- Respondents expressed the need of a long-term action plan for future scale up of SSK with specific policy direction for structural change
- If SSK is planned to be continued as a safety net programme in its current form it can be implemented by the DGHS
  - Necessary restructuring to be needed in the DGHS
  - Also need to coordinate with other safety-net programmes
- If it is planned to implement SSK as a insurance programme by including BPL and APL, it needs to be operated by modalities of health insurances for which two types of suggestions came
  - Establishing a National Health Security Office
  - Engaging Health Insurance companies instead of scheme operators

USAID FROM THE AMERICAN PEOPLE
icddr,b

Action already taken by the HEU based-on our research

- Had initiative to engage multiple scheme operators instead of one to promote competition and improve quality
- Investigated the issue of villages not having BPL list by spot-checking and inquiring the scheme operators
- Examined the issue of inclusion of non-BPL in the BPL list, by discussing with local leaders to bring a solution
- Decided to take measures for proper identification of the BPL in the new Upazilas for expansion of the SSK
- Intended to set a plan of bringing at least two-thirds of the targeted population within SSK by addressing the current limitations of the programme

Recommendations

USAID
FROM THE AMERICAN PEOPLE
icddr,b

Recommendations
Expansion of SSK in district health system

- Findings show the SSK reduce OOPE and CHE among the poor who used the SSK cards in the pilot phase
- We recommend that the SSK should be expanded to all the sub-districts of one district for adaptation in district health system model
- The future expansion of SSK should be linked with a well designed implementation research to guide the implementer in proper planning as well as identifying and addressing the demand and supply challenges

USAID FROM THE AMERICAN PEOPLE

*Statistically significant

icddr,b

Recommendations

Improving BPL identification process and awareness building

- Develop a clear guideline and strictly follow that guideline for identification of BPL HHs
- SSK cards should be handed over to all the identified BPL HHs within 7 days of identification as per SSK protocol
- Interpersonal communication strategy should be adopted for informing the SSK card holders about the benefits of SSK and use of the cards

Recommendations

Updating 78 disease list and computer system

- The existing 78 disease list of SSK in-patient care should be critically reviewed by an expert group for possible refinement
- The computerized system also should be updated by including the provision of treatment with co-morbidities
- For SSK patients, needing >7 days of medicine, follow-up mechanism should be developed for providing medicine

USAID FROM THE AMERICAN PEOPLE
icddr,b

Recommendations

Linking SSK with Primary Health Care System

- A system should be developed for referring SSK patients through the primary health care system to the SSK UHCs.
- For this necessary collaborative arrangements to be initiated with the CBHC, DGFP and DGHS.
- SSK patients who do not qualify for admission, a system should be developed for offering OPD services with special care within the existing system.

USAID FROM THE AMERICAN PEOPLE

icddr,b

Recommendations

Strengthening referral from UHC to higher level of facilities

- All the SSK patients should be provided with ambulance when referred to DH in Tangail
- An audit is also suggested to understand the extent of irregularities for ambulance services.
- Improve readiness of Tangail DH as a referral facility, also consider Mymensingh Medical College Hospital as an additional referral facility for SSK.

USAID FROM THE AMERICAN PEOPLE

icddr,b

Recommendations

Improving services of contracted pharmacies and diagnostic centres

- Contracted pharmacy and diagnostic centres should be oriented with the SSK protocol for their respective roles
- Collection of specimens from bed-side of the critical patients should be introduced for SSK patients
- For services in contracted diagnostic centres, free transportation should be provided for the SSK patients

USAID FROM THE AMERICAN PEOPLE
icddr,b

Recommendations

Strengthening monitoring and supervision system

- A monitoring framework to be developed to track progress in implementation of the SSK activities
- SSK monitoring team should participate in periodic (3-monthly) monitoring visits
- Regularly present monitoring data to steering committee and follow-up the implementation of the decisions

USAID FROM THE AMERICAN PEOPLE
icddr,b

Recommendations

Improving collaboration with DGHS and HSD

- HEU to further strengthen collaboration with DGHS for functionality of the SSK facilities for ensuring availability of medical doctors, IT system development/improvement etc.
- Collaboration with the HSD, MoHFW also should be strengthened for ensuring the availability of consultants
- Explore possibilities of using in-country capacities for BPL card development and maintenance of the medical and financial records using the existing IT platform of the DGHS

USAID FROM THE AMERICAN PEOPLE
icddr,b

Recommendations

Enhancing motivation of the provider and reducing workload

- For medical officers and nurses: introduce innovative **non-financial incentive** model like crest for best provider by type; opportunity for attending short-training/conferences within and outside country; annual feast etc.
- For consultants: introduce **non-practicing allowance** for 24/7 services
- In addition, possibility of **local level hiring** of doctors/nurses within the district by the Civil Surgeon could be explored

USAID FROM THE AMERICAN PEOPLE
icddr,b

Recommendations

Preparedness for future scale-up plan of SSK

- In short term, the capacity of DGHS needs to be enhanced by identifying a **Focal Person** (Deputy Director) under the Director Hospital for expansion of the SSK
- In the medium term, a complete health insurance model may be developed by including both BPL and APL under the authority of a **National Health Security Office**
- HEU and DGHS should continue as strategic partners for policy research and service delivery respectively for moving Bangladesh toward achieving UHC

USAID FROM THE AMERICAN PEOPLE
icddr,b

Acknowledgments

- This research has been fully funded by the USAID RDM Project to icddr,b
- We sincerely acknowledge the cooperation and support of the Health Economics Unit (HEU), MoHFW for conduction of this research

USAID
FROM THE AMERICAN PEOPLE

icddr,b

Disclaimer

This study was produced with the support of the United States Agency for International Development (USAID) under the terms of USAID's Research for Decision Makers (RDM) Activity cooperative agreement no. AID-388-A-17-00006. Views expressed herein do not necessarily reflect the views of the U.S. Government or USAID.

---

icddr,b thanks its core donors for their on-going support

Government of the People's Republic of Bangladesh

Canada