

Research brief

Evaluation of the Pilot Shasthyo Shurokhsha Karmasuchi (SSK)

Background

In Bangladesh out of pocket expenditure (OOPE) for healthcare (67%) and catastrophic health expenditure (CHE) (25%) are high. Annually, around 8 million people go below the economic poverty line due to health care expenditure. Therefore, for financial risk protection of the below poverty line (BPL) population, the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MoHFW) had developed a health protection scheme called Shasthyo Surokhsha Karmasuchi (SSK). During 2016-2019, SSK was piloted in three Upazilas of Tangail District. Under this pilot scheme, for each enrolled BPL households (HHs), the government provided a premium for in-patient healthcare services for selected 78 diseases. For in-patient care of the SSK enrollees, in each Upazila, the designated Upazila Health Complex (UHC) functioned as the first contact facility that was linked through referral with the Tangail district hospital for specialized care. The HEU had engaged a scheme operator and private pharmacies and diagnostic centers, and suppliers of support-staff for smooth functioning of the scheme. icddr,b under USAID's Research for Decision Makers (RDM) Activity evaluated the pilot SSK from June 2019 to September 2020.

The key objectives of the evaluation were to assess the effectiveness of the SSK in the reduction of financial hardship i.e. OOPE for healthcare and CHE, among BPL HHs and to document the scheme's implementation related barriers from both demand and supply-side perspectives.

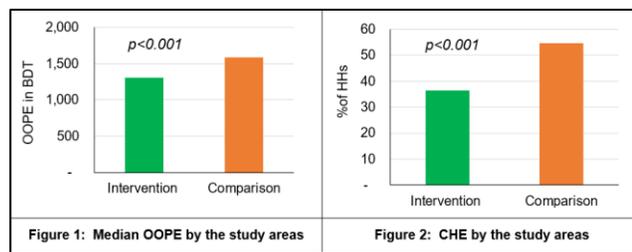
Methodology

The assessment employing both quantitative and qualitative methods compared health care related costs among the BPL HHs in three SSK Upazilas (intervention area)¹ with the BPL HHs in three equivalent comparison Upazilas (comparison area)² of Tangail. The OOPE for healthcare was defined as payments made at the point of service e.g., consultation, medicine, diagnostic, food, transport, attendant and any informal payments. The incidence of CHE was defined as households' OOPE for healthcare exceeding 10% of its total consumption expenditure thresholds level.

Findings

Effectiveness of SSK

- Overall, in the SSK intervention area, the BPL HHs using in-patient care in the past one year had reduced financial hardship as compared to those in the comparison area.
 - ✓ The monthly median OOPE for healthcare in the intervention area (Tk 1,306) was significantly lower than that in the comparison area (Tk 1,583) as shown in **Figure 1**.
 - ✓ The incidence of CHE in the intervention area (36.4%) was also significantly lower than the corresponding figure in the comparison area (54.6%) as shown in **Figure 2**.



¹ Kalihati, Ghatail and Madhupur

² Gopalpur, Shakhipur, Basail

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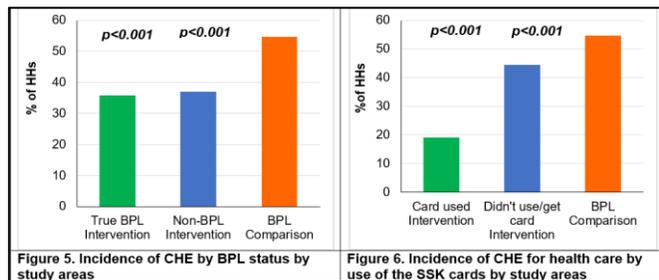
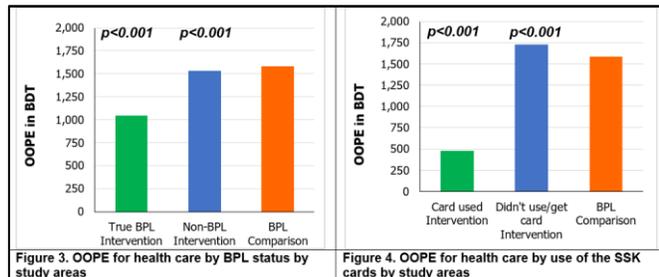
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Challenges in identification of BPL HHs, card distribution and SSK service use

- In the intervention area, 41.6% of BPL HHs were found as non-BPL and 58.4% as true-BPL after verification by the study team using the same BPL identification criteria that had been used by the scheme
- In the intervention area, around 82.0% of the BPL HHs had SSK cards, 16.7% had not received the cards and 1.3% had lost cards
- The utilization of SSK services for in-patient care among the SSK BPL population was low. In the three SSK Upazilas, while 16.3% of the SSK BPL HH had at least one in-patient care in the past one year, only 5.2% sought services under the SSK scheme. The rest 11.1% went elsewhere for in-patient care.
- About 31.8% of the SSK BPL HHs utilizing at least one in-patient care service in the last one year, had cards and used SSK services; 49.3% despite having the SSK card used services elsewhere and the rest 18.9% either did not get the card in time or lost the card.

Effectiveness of the SSK after controlling for actual BPL status and use of the SSK card

- In the intervention area, true-BPL HHs had much lower monthly median OOPE for healthcare (Tk 1,044) compared to non-BPL HHs (Tk 1,536) and those in comparison area (Tk 1,583) (**Figure 3**).
- HHs that used SSK card, had three-times lower OOPE compared to the HHs that didn't use/get card and those in the comparison area (**Figure 4**)
- In the intervention area, the true-BPL HHs had significantly lower CHE (35.9%) as compared to the non-BPL households (37.0%) and those in the comparison area (54.6%) (**Figure 5**).
- Similarly, HHs that used SSK card had more than 2-time reduced CHE (19.1%) compared to the households those didn't use/get card (44.4%) and those in the comparison area (54.6%) (**Figure 6**).



Other implementation related challenges of SSK: findings from qualitative assessments

- Weak community engagement activities failed to motivate the SSK cardholders to utilize the services at SSK facilities. Other reported reasons included long distance to SSK facility, providers' unfavorable attitude, unavailability of treatment for selected diseases, fear of referral to district hospitals resulting in additional indirect cost, unavailability of SSK booth services at night time, and on weekends, service interruption due to lack of providers.
- Retention of doctors in the designated facilities remained a major challenge. About 80% of the posts of the consultants remaining vacant in the SSK UHCs as well as in the Tangail District Hospital persists as a major challenge.
- Delay in referring emergency patients to the referral hospital due to the absence of specialist providers caused delay in seeking care and developed dissatisfaction among the patients.

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- The SSK programme could not always provide an ambulance for the referred patients, and sometimes patients had to pay out of pocket for transportation to the referral facility.
- Another major lacking of the scheme was not having a referral linkage from the primary health care settings below UHCs for inpatient care at the SSK facilities.
- In general, all the service providers, irrespective of cadres, felt over-burdened and demotivated to carry-out the services to SSK patients particularly for the additional managerial works including documentation in a prescribed format for which there was no provision of incentive.
- All types of providers had a strong expectation for incentives from SSK to uphold their motivation for the additional responsibilities of SSK.
- The study observed gaps in the supply of medicine and diagnostic services to SSK patients.
- Delay in partial supply of medicine to the SSK patients by the contracted private pharmacy was a common phenomenon.
- The labs at the SSK facilities were not fully functional for diagnostic services. In-patients needed to reach the diagnostic centers on their own without having transportation support from the SSK.
- The collection of claim documents and submitting a claim statement required more time than the anticipated due to the officials' engagement with non-SSK activities.
- The scheme lacked an effective monitoring and supervision system for regular monitoring and reporting of the key indicators and action-taking to fill-up the gaps.
- Shortage of human resources at the HEU also came out as a major challenge
- The study observed lacking in effective collaboration of the HEU with the DGHS and the Health Service Division (HSD) in the MoHFW for the successful implementation of SSK.

Recommendations

Based-on the findings from the evaluation of the pilot SSK, the authors made the short, medium and long-term recommendations as follows:

- *Short-term recommendations (within 1 - 3 years):*
 - ✓ The SSK should be expanded to all the 12 Upazilas of Tangail district including the Municipality areas of the respective Upazilas for adaptation to the district health system model, as the intervention reduces OOPE and CHE among the BPL HHs.
 - ✓ This should be backed-up by a well-planned implementation research to document the lessons learned and give necessary feedback to the program for refinements.
 - ✓ In short-term the study also recommends to
 - develop a clear guideline for improving the BPL identification process and interpersonal communication strategy for informing the SSK cardholders about the benefits of SSK and the use of the SSK cards
 - update the SSK 78 disease list based-on local needs
 - address the gaps in facility-readiness, strengthen referral services, ensure water and sanitation facilities, ensure transportation and so on.

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- strengthen referral system from SSK UHCs to higher facilities by improving ambulance support services to the referred SSK patients and related management;
 - improve services of contracted pharmacies and diagnostic centres by ensuring timely supply of essential medicine,
 - arrange transportation for the inpatients to reach the contracted diagnostic centres for lab tests;
 - introduce bed-side collection of specimens for the critical patients.
 - improve collaboration of HEU with DGHS for IT system development/improvement for management of BPL card holders, management of patient at SSK facilities
 - ✓ Collaboration with the HSD, MoHFW should be enhanced for ensuring the posting of consultants in the vacant posts both at the SSK UHCs and the referral hospital.
- *Medium term recommendations (within 4 - 5 years):*
 - ✓ HEU should strengthen the monitoring and supervision system of SSK by developing a monitoring framework and its implementation.
 - ✓ To motivate the providers, innovative models like non-financial incentive for doctors/nurses and non-practicing allowance for consultants also should be applied.
- *Long term recommendations (within 6 - 10 years):*
 - ✓ In the next 6 to 10 years (long term) the final SSK model should be scaled-up in all the 64 districts in Bangladesh in a phased manner. Economically disadvantaged and hard-to-reach upazilas with relatively poor health service infrastructure should be targeted first.
 - ✓ At the same time, initiative should be taken for developing an SSK model to cater to the health care need of the BPL population in urban settings, particularly for those living in large cities.
 - ✓ In addition, for effective management of SSK, the study recommends establishment of a National Health Security Office (NHSO) for regulatory and management-related activities.
 - ✓ Finally, HEU and DGHS should continue working together as strategic partners for policy research and service delivery respectively for nationwide scale-up of SSK.

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