FINANCING SSK IN BANGLADESH

DISCUSSION PAPER

AXEL WEBER

I. Background

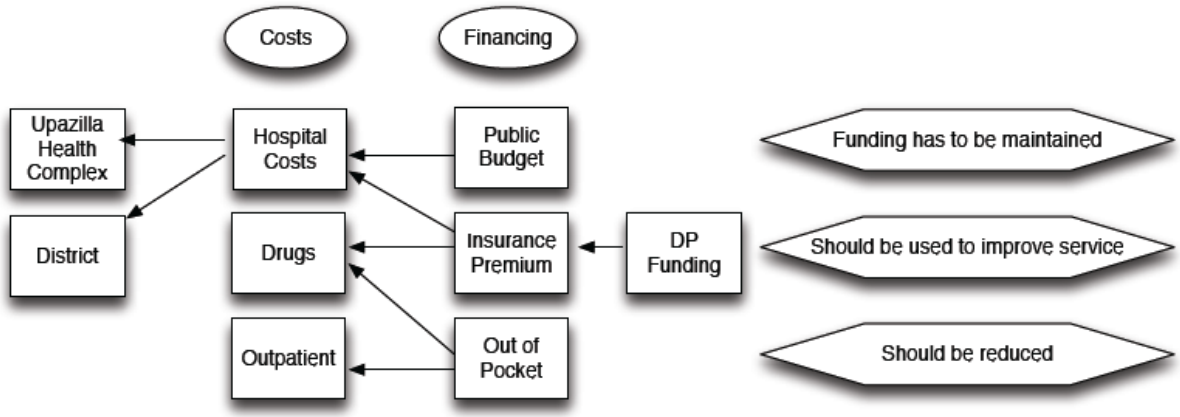
The introduction of SSK as a third party payer in the Bangladesh Health System raises a number of questions that will be discussed in this paper.

The following chart shows the financing structure under SSK. The main costs are inpatient care, outpatient care and drugs. Inpatient care is offered by Upazilla Health Complexes (UHC) and District Hospitals (DH). Both are under discussion to be included into SSK benefits (referrals to DH on a limited basis).

It is the intention of the Government not to include outpatient benefits under SSK. In how far drugs should be included is not yet decided. Drugs are distributed in hospitals (in theory for free, but in practice they are often not available and patients buy them outside hospitals in pharmacies).

The financial resources that will be available under SKK are public budget, insurance premiums (in the beginning mostly paid by DP, later out of public budget for the poor and by the non-poor members) and out of pocket payments. Currently, more that 60% are of the third category. The insurance is supposed to change this.

Figure 1: Financing Structure under SSK



II. Risks

There are some risks associated with the introduction of SSK.

- The first Risk is that in line with additional funding MoF will reduce budget funding for health care. The consequence will be that DP basically will give budget support but that there will be no improvement of health care, especially for the poor.
- The second risk is that additional funding will result in inflationary tendences, especially in higher incomes for health professionals or higher prices for products without bringing about substantial improvements of care, especially for the poor.

- The third risk is that consumers will increase demand and try to recover any contributions made through high consumption (moral hazard).

All three risks may blow up costs for DP, MoF and contributors without bringing about substantial improvements, especially for the poor.

III. Options

Prerequisite to the introduction of a health insurance is a proper definition of that what the insurance will cover. The insurance may cover costs that currently are borne by one of the main financiers of the system: The state or the users. In order to cover the costs that are currently borne by the state, it is necessary to introduce user fees. Otherwise nobody would understand why they should pay insurance contributions for something that used to be free. In order to cover items that currently are paid out of pocket, elaborate fee schedules or a system of prescriptions are needed.

Basically there are three options how to organize benefits and financing so that the impact for the population will be maximized.

1. To introduce an official system of co-payments and user fees and to cover these through health insurance.
2. To introduce a system of fees and payments that top up existing salaries and payments in a way that they improve performance and quality (performance based payments).
3. To introduce a system of prescription and control so that current out of pocket payments for diagnostics and drugs are formalized and covered.

DP inputs can have several objectives:

1. To create an incentive to introduce a new funding system.
2. To demonstrate possibilities to improve care, especially for the poor.
3. To help to set up a new system, especially in terms of investment in IT and infrastructure.

DP investments mainly should help to create sustainable structures, less cover recurrent income and costs. If they are used to cover recurrent expenses, these should help to try out new funding and payment schemes.

IV. Proposal

Inline with KFW key conditions, HEU strategic concepts and economic necessities we propose the following:

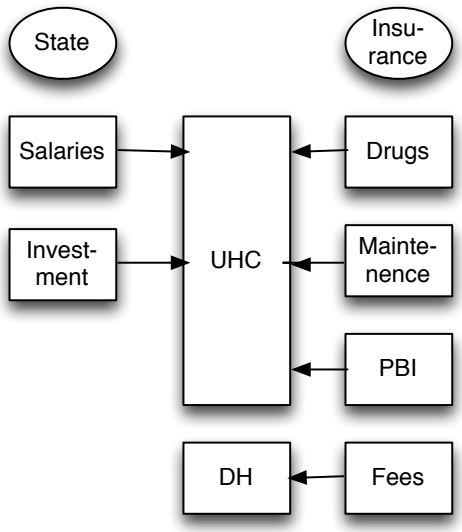
1. To make sure through appropriate legislation that salaries of UHC and DH as well as investment costs of UHC and DH are paid from public budget. A corresponding health care infrastructure plan should be set up that describes facilities depending on population covered and investment and staffing standards.
2. To describe in detail user payments, for example for drugs handed out in UHC and DC as well as fees for diagnostics (covering material and maintenance).
3. To introduce a system of performance related payments (PBI) for health staff that is covered by SSK.

4. To introduce guidelines for referral to DH as well as pre-defined referral fees.

For this purpose a several instruments should be elaborated:

1. A list of essential drugs
2. A schedule for PBI related to diagnostic groups
3. A fee schedule for diagnostics (Ultrasound, Xray, Laboratory) covering the costs of maintenance.
4. Referral guidelines with corresponding case based fees.

Figure 2: Proposed Financing Scheme



V. Proposal for DP inputs

Strategic DP funding should follow some guidelines:

1. It should follow a pre-defined time schedule, maximum 4 years.
2. It should follow a strict phasing out plan.
3. It should clearly show milestones of partner involvement, meaning strict phases of taking over of funding by either users of Government with strict monitoring.

Milestones should be laid down in an implementation partner agreement. Monitoring mechanisms should be agreed mutually and followed up by GOB and DB. Basket funding should be open for further partners.

VI. Further Proceeding

Next step will be to decide about the benefit package, payment mechanisms, and the organizational structure of SSK and NHSO. The logical steps can be seen in the next chart. After the basic decisions about the financing and what will be the areas of funding of the different sources, a decision about the benefit package with all its elements:

- List of essential drugs
- List of performance based payments,
- List of diagnostic procedures

- And List of Referrals

Can be elaborated.

The next step is to decide about the payment mechanisms like a system of DRGs, prices for drugs and for diagnostics, case payments for referrals.

The final step is to design the organizational structure of NHSO. This includes regional presence, staffing scheme, distribution of tasks etc.

Further decisions to be taken are:

- Co-payments
- Legal character of NHSO, UHC and DH
- Technical details like insurance card, IT, data management, etc

Figure 3: Decision Flow