# REVIEW OF BANGLADESH'S HEALTH CARE FINANCING STRATEGY 2012-32

July 25, 2023

The review of the Health Care Financing Strategy has been conducted over two years in two phases through a participatory process. The process has been led by the Health Economics Unit with technical and financial support from the World Health Organization (WHO).

DISCLAIMER: The views expressed in this publication are those of the authors and do not necessarily reflect the views of the Government of Bangladesh and WHO Bangladesh.

Report prepared by: Dr. Ricardo Bitran, Consultant, WHO
Professor Nahid Akhter Jahan, Consultant, WHO
Professor Rumana Huque, Consultant, WHO
Dr. Mohammad Touhidul Islam, WHO

Reviewed by: Ms. Sangay Wangmo, Team leader, Health Systems, WCO Bangladesh,
Dr Valeria de Oliveira Cruz, Regional Advisor Health Financing, WHO SEARO

The Director General of the Health Economics Unit Dr. Md. Enamul Haque and the former Director General of the Health Economics Unit Dr. Mohd. Shahadt Hossain Mahmud contributed remarkably to the process of the review of the Health Care Financing Strategy. Dr. Syeda Nawshin Pornini, Director (Research) of the Health Economics Unit and Dr. Nurul Amin, Former Director (Research) of the Health Economics Unit provided valuable inputs in the process of the review of the Health Care Financing Strategy. A technical review committee (TRC) was formed for this study, comprising national health care financing experts and policymakers as well as development partners. All the members of the TRC committee validated the method of the review and the findings of the review in different phases of the assignment. Mr. Ashadul Islam, Former Senior Secretary of, the Ministry of Health and Family Welfare and Mr. M. M. Reza, Former Senior Secretary of the Ministry of Health and Family Welfare provided their estimable opinions and key support in the process of the review. All the key informants and participants of the FGDs enthusiastically expressed their views and suggestions on the review of the Health Care Financing Strategy. Special thanks to Dr. Shamsul Alam, State Minister of Planning, Ministry of Planning for providing his vital opinions. In addition, Member of Parliament and representatives of HSD, MEFWD and Planning Wing of the Ministry of Health and Family Welfare, Ministry of Finance, DGHS, DGFP, University of Dhaka, Health System Experts, and NGOs provided their valuable insights regarding the challenges and way forward for the implementation of the Health Care Financing Strategy. Two International Health Financing Experts, Prof. Tim Ensor, University of Leeds, UK and Prof. Abdo Yazbeck, John Hopkins Bloomberg School of Public Health, USA expressed their perspectives on the directions and obstacles of the Health Care Financing Strategy. Special thanks to representatives of WHO, World Bank, UNICEF, Embassy Of Sweden, and USAID for providing key inputs in the review. Last but not least, the participants in the two consultation workshops and a three-day sensitization workshop deserve special mention for their contribution to making the review document more evidence-based.

# CONTENTS

# LIST OF TABLES

# LIST OF FIGURES

# ACKNOWLEDGEMENTS

The authors would like to extend their gratitude and acknowledge the invaluable contributions of several individuals and organizations throughout the review process of the Bangladesh Health Care Financing Strategy 2012-2032.

First and foremost, we would like to express our sincere appreciation to Dr. Md. Enamul Haque, the Director General of the Health Economics Unit (HEU), Health Services Division (HSD), and Dr. Mohd. Shahadt Hossain Mahmud, the former Director General of the HEU, HSD, for their instrumental roles in initiating this review.

We are deeply grateful to Dr. Bardan J. Rana, WHO Representative to Bangladesh, for his unwavering support and guidance throughout the entire review process. Our gratitude also goes to Ms. Sangay Wangmo, Team leader, Health Systems, WCO Bangladesh, Dr Valeria de Oliveira Cruz, Regional Advisor Health Financing, WHO SEARO; Dr. Mohammad Touhidul Islam, NPO-HF WHO Bangladesh for their continued technical guidance and support for the review.

We extend our thanks to Dr. Syeda Naushin Parnini, Director (Research) of the HEU, and Dr. Md. Nurul Amin, Former Director (Research) of the HEU, for their valuable inputs and expertise that significantly contributed to the review.

A special mention goes to the members of the technical review committee (TRC), which consisted of national healthcare financing experts, policymakers, and development partners. Their validation of the review methodology and findings at various stages of the assignment was crucial.

We would like to acknowledge the pivotal roles played by Mr. Ashadul Islam, Former Senior Secretary of the Ministry of Health and Family Welfare, and Mr. M. M. Reza, Former Senior Secretary of the Ministry of Health and Family Welfare, who provided invaluable opinions and key support during the review process.

Our heartfelt thanks go out to all the key informants and participants of the FGDs who enthusiastically shared their views and suggestions regarding the Health Care Financing Strategy review.

We extend our gratitude to Dr. Shamsul Alam, Honorable State Minister of Planning, Ministry of Planning, for providing vital opinions that enriched the review.

In addition, we highly appreciate the contributions of Members of Parliament, representatives of HSD, MEFWD, and the Planning Wing of the Ministry of Health and Family Welfare, Ministry of Finance, DGHS, DGFP, University of Dhaka, Health System Experts, and NGOs who provided valuable insights regarding the challenges and the way forward for the implementation of the Health Care Financing Strategy.

We would like to convey our sincere thanks to Prof. Tim Ensor, University of Leeds, UK, and Prof. Abdo Yazbeck, John Hopkins Bloomberg School of Public Health, USA, for their expert perspectives on the directions and obstacles of the Health Care Financing Strategy.

Special thanks are also due to representatives of FCDO, UNICEF, World Bank, SIDA, and USAID for providing key inputs during the review process.

We appreciate the continuous collaboration and support of Md. Nuruzzaman and Mr. Gazi Golam Mehdi from WHO Bangladesh for their assistance in successfully concluding the project.

Finally, we would like to give special recognition to the participants in the two consultation workshops and a three-day sensitization workshop for their invaluable contributions, which played a pivotal role in making the review document more evidence-based

# ACRONYMS

| | |
|---|---|
| BDT | Bangladeshi Taka. As of March 9, 2023, 1 US$ = 105.44 Bangladeshi Takas |
| BPL | Below the poverty line |
| CBHI | Community-Based Health Insurance |
| CS | Civil servant |
| CSs | Civil servants |
| CSHIS | Civil Servants Health Insurance Scheme |
| DGFP | Directorate General of Family Planning |
| DGHS | Directorate General of Health Services |
| EHIA | Ethiopian Health Insurance Agency |
| FCDO | Foreign, Commonwealth and Development Office |
| FGDs | focus group discussions |
| FONASA | Fondo Nacional de Salud (National Health Fund) from Chile |
| GDP | Gross domestic product |
| HCFS | Health Care Financing Strategy |
| HEU | Health Economics Unit of the MoHFW |
| HSD | Health Services Division of the MoHFW |
| iBAS | Integrated Budget and Accounting System |
| Isapre | Institución de Salud Previsional (Health providence institution) from Chile |
| ISWs | Nonpoor informal sector workers |
| KII | Key informant interviews |
| LLMICs | Low- and lower-middle-income countries |
| M&E | Monitoring and evaluation |
| MOF | Ministry of Finance |
| MoHFW | Ministry of Health and Family Welfare |
| MTBF | Medium-Term Budgetary Framework |
| NCDs | Non-communicable diseases |
| NHI | National health insurance scheme |
| NHIS | Ghana's National Health Insurance Scheme from Ghana |
| NHS | National Health System |
| NHSO | National Health Security Office |
| NHSO | National Health Security Office |
| OECD | Organization for Economic Cooperation and Development |
| OOPS | Out-of-pocket health care spending |
| PBF | Performance-based financing |
| PFM | Public financial management |
| PPP | Public-private partnerships (PPP) |
| RBF | Results-based financing |
| SHI | Social health insurance |
| SHP | Social health protection |
| SSO | SSK Scheme Operator |

| | |
|---|---|
| SSK | Shasthyo Shuroksha Karmasuchi health protection scheme for the BPL population |
| SSS | Social Security System |
| SUS | Unified Health System from Brazil |
| THE | Total health expenditure |
| TRC | Technical Review Committee |
| UCS | Universal Coverage Scheme from Thailand |
| UHC | Universal Health Coverage |
| AUGE | Universal Access with Explicit Guarantees program from Chile |
| WHO | World Health Organization |

# EXECUTIVE SUMMARY

## Goal and objectives of this review

The World Health Organization's Bangladesh office hired and led a team of national and international consultants to support through this review the government's effort to make progress toward Universal Health Coverage (UHC). The review had two objectives. First, it conducted a critical assessment of Bangladesh's Health Care Financing Strategy 2012-2032 (HCFS 2012-2032) drawing on (1) the findings of a series of interviews of key national informants; (2) a critical analysis of the approach to HCFS implementation; (3) an analysis of health financing in Bangladesh; and (4) the experience of other developing countries seeking to achieve UHC. The review's second objective was to prepare the current report, disseminate its findings, and draw feedback from the participants of key stakeholders workshops and meetings.

## Methods

The report describes the government's HCFS formulated 10 years ago for the period 2012-2032, including its design and progress to date. It also discusses the challenges facing any developing country seeking to achieve UHC. Additionally, it presents the findings from an extensive consultation with key informants regarding both the reform design and the associated implementation challenges. The report offers a detailed review of the health financing situation in Bangladesh drawing on statistical information and previous work by the World Bank on the fiscal space for health (WHO, no date). It also analyzes the strategies of other developing countries to pursue UHC in order to draw lessons for Bangladesh.

The study team adopted Kutzin's (2013) conceptual framework on health financing as a guide for this assessment. The framework focuses on six policy levers, or core elements of any health financing strategy: resource mobilization, pooling, purchasing, benefits package, leadership and governance, and organization (or supply-side readiness). The questions asked of key informants, the literature gathered and reviewed, the data obtained, and the kinds of analyses conducted for this assignment were guided by the above conceptual framework. Within each of these core elements we formulated research hypotheses and associated research questions.

## The challenge of achieving UHC

According to WHO, UHC means that everyone has access to the full range of quality health services they need, without facing financial hardship (WHO, no date). It encompasses essential health services from promotion to prevention, treatment, rehabilitation, and palliative care. No country has achieved UHC entirely, but wealthier countries with more resources for health care financing and delivery are generally closer to the ideal.

Health insurance is not indispensable for UHC. Countries as diverse as the U.K., Brazil, and Sri Lanka have achieved or made significant strides toward UHC without health insurance as the main

financing mechanism. In these countries financing for health comes from the government's treasury, eliminating the need for public health insurance. Other countries employ social health insurance (SHI) systems that combine mandatory contributions from formal sector workers with government subsidies for the poor and the nonpoor informal sector workers (referred to here as ISWs). Countries that have adopted SHI models typically follow an incremental approach to coverage expansion, starting with formal sector workers and gradually extending coverage to ISWs and the poor.

To make progress towards UHC, governments need to increase public financing for health to cover a broader set of services in the country's health benefits package, to extend coverage to all population groups, and to pay for a greater share of covered health services. Formal sector workers along with their employers generally can finance all of much of their coverage through mandatory health contributions, which can be collected based on their known salary. Drawing contributions from ISWs is a major challenge, however because they are generally reluctant to enroll in health insurance schemes, even when mandated to do so and even when part of their premium is subsidized (Bitran 2014a). The poor are seldom required to prepay for health care.

While no developing country has achieved UHC, some have made significant progress. Chile, for example, first expanded health coverage in the 1980s through a social health protection (SHP) scheme for the indigent population, followed by formal workers and ISWs. Countries like China, South Korea, and Indonesia have also followed an incremental for coverage expansion under SHI. They started with specific target groups, such as civil servants (CSs) and employees of large corporations, and gradually extended coverage to other segments of the population, including the poor and rural residents.

### HCFS 2012-2032: Design

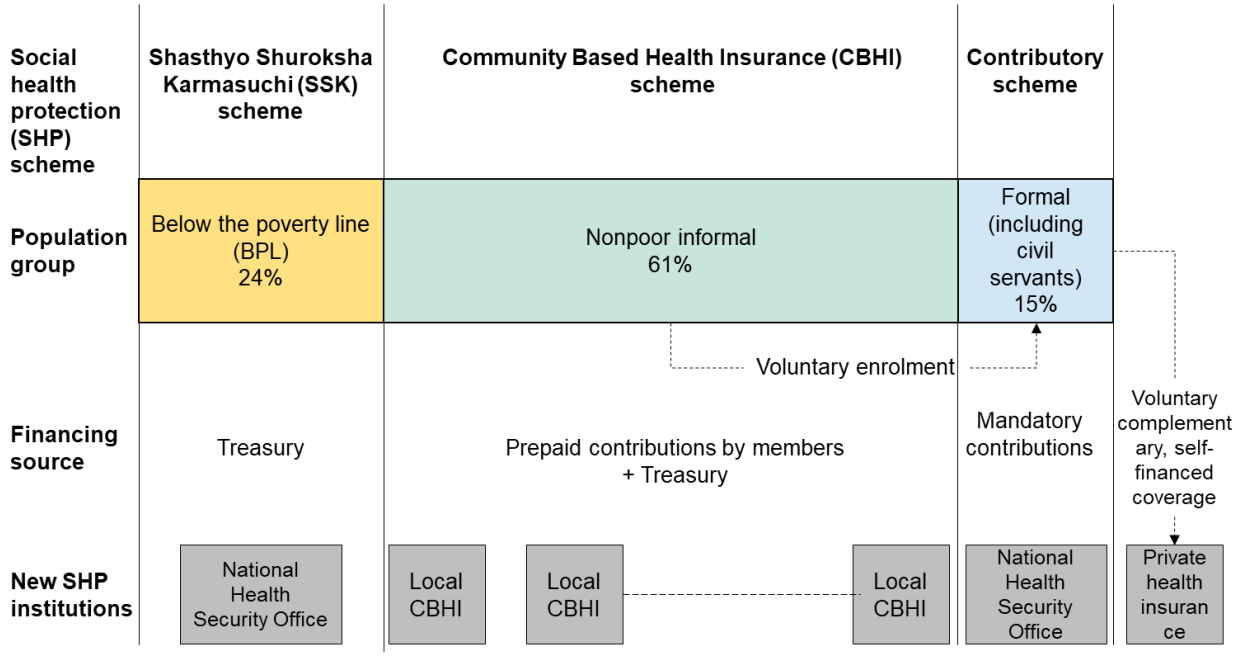
The Health Care Financing Strategy (HCFS) 2021-2032 was formulated by the Ministry of Health and Family Welfare (MOHFW) and put together in a report by its Health Economics Unit (2012). It contained three strategic objectives (SO): (SO1) generate more resources from prepaid/pooled funds for the provision of effective health services; (SO2) enhance efficiency in resource allocation and utilization; and (SO3) improve equity and increase access, especially for the poor and vulnerable. Under each of these SOs, it proposed a series of supportive actions (SAs) aimed at: (A1) setting up health financing schemes and the institutions in charge; (SA2) strengthening the public supply of health care; (SA3) increasing data generation and analytical capacities required for UHC. Among the supportive actions of SO1 was the establishment of a compulsory, prepaid *social health protection* (SHP) scheme that would *"include both noncontributory and contributory mechanisms [...] The proposed strategy [would] start its health protection coverage with the poor and the formal sector. Then it [would] expand/extend its coverage to informal sector in order to achieve universal coverage."* (Health Economics Unit 2012).

The SHP scheme comprised three different arrangements for as many segments of the population:

- **SSK.** The *Shasthyo Shuroksha Karmasuchi* (SSK) scheme would be aimed at the population below the poverty line (BPL), which in 2012 accounted for about 31% the country's population (at present 24%). Financing for SSK would come entirely from the treasury.
- **Contributory Scheme.** Formal sector workers who accounted for around 15% of the country's population at the time, and included civil servants (CSs), the employees of government-owned corporations, and the employees of private firms, would join this scheme and make a mandatory contribution along with their employer. This scheme would be managed by the National Health Security Office (NHSO), to be created. The scheme would first incorporate CSs and the employees of government-owned corporations, along with their respective families. Private sector formal workers and their families would join at a later stage. Financing for this scheme would come from workers' and employers' contributions.
- **Community Based Health Insurance (CBHI).** This scheme would cover the ISWs, accounting for around 61% of the citizens. There would be multiple CBHI schemes around the country, each covering the population of a defined geographic area. These schemes would be partly financed through government subsidies and partly through contributions from enrollees. Those covered by CBHI could voluntarily opt out and enroll in the Contributory Scheme by making the required contribution.

The segmentation of the population by socioeconomic group, the three different SHP schemes, their financing sources, and the new institutions that would have to be created to run the schemes are shown in the following figure.

**Figure 1 The three SHP schemes proposed in the government's HCFS 2012-2032**




Source: Constructed by the authors.

## HCFS 2012-2032: progress to date

To date there has been a significant delay in the development and implementation of the schemes, as shown in Table 1, which describes the schemes' short- and medium-term goals and the progress in their implementation by the end of 2021.

The government's plan was that the NHSO would be established by 2016, the year in which SSK pilot schemes were to be conducted. The analysis of the pilots was expected to offer design and implementation insights so that by 2021 the SSK scheme would be expanded nationally. Whereas the NHSO has not yet been created, three SSK pilots were conducted in three sub-districts with management by the MOHFW's Health Economics Unit (HEU. The evaluation of the pilots has concluded (Chowdhury, Hasan, and others 2021) and the scaling up of SSK is currently being planned in eight sub-districts.

**Table 1 The HCFS's three social health protection schemes**

| Population segment [a] | Short- and mid-term goals | Progress by the end of 2021 |
|---|---|---|
| Below Poverty Line (24%) | • By 2016<br>  ○ SSK piloting started<br>  ○ An autonomous body (National Health Security Office, NHSO, established)<br>• By 2021<br>  ○ Expansion of SSK across the country | • SSK is being piloted in three sub-districts managed by the HEU and scaling up in eight sub-districts is in process.<br>• An evaluation report was released in March 2021. |
| Informal sector (61%) | • By 2016:<br>  ○ CBHI introduced<br>  ○ Voluntary subscription to the SHP scheme | • No significant progress has been made. |
| Formal sector (15%) | • By 2016<br>  ○ An autonomous body (NHSO established)<br>  ○ Introduce social protection scheme for the formal sector<br>• By 2021<br>  ○ Expansion of mechanism for formal sector | • Different models of health insurance at public and private sector have been consulted. |

a. Estimated percentages as of 2012.
Source: Health Economics Unit (2012) and information collected by the authors during this review.

Also by 2016 CBHI was expected to begin, but there has been no progress with the detailed design and implementation of this scheme. Similarly, by 2016 an SHI-like entity was expected to have been set up and be in operation, covering an initial batch of formal sector workers, possibly CSs. Starting in 2021, coverage should be expanded to the rest of the formal sector population.

The scheme covering ISWs and the SHI scheme covering formal workers have not yet been set up as government reviews its HCFS. There have been policy discussions in government circles, among the development community and in academia about the setting up of a civil servants' health insurance scheme (CSHI) as the stepping stone into SHI for the formal sector (Hamid 2014; Bitrán 2021a). Yet, there has been no concrete action in this area either.

Contrary to expectations, key health financing indicators have worsened since the release of the HCFS 2012-2032. The following table shows the stark discrepancy between policy expectations

set forth in the HCFS 2012-2032 and reality. For example, out-of-pocket health spending (OOPS) was expected to decline systematically from its 2012 value of 64% of total health expenditure (THE) to the target value of 32% in 2032. The reality has been contrary to expectations: OOPS has actually increased as a share of THE and in 2020 it was estimated at 68.5%. Consequently, the share of households facing catastrophic health expenditures actually rose from 15% in 2012 to 24.6% in 2016, when the expectation was that it would decline to zero by 2023. The government's health budget was expected to increase from its 5% share of the total public budget to 15% by 2032, yet as of 2020 it remained at the same level as in 2012, or 5%. The share of the public budget that was unspent in 2012 was 4%, an amount that was expected to decline to 0.5% by 2032. The opposite has happened, however: by 2021-22 nearly one-fourth of the government's budget for health remained unspent at year's end. Finally, the policy document hoped that by 2023 the entire population of the country would be covered by prepayment schemes. Reality, here too, is far from expectations: by 2020 less than 1% of the country's population was covered by prepayment schemes.

**Table 2 Progress in selected health financing indicators of HCFS 2012-32**

| Indicator | 2012 (Baseline) | 2032 (Target) | As of 2020 (Current) |
|---|---|---|---|
| OOPS as % of THE | 64% (2007) | 32% | 68.5% |
| % of household facing catastrophic health expenditures | 15% (2007) | 0% | 24.6% (2016) |
| Health budget as % of national budget | 5% | 15% | 5% (2023-24) |
| % of unspent budget per year | 4% | 0.5% | 22% (2021-22) |
| % of population covered by prepayment schemes | Not available | 100% | <1% |

In sum, all key health care financing indicators have deteriorated in a significant way since 2012 and the country finds itself farther from UHC than it was in 2012. Understanding the reasons for this bleak scenario is the main motivation of this review, as well as recommending policy actions that may redress the situation and move the country toward UHC in an effective and swift way.

### Health financing in Bangladesh

The ambitious goals of Bangladesh's HCFS 2012-2023 appear inconsistent with the country's low overall CHE at 2.5% of gross domestic product (GDP) in 2019. This modest figure contrasts with a twice as high regional average of 5.0%. In fact, in 2020 Bangladesh featured the lowest CHE-to-GDP share of all countries in its region. Nations with significant progress toward UHC, such as Sri Lanka and the Maldives, exhibit a much higher CHE-to-GDP share (4,1% and 11.35% respectively) (Global Health Expenditure Data, WHO 2020. Bangladesh's low CHE partly results from a small participation of health in the government's budget (5.0%) a share that was one-half the regional average.

Bangladeshi households are required to finance the lion's share of their health care to make up for limited public financing. With OOPS at 68.5% of total health financing, Bangladesh has the second highest share of household health financing in the South Asian region, after Afghanistan.

UHC tracking data shows that Bangladesh belongs to the least favorable of all country groups, featuring low service coverage combined with high catastrophic OOPS. In 2022, it was the sample country with the worst performance in UHC, with the highest (24.9%) share of households experiencing catastrophic OOPS and a low (51%) service coverage indicator that was below the median.

Bangladesh's government has the lowest tax collection rate, as a share of GDP, of all South Asian countries, limiting its ability to spend on health and other social sectors. While poorer than Bangladesh, Nepal and Pakistan managed to collect more than twice the amount of tax revenue in relation to GDP than Bangladesh.

Bangladesh's low tax revenue does not fully justify the low share of the government's budget going to health. Indonesia, China, and Sri Lanka also draw a low tax revenue yet they assigned a much greater importance to the health sector in their budgets. For example, the government of China's tax revenue is 9.1% of GDP (versus Bangladesh's 7.7%) yet the share of its budget going to health is 8.9% (versus Bangladesh's 3.0%).

### UHC strategies in other countries

These reviewers carried out an analysis of seven developing country case studies describing their health financing strategies to seek UHC. The cases were selected to encompass diverse financing strategies, from two-tiered SHI to national health systems financed by the public treasury. The countries are Brazil, Chile, and Colombia in Latin America, Ethiopia and Rwanda in Sub-Saharan Africa, Thailand in East Asia, and Sri Lanka in South Asia. Health policymakers in Bangladesh can learn from the enabling factors for these strategies, their pros and cons, and their policy and implementations challenges. The detailed write up of the cases can be found in 0. A summary of the country cases follows focusing on the policy lessons for Bangladesh.

**Brazil.** Brazil underwent a significant shift in health policy with the introduction in 1988 of the Unified Health System (SUS). By providing free public and private health care to all citizens, SUS led to increased coverage and improved health outcomes. The relevance of Brazil's case study for Bangladesh is that the former first had for decades a two-tied SHI health system offering unequal access to care, with the population segmented in SHI sub-systems defined along socioeconomic lines. The setting up of SUS responded to policymakers' decision to put an end to segmentation and offer the same set of health services free of direct cost to all citizens irrespective of individual characteristics. The main challenge facing SUS, however, is considerable underfinancing.

**Chile.** Like Brazil before 1988, Chile, had a segmented SHI system where 80% of the population, including the poor, the ISWs, and the formal, are covered by the public insurer FONASA, while the 20% upper income, mostly formal, is covered by private SHI insurers known as Isapres. To ensure that all Chileans would have access to the exact same health benefits package, irrespective of who their insurer was, a reform implemented in 2005, known as AUGE, defined a set of explicit health guarantees for all Chileans, including the priority diseases to be covered, the services that would be provided to prevent and treat them, the standard treatment protocols that would be used, the

maximum waiting times by diagnosis, and the maximum OOPS. The relevance of Chile's AUGE reform to Bangladesh is that it is possible to operate a segmented national SHI system that can achieve significant levels of equity by guaranteeing the same health benefits package to all citizens and relying on differential public subsidization by segment.

**Colombia.** Colombia implemented a broad SHI reform in 1994, known as Law 100, dividing the population into two groups based on their ability to self-finance SHI. Colombia's health system is relevant for Bangladesh for the same reasons as is Chile's: a segmented SHI system, which is equivalent to a hybrid model combining a national health service for the poor and the low- and middle-income can lead to acceptable levels of equity by having a universal health benefits package.

**Ethiopia.** This country set out to achieve UHC by implementing a hybrid system that combines SHI for the formal sector with CBHI for the poor and the ISWs. CBHI coverage has expanded, but challenges remain in terms of sustainability and service delivery. Ethiopia may offer a lesson for Bangladesh, however, by having a dedicated agency, the Ethiopian Health Insurance Agency (EHIA), working exclusively and autonomously from the Ministry of health to manage reform implementation.

**Rwanda.** This country's CBHI system, financed by member premiums, external funds, and the government, has achieved high enrollment rates and improved health outcomes. Performance-based financing (PBF) and decentralization reforms have also played a role in improved performance. Rwanda's health reform for Bangladesh is pertinent for Bangladesh considering the African country's reliance on CBHI for its large informal sector. Yet, it is the only developing country that has successfully covered its entire population through CBHI, and in so doing it has benefitted from considerable external technical assistance and funding.

**Sri Lanka.** Sri Lanka has a well-performing NHS-type of health system that provides universal and free access to publicly-financed government health services.[1] Its experience is pertinent for policymakers in Bangladesh. As an alternative design to the segmented health system envisioned in the HCFS 2012-2032, Sri Lanka features an NHS-type system offering equal coverage to all citizens. Nevertheless, while this country is internationally admired for its system's efficiency and equity, households have to shoulder nearly one-half (45.6% in 2019) of THE through OOPS.

**Thailand.** Thailand has implemented an incremental approach to achieve UHC, expanding health protection through separate public health insurance schemes which have significantly reduced OOPS and improved access to health care. Thailand's case matters for Bangladesh because coverage expansion relied on a combination of schemes to achieve UHC. Its government used general taxation to finance the Universal Coverage Scheme (UCS) without relying on contributions from members, at the time when per capita income was a mere US$ 2,091 in current dollars. This

[1] With the COVID-19 pandemic a crisis unfolded in Sri Lanka's health system. The authors of this review have not sought to determine from the available literature if the crisis was temporary and caused by the pandemic or f it has structural weaknesses.

may be a more realistic model in Bangladesh for the coverage of the ISWs, particularly given the challenges involved in setting up CBHI for them.

Overall, these countries have implemented different approaches to achieve UHC, with varying levels of success. Bangladesh can learn lessons from their experiences in expanding coverage, improving health outcomes, and addressing challenges.

## Findings from focus group discussions and key informant interviews

**FGDs and KIIs.** Study authors found that the proposed health financing reform is considered to have valuable design elements but also ones that appear not appropriate for Bangladesh. The interviews revealed that a government subsidized regime for the BPL population, SSK, is considered a good feature of the reform, while the adoption of CBHI for the nonpoor informal is seen as unsuitable for that large population segment. A contributory SHI system for the formal sector was seen as feasible and was liked by some experts while others though that it was not feasible or feasible but not desirable as it could result in a two-tier health system that would perpetuate inequities in access to health care in the country. Feeble leadership and governance, as well as the assignment of implementation duties to the HEU, have been impediments for the successful execution of health financing reform. Insufficient public financing for health is inconsistent with the country's expressed desire to achieve UHC. Finally, inefficiency in public financial management and weaknesses in the supply side of the health system need to be overcome for a health financing reform to succeed.

**Evaluation of SSK pilots.** The authors also analyzed the results of an evaluation by Chowdhury, Hasan, and others (2021) of three SSK pilots tests conducted in Tangail district, with upazila hospitals serving as the primary contact facilities for SSK enrollees. Pilot SSK schemes cover several inpatient conditions up to BDT 50,000 per household per year. Findings from the evaluation revealed that SSK cardholders experienced significantly lower OOPS, but there was no poverty reduction effect. The availability of equipment and supplies in SSK facilities was generally good, although some areas lacked functional generators and communication equipment. Compliance with treatment protocols was moderate and did not improve over time. Community engagement activities were weak, and there were challenges related to staffing, specialist availability, and the referral system. Patient satisfaction varied, with positive feedback on privacy and negative feedback on information sharing by providers. The evaluation made several recommendations, including scaling up the SSK scheme to additional areas in Tangail district and eventually to all districts in Bangladesh. It recommended strengthening operational components, improving collaboration between relevant institutions, enhancing monitoring and supervision, increasing provider motivation through non-financial incentives, and expanding the SSK model to urban areas. The establishment of the NHSO was also proposed for effective management of the SSK scheme.

## Reasons for slow and partial implementation of the HCFS 2012-2032

There seem to be two kinds of reasons behind the strategy's limited implementation. First, there's is a lack of consensus among national policy makers about the appropriateness of some of the strategy's central elements. Specifically, there are questions about the suitability and feasibility of CBHI as the primary mechanism to cover the largest share of the population, comprising the ISWs. The review of country experiences provided in this report shows that aside from Rwanda –a country that has benefitted from huge external assistance in health–, no other developing country has managed to cover its entire population through an array of CBHI schemes. It is therefore doubtful that Bangladesh would succeed where so many others have failed. Additionally, there a questions about the rationale for and merits of SHI. SHI would cover only a small share of the country's population (about 15% or less). An actuarial study showed that SHI could be feasible for civil servants (Chowdhury, Hasan, and others 2021) and a policy note showed that many other developing countries have started their SHI regime by first covering civil servants (Bitrán 2021a). Still, some experts believe that the creation of SHI for this population segment could set the basis for a two-tier health system, with a few covered by a regime that would confer a broader and better financed package of health benefits of better quality, and the remaining large majority of the population getting more limited health benefits. Of the three social protection schemes proposed in the HCFS, only one, the SSK, has shown some progress by conducting the already mentioned pilot tests and by planning its national expansion.

The second apparent cause of the delay in implementation seems to be the limited operational capacity of the MOHFW, specifically of its HEU, which de facto has been given the responsibility of implementing the entire HCFS in absence of a dedicated body from the MOHFW. The recently-conducted study that evaluated the SSK pilots also concluded that the scaling up of SSK would benefit from institutional strengthening. Specifically, its authors recommended that the NHSO be set up for effective scaling up and management of the SSK scheme. The establishment of such a body was also a part of the financing strategy but has been delayed up until today.

HCFS implementation has been slow and there appears to be a need to revise the strategy's contents, its timeline and also its implementation plan. Below is a discussion of potential revisions to the strategy based on the current review; it is followed by recommended basic elements of an implementation plan. Actions are categorized as short term (to occur between this report's release and December 2024, medium term (2025 and 2026) and long term (2027-2030).

## Recommended revisions to the HCFS

This review has concluded that the following 11 main areas contained in the HCFS 2012-2032 warrant revising:

**1. CBHI for the nonpoor informal is infeasible.** Possibly the most salient conclusion made by experts interviewed for this review was that a national network of CBHI schemes was not a feasible or desirable solution to the challenge of covering ISWs. An associated, frequently-mentioned recommendation was to expand SSK to cover ISWs in addition to the BPL population.

**2. A new dedicated entity is essential for HCFS implementation.** The second most frequent recommendation heard was that the HEU or the MOHFW were not designed for, and lacked the means to implement the HCFS, and that a separate agency, such as the one commonly referred to as the NHSO should set up with that exclusive mandate.

**3. More public financing for health is a requisite.** The third frequently-cited criticism from experts was that Bangladesh's health sector is underfinanced. They stated that government health spending is unusually low in comparison with other countries in the region and with developing countries elsewhere that have made progress toward UHC. This low level of public financing for health necessarily translates into high levels of OOPS leading to catastrophic and impoverishing health spending. These experts asserted that any HCFS design would fail in its implementation unless government made a sizable increase to the share of its public budget going to health.

**4. Strengthening the public network of health providers is indispensable.** A common remark heard was that any HCFS would fail in Bangladesh so long as public health care providers remain understaffed and underfinanced. Thus, strengthening the public supply of health care services was indispensable for the success of any HCFS.

**5. Improving efficiency in public financial management is urgent.** Rigidities and inefficiency in public financial management in Bangladesh are considered bottlenecks for effective health spending. Evidence showed that budget planning and budget allocation for health sometimes cannot meet national health policy objectives and limit or obstruct the expected benefits of public investments in health. On the other hand, is a persistent problem in health financing, which even weakens the stance of MOHFW for demanding a higher share of the national budget from the Ministry of Finance (World Bank, PFM, 2019).

**6. Purchaser-provider split advisable in public subsystem.** An idea often heard was that a purchaser-provider split would be desirable in the MOHFW, with the Ministry retaining its policymaking capacities but giving away its ownership, management, and financing of government health care providers. A special policy would have to be defined to pay health care providers while systems would have to be set up to formulate and sign contracts between the MOHFW, or a separate agency such as a NHSO, and both public and private providers, establish payment methods, implement them, and put in place the necessary control mechanisms.

**7. Divided opinions about the merits of SHI in the formal sector.** A common reflection on the HCFS was on the need and merits of setting up SHI for the formal sector. Opinions were divided on this question. Some respondents through that it was a desirable strategy, particularly to improve access to care by civil servants, but also to inject further financing into the health system and to relieve pressure from public providers. Other experts interviewed through that the setting up of SHI would establish a two-tier health system that would give rise on the one hand to a better endowed system offering superior access to quality care for the better off (those working in the formal sector and their families) and, on the other hand, a less well financed public system for the large majority of the population that is either BPL or ISWs.

**8. Adopt a uniform health benefits package.** A frequent comment was that the existence of two separate health benefits packages, the ESP on one side, designed as the national benefits package, and the SSK package on the other side, designed as the SKK package, was confusing and led to limited access to needed care for SSK beneficiaries, in part because of the limited availability of ambulatory ESP services among public providers.

**9. Set up monitoring and evaluation for HCFS.** Several respondents though that the monitoring and evaluation (M&E) capabilities of the MOHFW were limited and reflected a culture that paid little attention to this function in health. They indicated that a revised HCFS should contain and be accompanied by a strong M&E plan.

**10. The HCFS 2012-2032 was overly ambitious and lacked consensus.** Several experts consulted for this review though that the original HCFS was too ambitious as it did not anticipate all the implementation challenges that would arise. Furthermore, they cast skepticism about the degree of consensus reached within government and with national experts about the strategy's design.

**11. HCFS lacks focus on curbing private expenditure and on promoting strategic purchasing from private providers.** At present, only around 15% of country's population receive health care from the public facilities and 77% of health expenditure in private facilities. Government has limited regulatory control on private sector prices and quality. While government providers cannot meet the health care demands of the population, it has not shown a clear interest in engaging in strategic purchasing of services from the private sector to address the gap.

### HCFS implementation strategy and timeline

Many of the activities that need to be undertaken to put together and implement a reformed HCFS can be carried out by the MOHFW. For example, no other institutions is better positioned in the country to design the contents of a health benefits package or to formulate its standard treatment protocols. Likewise, only the MOHFW can come up with the accreditation, certification, and quality standards for health care providers. The MOHFW may also lead the revisions to the HCFS.

Yet, there are activities required as part of the strategy that the MOHFW was not designed to take on. Chief among them is the role of strategy implementer. The Ministry's HEU cannot fulfil that role either. Its mandate would have to be drastically modified and its organization revamped. The entity doing so must play the equivalent role of an orchestra director, ensuring that all the parts are in place when needed and that each actor fulfills its role according to plan. The implementing agency must manage the transition from the current to the reformed system and, under the steady state, act as the national health financing agency. This is the role that those interviewed for this review assigned to the NHSO. The authors of this review concur with those experts that a separate implementing agency should be set up to fulfill the role previously described.

**Revising the HCFS.** This should be a short-term action, starting in the remaining months of 2023 and be completed by no later than June 2024.

**National Health Security Office.** This entity's institutional design could begin concurrently with the revision of the HCFS, but should be completed some months later, to incorporate the changes in the revised financing strategy. Thus, the NHSO's design could start in the remaining months of 2023 and be completed in December 2024. NHSO operations could begin in early 2025.

**Securing increased public financing.** The MoHFW should negotiate with the MOF an increase in the share of the government budget allocated to health. Additional revenue sources may be considered, such as health taxes, along the lines of the World Bank's recommendations (The World Bank 2016), although those taxes would raise a small amount of revenue compared to the additional financed needed. The MOHFW should commit to certain measurable short- and medium-term milestones linked to the implementation of the reformed HCFS. The MOHFW and the Ministry of Finance (MOF) should reach a long-term financing pact during 2024.

**Improving efficiency in PFM.** The problems in PFM seem to have been well-documented. Making PFM both less bureaucratic and efficient should be the task of a joint committee with the participation of the MOHFW and the MOF which should begin operations in the second half of 2023. An action plan should be ready by mid-2024 and its implementation should begin in the second half of 2024. Efficiency gains in the health sector through efficient use of existing resources could help to make the case for more investment. Addressing the underlying causes of inefficiency in public budget formulation and allocation, budget execution, and monitoring may improve efficiencies.

**Scaling up SSK.** Government should scale up SSK to cover selected districts. The speed of this expansion should be carefully defined considering the amount of financing that will be required and available for it. Moreover, the organizational capacity of HEU needs to improve for further for scaling up of SSK in other districts. While the HEU has taken initiatives to develop its information technology platform, it is yet to be functional. In most cases, the claims management and verification process remain incomplete either because claims are not submitted or health services provided fail to comply with SSK's treatment protocols. The speed of SSK scaling up will also depend on the institutional arrangements that government will make to continue with reform implementation. A dedicated implementing agency, such as the NHSO, would likely be more effective than the MOHFW or some of its departments. However, any notable progress in establishing such a regulatory and management body is yet to be seen. The SSK model should be strengthened in what remains of 2023 and throughout 2024 in response to the recommendations made by SSK's reviewers (Chowdhury, Hasan, and others 2021). If a decision is made to also cover the informal under SSK, then the cost and expansion effort will be greater, and this must be considered in the implementation plan. It is too early and there's insufficient information for these reviewers to recommend the speed of SSK's territorial expansion. Focus group participants stated that the transition path of SSK, from the pilot stage to the full implementation stage, is yet to be clearly specified.

**Supply-side strengthening.** Weakness in the government health care delivery system have also been well documented. Current efforts to strengthen public supply should continue and accelerate. The MOHFW should formulate an investment and implementation plan for supply strengthening even in the face of insufficient human resources. The guiding principle to strengthen public supply should be to ensure that government providers can deliver a subset of the services contained in the ESP by the end of 2024 and a larger subset by the end of 2026, and so on in subsequent years. The MOHFW should also take actions aimed at expending the national supply of human resources for health, keeping in mind that this is a long-term effort that will take one to two decades.

***Strengthening regulatory control over the public and private sectors.*** Governance and regulation of public and private sectors are crucial for implementing the health care financing strategy. It is evident from the literature that government could not establish strong regulatory control over both the public and private sectors. Regulation and supervision of the private sector are integral parts of strategic purchasing and successful public private partnerships. The importance of this issue has been uttered in the 4th Health, Population and Nutrition Sector Programme (HPNSP) and Strategic Investment Plan (SIP) of the 5th Health, Population and Nutrition Sector Programme (HPNSP). It was planned to develop a comprehensive private health act (to replace the old 1982 ordinance) and to establish a National Accreditation body for the accreditation of hospitals and diagnostic facilities in private sectors by 2022. However, these plans need to be implemented without any delay.

***Developing and implementing strategic public purchasing of private health care.*** Strong public reliance on private health care is the natural consequence of weaknesses in public supply. Expanding access to health care may call for public purchasing of quality private services. Doing so calls for an explicit policy and the development of purchasing capabilities. The framework for the health care purchasing system must be balanced, incorporating the different interests and proper provider payment and incentive mechanisms. The process of developing the framework should engage all stakeholders for convincing policy changes required to move towards more strategic purchasing. The framework should be ready by mid-2024 and its implementation should begin by the FY 2024.

## Institutional design: Health system architecture with a revised HCFS

The review of international country cases showed convincingly that there is no such thing as a unique or correct way of financing health care or of organizing a health system (with existing and new institutions) to move toward UHC. Very different strategies, including financing methods and institutional designs, have produced good results in the reviewed countries.

It is therefore difficult to recommend a unique financing strategy or a preferred institutional design for Bangladesh. The final section of this report proposes for illustrative purposes only, one of many possible institutional arrangements to be made for the implementation of a revised HCFS. Deciding on a HCFS and its associated institutional design involves answering the following questions:

### Health care financing strategy

- Where will the money come from to cover the costs of health insurance or health coverage, including both the administrative costs of the insurer(s) or schemes and the health care delivery costs of the providers?
- How many different risk pools will there be in the country and for which population groups?
- What purchasing methods will the insurers or schemes managing the risk pools to compensate providers for the health care services delivered to the insured?

### Institutional design

- Which institutions will collect the contributions to health insurers or schemes?
- What entities will manage the risk pools (that is, who will be the insurers)?
- What will be the hierarchical relationship between the various institutions operating in the reformed health system?
- Will there be a single or multiple health benefits packages and who will define their contents?
- Will health care providers be only those owned and operated publicly or will private providers also be able to deliver the services from the benefits package?
- Who will regulate health insurers and providers? What will be the aspects of health insurance and health care delivery that will be regulated and how will regulation take place?
- Who will formulate various needed regulations such as: the contents of the benefits package, including the standard treatment protocols; the conditions for being a health insurance beneficiary; the provider accreditation and certification standards; the health care quality standards; the instruments in which health insurers must invest their surplus funds; the regulatory requirements for health insurers; and so on.
- Who will control fraud?
- How will health system performance be defined and measured and who will be responsible for and who will finance M&E?

A revised HCFS must contain answers to all these questions.

# 1. INTRODUCTION

## (a) Bangladesh's Health Care Financing Strategy 2012-2032

In 2012 the Health Economics Unit (HEU) of Bangladesh's Ministry of Health and Family Welfare (MOHFW) released the policy document titled "Health Care Financing Strategy 2012-2032" (Health Economics Unit 2012). The plan encompassed a 20-year time horizon and recommended a series of policy actions to, among other things, increase public financing for health, improve financial protection in health and, consequently, reduce the incidence of catastrophic and impoverishing health spending.

More specifically, the Health Care Financing Strategy (HCFS) 2021-2032 contained the following three *strategic objectives*: (1) generate more resources from prepaid/pooled funds for the provision of effective health services; (2) enhance efficiency in resource allocation and utilization; and (3) improve equity and increase access, especially for the poor and vulnerable. Under each of these strategic objectives, the document proposed a series of *supportive actions* shown in Figure 2 on the next page.

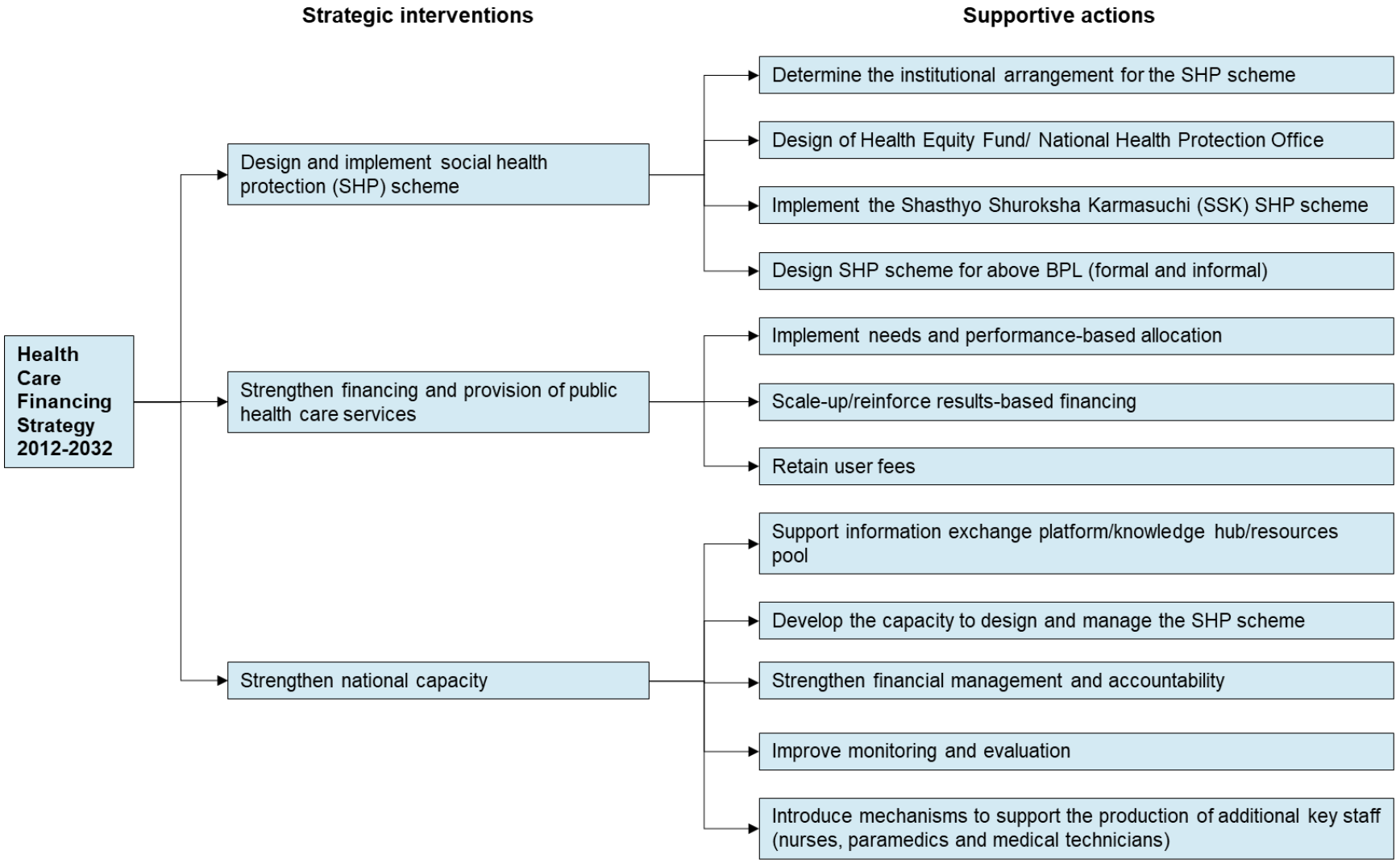
Among the supportive actions of Strategic Objective 1, was the establishment of a compulsory, prepaid *social health protection* (SHP) scheme. The document states:

> *"Prepayment will include both noncontributory and contributory mechanisms [...] The proposed strategy will start its health protection coverage with the poor and the formal sector. Then it will expand/extend its coverage to informal sector in order to achieve universal coverage." (page 20) (Health Economics Unit 2012)*

The SHP scheme comprised three different financial protection arrangements for as many segments of the population:

- **SSK.** The *Shasthyo Shuroksha Karmasuchi* (SSK) scheme would be aimed at the population below the poverty line (BPL), which in 2012 accounted for about one-fourth of the country's population. Financing for SSK would come entirely from the treasury.
- **Contributory Scheme.** Formal sector workers, including civil servants (CSs), the employees of government-owned corporations, and the employees of private firms would join this scheme and make a mandatory contribution. Together, they accounted for 15% of the country's population at the time. This scheme would be managed by the National Health Security Office (NHSO), to be created. The scheme would first incorporate CSs and the employees of government-owned corporations, along with their respective families. Private sector formal workers and their families would join at a later stage. Financing for this scheme would come from workers' and employers' contributions, with employers being both private and government-owned firms.

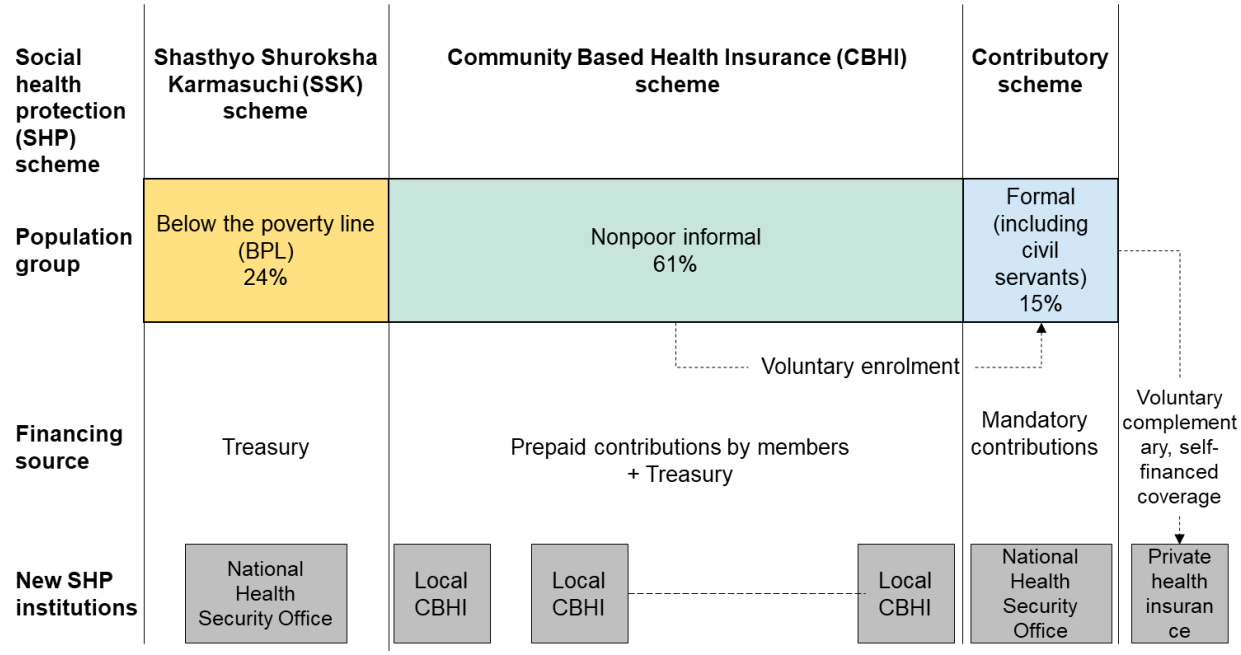
**Figure 2 Strategic interventions and supportive actions of Bangladesh's Health Care Financing Strategy 2021-2032**



- **Community Based Health Insurance (CBHI).** This scheme would cover the nonpoor informal population, accounting for 61% of the citizens. There would be multiple CBHI schemes around the country, each covering the population of a defined geographic area. These schemes would be fully financed through government subsidies. Those covered by CBHI could voluntarily opt out and enroll in the Contributory Scheme by making the required contribution.

The segmentation of the population by socioeconomic group, the three different SHP schemes, their financing sources, and the new institutions that would have to be created to run the schemes are shown in the following figure.

**Figure 3 The three SHP schemes proposed in the government's HCFS 2012-2032**




Source: Constructed by the authors.

## (b) HCFS strategy: Progress to date

To date there has been a significant delay in the development and implementation of the schemes, as shown in Table 3, which describes the schemes' short- and medium-term goals and the progress in their implementation by the end of 2021.

The government's plan was that the NHSO would be established by 2016, the year in which several SSK pilot projects were to be conducted. The analysis of the pilots was expected to offer design and implementation insights so that by 2021 the SSK scheme would be expanded nationally. Whereas the NHSO has not yet been created, three SSK pilots were conducted in three sub-districts with management by the Ministry of Health's HEU. The pilots' evaluation has concluded (Chowdhury, Hasan, and others 2021) and the scaling up of SSK is currently being planned in eight sub-districts.

**Table 3 The HCFS's three social health protection schemes**

| Segment of Population* | Short- and mid-term goals | Progress by the end of 2021 |
|---|---|---|
| Below Poverty Line (24%) | • By 2016<br>  ○ SSK piloting started<br>  ○ An autonomous body (National Health Security Office, NHSO, established)<br>• By 2021<br>  ○ SSK will be expanded across the country | • SSK is being piloted in three sub-districts managed by the HEU and scaling up in eight sub-districts is in process.<br>• An evaluation report was released in March 2021. |
| Informal sector (61%) | • By 2016:<br>  ○ CBHI introduced<br>  ○ Voluntary subscription to the Social Health Protection Scheme | • No significant progress has been made. |
| Formal sector (15%) | • By 2016<br>  ○ An autonomous body (NHSO established)<br>  ○ Introduce social protection scheme for the formal sector<br>• By 2021<br>  ○ The mechanism for the formal sector will be expanded | • Different models of health insurance at public and private sector have been consulted. |

* Estimated percentages as of 2012.
Source: Health Economics Unit (2012) and information collected by the authors during this review.

Also by 2016 CBHI was expected to begin, but there has been no progress with the detailed design and implementation of this strategic element. Similarly, by 2016 a social health insurance (SHI)-like entity was expected to have been set up and be in operation, covering an initial batch of formal sector workers, possibly civil servants. Starting in 2021, coverage should be expanded to the rest of the formal sector population. These two milestones have not yet occurred as government reviews its HCFS. There have been policy discussions in government circles and in academia about the setting up of a civil servants' health insurance scheme (CSHI) as the stepping stone into SHI for the formal sector. Hamid et al. (2015) wrote a concept paper on a Civil Servants' Health Protection Scheme in Bangladesh while the World Health Organization (WHO) supported the write up of a policy brief on the subject (Bitrán 2021b). Yet, there has been no concrete action in this area either.

Contrary to expectations, key health financing indicators have worsened since the release of the HCFS 2012-2032. The following table presents indicators included in the 2012 strategy, their value at the time, the target value for 2032 and the estimated value as of 2020. It shows the stark discrepancy between policy expectations set forth in the HCFS 2012-2032 and reality. For example, a key indicator, out-of-pocket health spending (OOPS), was expected to decline systematically from its 2012 value of 64% of total health expenditure (THE) to reach the target value of 32%, or one-half of its initial value. The reality has been contrary to expectations. As a share of THE, OOPS has actually increased and in 2020 it was estimated at 68.5%. Similarly, and most likely as a

consequence of this, the share of households facing catastrophic health expenditures actually rose from 15% in 2012 to 24.6% in 2016, when the expectation was that it would decline and be zero by 2023. The government's health budget was expected to increase from its 5% share of the total public budget to 15% by 2032, yet as of 2020 it remained at the same level as in 2012, or 5%. The share of the public budget that was unspent in 2012 was 4%, an amount that was expected to decline to 0.5% by 2032. The opposite has happened, however: by 2021-22 nearly one-fourth of the government's budget for health remained unspent. Finally, the policy document hoped that by 2023 the entire population of the country would be covered by prepayment schemes, starting from no coverage in 2012. Reality, here too, is far from expectations: by 2020 less than 1% of the country's population was covered by prepayment schemes.

**Table 4 Progress in selected health financing indicators of HCFS 2012-32**

| Indicator | 2012 (Baseline) | 2032 (Target) | As of 2020 (Current) |
|---|---|---|---|
| OOPS as % of THE | 64% (2007) | 32% | 68.5% |
| % of household facing catastrophic health expenditures | 15% (2007) | 0% | 24.6% (2016) |
| Health budget as % of national budget | 5% | 15% | 5% (2023-24) |
| % of unspent budget per year | 4% | 0.5% | 22% (2021-22) |
| % of population covered by prepayment schemes | Not available | 100% | <1% |

In sum, all key health care financing indicators have deteriorated in a significant way since 2012 and the country finds itself farther from Universal Health Coverage (UHC) than it was in 2012. Understanding the reasons for this bleak scenario is the main motivation of this review, as well as recommending policy actions that may redress the situation and move the country toward UHC in an effective and swift way.

## (c) Goal, objectives, and structure of the report

WHO's Bangladesh office hired national consultants Rumana Huque and Nahid Jahan, and international consultant Ricardo Bitrán to support the government's effort to make progress toward Universal Health Coverage (UHC). The three consultants received guidance from WHO's Mohammad Touhidul Islam. The study objectives were:

1. To conduct a critical review of Bangladesh's Health Care Financing Strategy (HCFS) drawing on both the findings of a series of interviews of key national informants (Huque and Jahan 2022) and the experience of other developing countries seeking to achieve UHC.
2. To write a review report, disseminate its findings, and draw feedback from the participants of several workshops and meetings with key stakeholders.

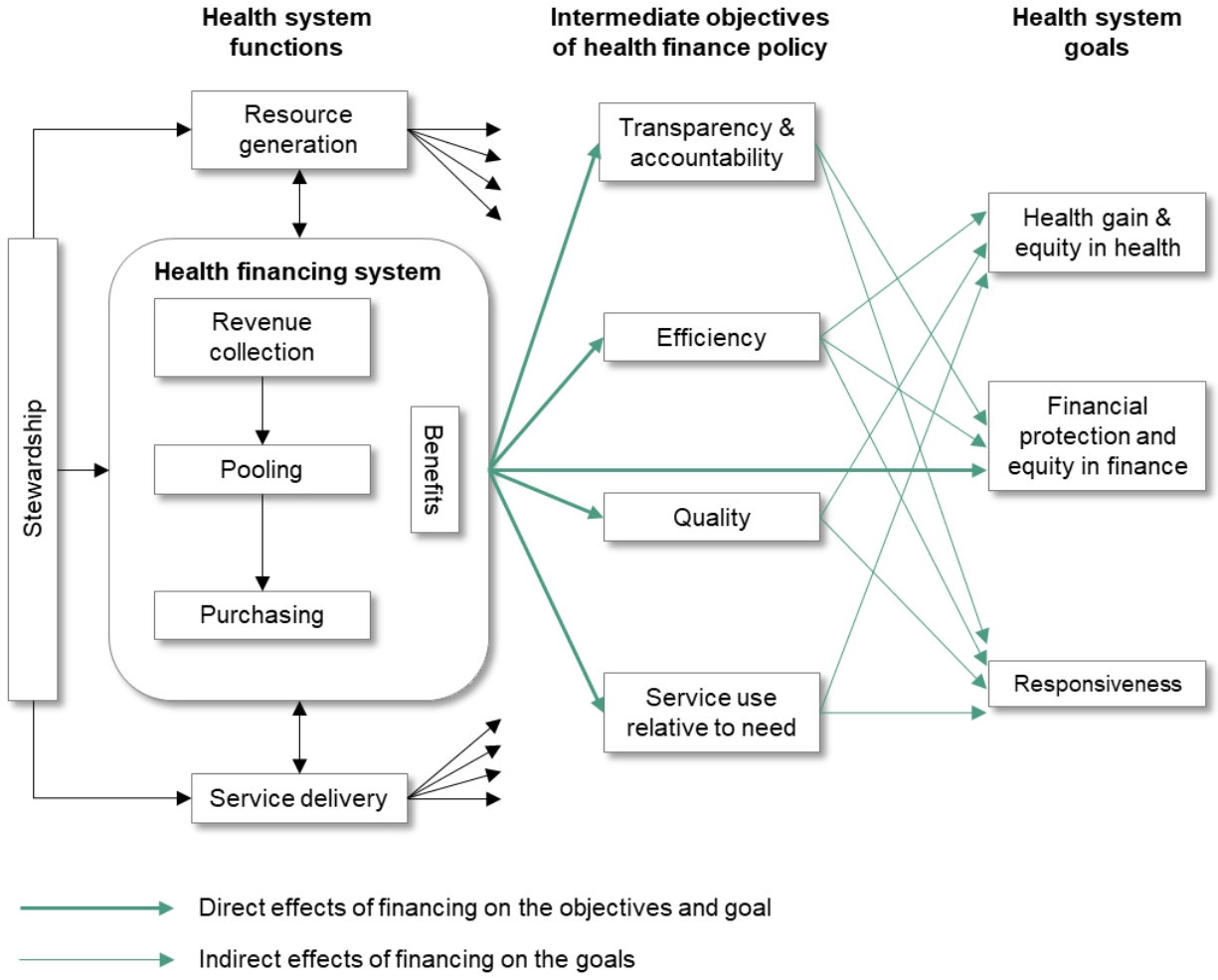
The remainder of this report is structured as follows. Chapter 2 presents the conceptual framework we adopted to carry out our critical review of the HCFS. Chapter 3 discusses the challenges involved in achieving UHC. Chapter 4 is a review of the health financing situation in Bangladesh. It draws on statistical information as well as previous work on the fiscal space for health carried out by the World Bank. Chapter 5 reviews the strategies adopted by a diverse set of seven developing countries to pursue UHC to draw lessons for Bangladesh. Chapter 6 presents background information on how other countries have dealt with the challenge of providing health coverage for civil servants and reviews a study on the subject conducted in Bangladesh. Finally, section 7 contains a discussion and policy implications for Bangladesh in terms of whether and how it should revise its HCFS to make further and faster progress toward UHC.

# 2. METHODOLOGY

## (a) Conceptual framework

To conduct this assignment, focusing on Bangladesh's HCFS to achieve UHC, we adopted the conceptual framework proposed by Kutzin (2013) (Figure 4). He states that "UHC is a utopian ideal that no country can fully achieve. To translate UHC into country-specific reality involves disaggregating the concept into its separate objectives and emphasizing progress towards (rather than full achievement of) these goals: improving equity in the use of needed health services, in service quality, and in financial protection. All countries share these goals to varying degrees. Therefore, making progress towards UHC is relevant to every country in the world."

**Figure 4 Health system goals and health financing policy objectives**




Source: Kutzin (2013).

Like Kutzin's, the Harvard/World Bank's "Flagship" conceptual framework (Roberts et al. 2008) recognizes that health financing involves three necessary and distinct functions: the collection of health system revenue, the pooling of this revenue into one or several large funds, and the use of

pooled revenue to purchase health services from the various providers (see left portion of Figure 4). Kutzin further writes that

> *"[…] health financing for UHC implies that reforms in collection, pooling, purchasing and benefit design are aimed specifically at improving one or several of those objectives and goals, as measured at the population or system level. All health financing systems perform these functions, and […] every country can do something to move towards UHC. […] "making such progress requires action across the health system, not only in financing policy. For example, health financing cannot do much to improve people's awareness of their health needs. Financing policy action is a necessary but not sufficient condition for progress. Universal means universal.*
>
> *[…] The appropriate unit of analysis when planning or analyzing reforms is the entire population. How a particular financing scheme affects its members is not of interest per se; what matters is how the scheme influences UHC goals at the level of the entire population. A concern only with specific schemes is not a universal coverage approach. Schemes can contribute to systemwide UHC goals, but they need to be explicitly designed to do so. Otherwise, increased population coverage with health insurance can actually become a potential obstacle to progress towards UHC. "*
>
> *[…] "The combination of UHC goals and intermediate objectives can be used to set the direction of health financing reforms in any country, when contextualized into specific and measurable objectives for that country. 'Health financing for UHC' implies that reforms in collection, pooling, purchasing and benefit design are aimed specifically at improving one or several of those objectives and goals, as measured at the population or system level. All health financing systems perform these functions, and this is why […] every country can do something to move towards UHC".*

The questions asked of key informants, the literature gathered and reviewed, the data obtained, and the kinds of analyses conducted for this assignment were guided by the above conceptual framework. Thus, our review considered the six policy levers, or core elements of any health financing strategy: Resource mobilization, Pooling, Purchasing, Benefits package, Leadership and governance, and Organization, or Supply-side readiness (Table 5). Within each of these core elements we formulated research hypotheses and associated research questions. As is shown in Table 5, our review was thus structured around these core elements to explore our hypotheses and answer our research questions.

**Table 5 Core elements of the health care financing strategy, hypotheses and research questions**

| Core elements | Hypotheses | Research questions |
|---|---|---|
| Resource mobilization | The low level of government spending on health is an impediment for the successful implementation of the HCFS | • Does Bangladesh's government allocate to the health sector as much as other developing countries pursuing UHC?<br>• If not, can it increase financing, by how much, and to finance which activities? Are there any other sources of financing?<br>• Does the government spend the allocated fund efficiently and equitably? |
| | Weaknesses in public financial management (PFM) is an impediment for higher and more timely public financing of health activities | • If yes, is there a clear diagnosis of the weaknesses and their causes and a feasible implementation plan to overcome weaknesses? |
| | There is still a debate on the financing design and there is no clear-cut pathway for achieving UHC | • Which of the two broad health care financing policies provide better financial risk protection, general government financing or social health insurance? Or should it be a combination or both? |
| Pooling | Three risk pooling mechanisms envisioned in the HCFS may need revision for feasible implementation | **Formal sector**<br>• Should the country envision a single insurance scheme for the population employed in the formal sector? If yes, what are the enabling factors and if no, what are the challenges?<br>• Is a Civil Servants Health Insurance Scheme (CSHIS) a good initiative? Is it feasible? Have other reference countries set up this kind of scheme?<br>• Should health insurance for other formal sector workers wait until the CSHIS is in place or should development begin soon? |
| | | **Nonpoor informal sector**<br>• Is voluntary, CBHI a good idea for this sector (including micro health insurance)? Is it feasible? Have other countries succeeded in implementing it?<br>• What would be alternative risk pooling or financial protection approaches available for the nonpoor informal sector? |
| | | **Below Poverty Line (BPL) population**<br>• What do we know so far about the implementation of SSK? What are the lessons learned from the evaluation of SSK?<br>• Will it be feasible to scale up SSK in the country, over what time frame, and through which leadership and implementation arrangement?<br>• How much public financing will the scaling up of SSK call for? |
| Purchasing | Strategic purchasing is important for achieving UHC | • What are the current purchasing methods for health services in Bangladesh's government health sector?<br>• What is the international experience?<br>• Should there be a single purchaser of health benefits covered publicly, or should there be multiple purchasers? |

**Table 5 Core elements of the health care financing strategy, hypotheses and research questions**

| Core elements | Hypotheses | Research questions |
|---|---|---|
| | | • If a single purchaser were desirable, would the NHSO be the single purchaser? |
| | Setting up an appropriate provider payment mechanism is important for feasible implementation of HCFS | • What are the current provider payment mechanisms in Bangladesh? Do we need any reforms in current provider payment mechanisms? |
| | Autonomy of public facilities is required to improve their performance | • Is hospital autonomy of public facilities desirable in the current context? Is it feasible? |
| Benefit package | A comprehensive health benefits package is important for achieving UHC | • Is the country's Essential Services Package (ESP) operationally and financially feasible to be implemented?<br>• If not, what would be the suitable benefits package to move towards UHC?<br>• What are the benefits packages of the existing social health insurance schemes?<br>• Is it possible to design a single benefit package for all schemes? |
| Leadership and governance | The successful implementation of the HCFS calls for a strong implementation body | • Does the HCFS have a body responsible for its implementation?<br>• If yes, does this body possess the skills and resources necessary for its task?<br>• If not, who will be the implementing body? Should it be the so-called National Health Security Office (NHSO)<br>• Is any legislation needed to create and operate the implementing body? |
| | Necessary legislation is needed for feasible implementation of the HCFS | • Is a separate legislation required for implementing the HCFS ?<br>• Why the necessary legislations for health protection scheme could not be finalized and approved? What are the main challenges? |
| Supply-side readiness | The government health system currently lacks the human resources for health necessary to deliver the services in the Health Benefits Package throughout the country. | • Can existing human resources be reallocated?<br>• Can new human resources be formed, and at what cost and over what time frame?<br>• Should government consider purchasing health care from private providers and through which mechanisms to ensure quality, timeliness, and equity in access? |
| | There is insufficient medicine and equipment in the public facilities to provide deliver quality health services | • Are the public facilities endowed with enough medicines, medical supplies and equipment to provide quality health services to patients? If not, how this unreadiness impacting on service coverage and health care expenditure? |

## (b) Review methods

### *Desk review*

As explained above, the hypotheses and research questions we formulated based on Kutzin (2013) which guided our desk review led us to consult multiple documents on Bangladesh's health sector and ones related to the HCFS 2012-2032, including policy reports, project briefs, research papers, evaluations, and journal articles. Additionally, our desk review examined and documented the experience of countries which the MOHFW selected as reference countries for Bangladesh, including Brazil, Chile, Colombia, Ethiopia, India, Rwanda, Sri Lanka, and Thailand.

### *Technical Review Committee (TRC) meetings*

A technical review committee (TRC) was formed for this study, comprising national health care financing experts and policymakers as well as development partners. We held three TRC meetings during the study, the first to agree on the methods of the review process and the second and the third to go over the findings from both focus group discussions (FGDs) and key informant interviews (KIIs).

### *Consultation and Sensitization Workshops*

We held two consultation workshops and a three-day sensitization workshop to validate the findings from both focus group discussions (FGDs) and key informant interviews (KIIs), and to present our review of selected international case studies countries. The participants were high officials of MOHFW, national health care financing experts and policymakers, and development partners. The views and opinions of workshop participants during the three-day sensitization workshops were incorporated into our analysis.

### *Focus group discussions (FGD)*

We held nine FGDs with the following experts from the organizations listed below. The FGD inquired about the choice of reform strategy in Bangladesh, the progress with strategy implementation to date, the implementation challenges, and needed changes in strategy or implementation approaches.:

- Planning Wing, MOHFW
- HRD, MOHFW
- SSK cell and HEU, MOHFW
- Directorate General of Health Services (DGHS), MOHFW
- The World Bank
- Foreign, Commonwealth and Development Office (FCDO)
- WHO

### *Key informant/in-depth interviews*

We also conducted 13 KIIs with national experts from the State Minister of the Ministry of Planning, Members of Parliament, national health system experts, representatives of the DGHS and Directorate General of Family Planning (DGFP) of MOHFW, representatives of the Ministry of Planning, Development Partners, and three international experts. A list of the members of the FGDs and the KIIs can be found in Annex B.

### *Webinars and stakeholder consultation*

We held three webinars with government representatives from the MOHFW, the Ministry of Finance, development partners, health financing experts, and members of the TRC. The webinars' topics were "Concepts & evidence on health system performance in selected countries", "Alternative strategies toward universal health coverage", and "Critical review of Bangladesh's Health Care Financing Strategy". Comments and suggestions by participants were also used as inputs for this report.

One stakeholder consultation meeting was organized to share the preliminary opinions and suggestions of the FGDs and key KIIs and received feedback from a wider range of stakeholders. See Annex B for the list of the TRC members, participants of the webinars and stakeholder consultation workshop.

## (c) Analysis

We reviewed and summarized the concept of UHC and the challenges involved in achieving it. Next, we conducted a critical and quantitative review of health financing Bangladesh and in selected South Asian reference countries with per capita GDP similar to Bangladesh's. Next we carried out a critical analysis of the implementation progress to date of Bangladesh's HCFS, identifying factors facilitating or impeding implementation, and design elements that may warrant revision. We then reviewed the strategies of selected countries to move towards UHC and drew lessons for Bangladesh. Finally, we combined the information arising from this combined set of activities to conclude on the strengths and weaknesses of both Bangladesh's HCFS 2012-2032 and the implementation arrangements to put together.

# 3. THE CHALLENGE OF UNIVERSAL HEALTH COVERAGE (UHC) AND THE EXPERIENCE OF SELECTED COUNTRIES

This two-part section of the report first discusses the concept of UHC, the role of insurance in achieving UHC, and the financing needs associated with a country's progress toward UHC. The second part presents selected case studies of developing countries describing their varied approaches along the path toward UHC. Both parts are preceded by a summary.

## (a) The challenge of UHC

### *Summary*

According to WHO, UHC means that everyone has access to the full range of quality health services they need, without facing financial hardship. It encompasses essential health services from promotion to prevention, to treatment, rehabilitation, and palliative care.

No country has achieved UHC entirely, but wealthier countries with more resources for health care financing and delivery are generally closer to the ideal. The WHO presents a conceptual representation of UHC based on three dimensions: the share of the population covered by a financing scheme, the types of health services covered, and the extent to which the scheme covers the cost of services.

Health insurance is not indispensable for progress towards UHC. Some countries have made significant strides without health insurance as the main financing mechanism. For example, countries as diverse as the United Kingdom and Sri Lanka finance health care services for all citizens through the government treasury, eliminating the need for health insurance. Other countries employ SHI systems that combine mandatory contributions from formal sector workers with government subsidies for the poor and nonpoor informal sector workers.

To make progress towards UHC, governments generally need to allocate additional public financing to cover a set of health services that is broader and of better than what is being delivered. Additionally, making progress toward UHC requires extending effective access to priority services to a large segment of the population, including the poor and the nonpoor workers from the informal sector who may be unable to afford the full cost of coverage.

Formal sector workers can cofinance the cost of their coverage through mandatory health contributions, which a health financing agency can collected based on the workers' known salary. Informal sector workers pose a challenge for the collection of contributions because they are generally reluctant to enroll in health insurance schemes even when mandated to do so, and also because their income tends to be irregular and is not publicly known. The poor are seldom required to prepay for health care although if the publicly-subsidized health services they are entitled to are in practice unavailable they may still face financial challenges from having to incur sizable OOPS.

Different countries employ different financing strategies for UHC. Some rely on public financing from the government's treasury to cover health care costs for all citizens, although they may still rely to some extent on OOPS or copayments for certain services. Countries that adopt SHI models typically follow an incremental approach to coverage expansion, starting with formal sector workers and gradually extending coverage to nonpoor informal workers and the poor. Public subsidies are necessary to induce enrollment among these groups.

While no country has achieved UHC, some countries have made significant progress. Chile, for example, achieved UHC in the 1980s by covering the indigent population first, followed by formal and informal sector workers. Countries like China, South Korea, and Indonesia have followed an incremental approach to expand coverage under SHI. They started with specific target groups, such as civil servants, followed by employees of large corporations, then gradually extended coverage to other segments of the population, including the poor and rural residents.

Overall, achieving UHC requires significant efforts from governments to allocate additional public financing and ensure coverage for the poor and nonpoor informal workers. The specific strategies and approaches employed by countries vary, but the ultimate goal is to provide equitable access to quality health services for all without causing financial hardship.

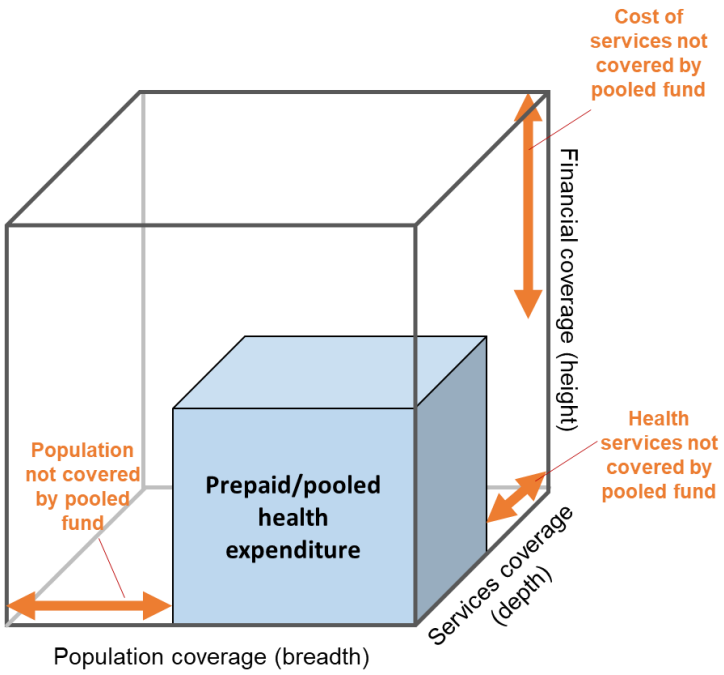
### *What is UHC?*

According to the WHO (No date),

> *"Universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care"*

The WHO came up with a useful conceptual representation of UHC, where coverage comprises three dimensions, *the share of a country's population* that is covered by a financing scheme which allows them to have effective access to certain health services, the *kinds of health services* covered by the scheme, and the *part of the cost of the services* covered by the scheme. The scheme assumes that the resources required to pay for the covered services, which may come from different sources (government subsidies, mandatory contributions by workers and employers), are combined or *pooled* into a large fund (Figure 5).

**Figure 5 The UHC cube**




Source: World Health Organization (2005).

### *Has any country achieved UHC?*

No country has achieved UHC, but richer countries have more resources for health care financing and delivery, and therefore their governments and citizens can afford more and better health care. Thus, in general, the richer a country is, the closer it is to the ideal of UHC.

The above figure presents the situation of a hypothetical developing country that has yet to cover its entire population, to deliver a broad package of health services (also referred to in here as a *health benefits package*), and to cover the bulk or the totality of their cost.

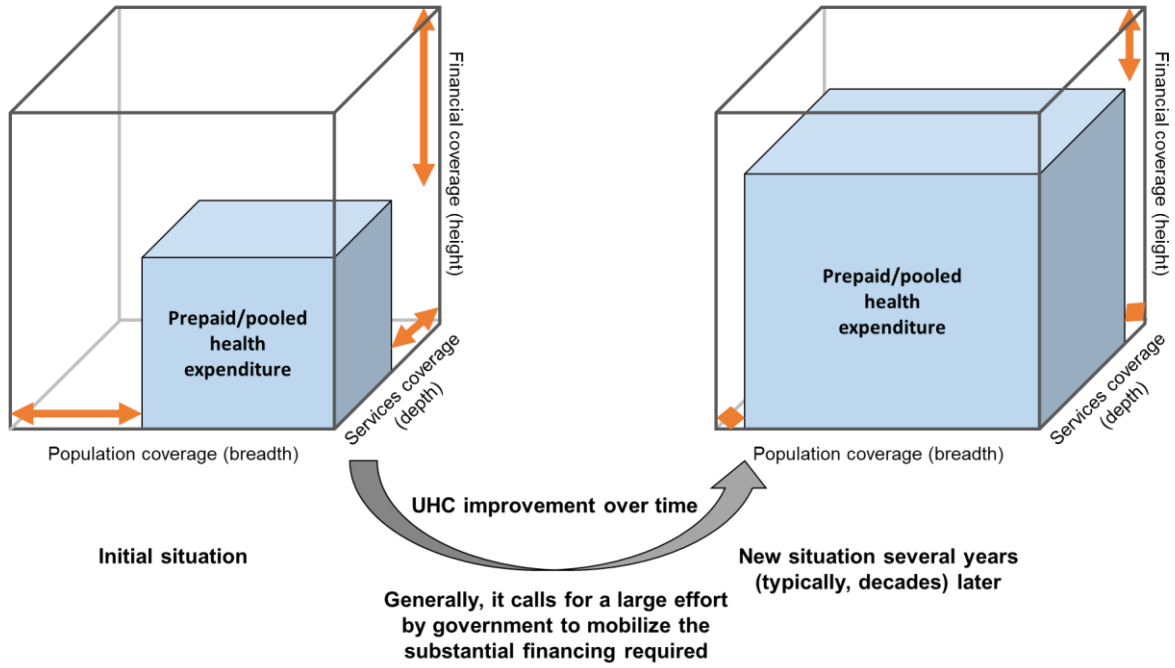
### *Is health insurance indispensable to make progress toward UHC?*

No. Moving toward or achieving UHC *does not* necessarily require the existence of health insurance. Many countries around the world have made great progress toward UHC yet they have done it without health insurance as the main financing mechanism. The U.K. is a notable example of this, where financing from the government's treasury pays for a broad package of health care services for all citizens while these do not have to purchase health insurance to obtain this coverage. Yet, there are many other countries, both developing and developed, which have decided to finance health coverage through a combination of mandatory contributions by the insured, made mostly by formal sector workers, and contributions from government, to subsidize coverage for the poor and the nonpoor informal. These countries' schemes are generally referred to as SHI systems.

### *What does it take for a country to make progress toward UHC?*

Generally, it calls for a significant effort by government to finance coverage for the poor and for the nonpoor informal. In other words, government must come up with the additional public financing necessary to cover the cost of a larger set of health services contained in the country's health benefits package, and it must do so for a large segment of the population –the poor and the nonpoor informal—who would otherwise not be willing or able to pay for the full cost of coverage (Figure 6).

**Figure 6 UHC coverage expansion over time in a hypothetical country**




Source: Author's own based on WHO (2005).

### *Should government finance coverage for the poor only and let the nonpoor informal workers and the formal workers finance their coverage with their own resources?*

No. Formal workers have an explicit work contract and therefore their salary is known. Governments can devise mechanisms to collect mandatory health contributions from them if the coverage mechanism does call for such contributions (as noted, UHC does not necessarily have to rely on mandatory health contributions).

With regard to the population defined as poor, few governments nowadays attempt to collect any prepaid –mandatory or voluntary– financial contributions for health from this segment. Throughout the world, governments have accepted the principle that the poor cannot afford their health care. Yet, despite this widely shared view, in many developing countries the poor are forced to incur OOPS to obtain needed health services from both public and private health care providers. This occurs even in countries where government-run health systems are legally required to deliver quality health care at no direct cost to patients. In practice, many patients there, including the

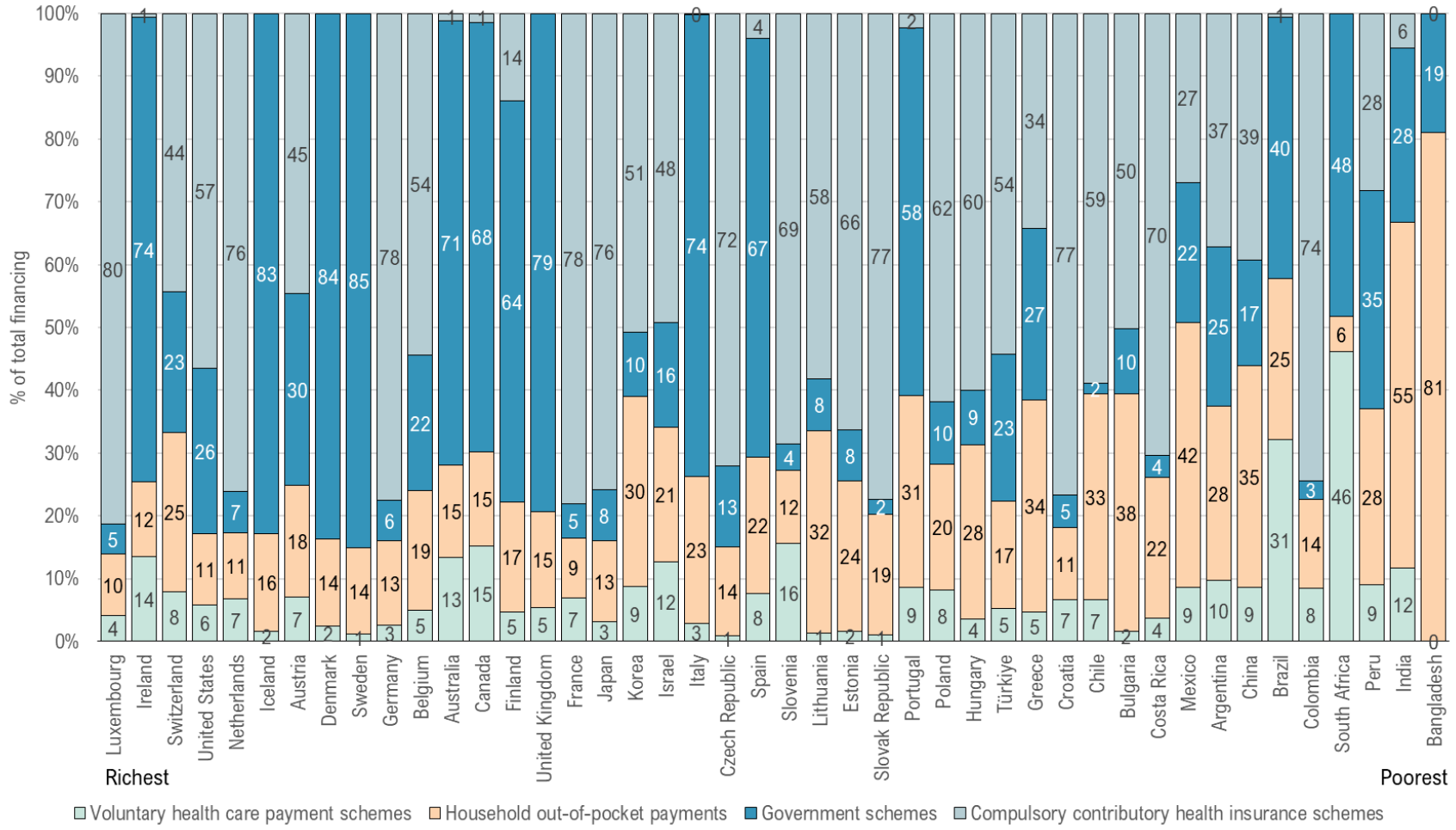
poor, must make OOPS to pay for under-the-table user fees, to purchase medicines, and to obtain diagnostic exams. Thus, while the poor are seldom required to prepay for health care by enrolling in some health coverage scheme, they may remain financially unprotected if they must make significant OOPS to get the care they need.

Between the formal sector workers and the poor lies a population group that in many developing countries accounts for the bulk of the population. It's that comprising informal sector workers and their family members. Since these families are above the poverty line, many governments around the world have been temped with the idea of somehow drawing revenue from them to help finance their health coverage. But collecting contributions from informal sector workers has proven to be a major challenge in practice. It has been widely documented in developing and developed countries alike that nonpoor informal workers are generally reluctant to contribute to health insurance schemes even when there's a legal mandate to do so, and even if government offers to subsidize a large share of their contribution (Bitran 2014a; Jeong 2010; Nga, Gerard FitzGerald, and Dunne 2018; Gumber 2002; Acharya et al. 2013). Consequently, governments seeking to make progress toward UHC must be prepared to mobilize significant public financing to cover the informal.

### *Where do countries draw their financing for UHC?*

Different countries have different financing strategies. This can be inferred from Figure 7, which has been constructed with data from countries from the Organization for Economic Cooperation and Development (OECD) and other selected developing countries, including Bangladesh. Some nations rely mostly on public financing from the government's treasury to finance health care for all citizens. This financing source is categorized as "Government schemes" in the figure and shown in blue. Examples of these countries include Ireland, Iceland, Denmark, Sweden, Austria, Canada, Finland, the U.K., Italy, Spain and Portugal. In these countries, more than one-half of all health financing comes from the treasury and a referred to in the figure as *government schemes*.

**Figure 7 Share of main health financing mechanisms in OECD and selected developing countries, 2019 (% of total financing)**




Source: Constructed by the author from OECD Health Database at https://stats.oecd.org/Index.aspx?ThemeTreeId=9 .

Citizens in these countries, irrespective of their employment or socioeconomic status, are not required to contribute collectively with a large share of the country's health financing. Yet, OOPS is not zero in these countries because citizens may still be required to make some small copayments for their health care or may choose to resort to private care which require direct OOPS. For example, in Iceland 83% of all health financing comes from the government's treasury while citizens are not required to make any legal payroll or other premium contributions for health care. Still, 16% of all health spending in Iceland comes from OOPS.

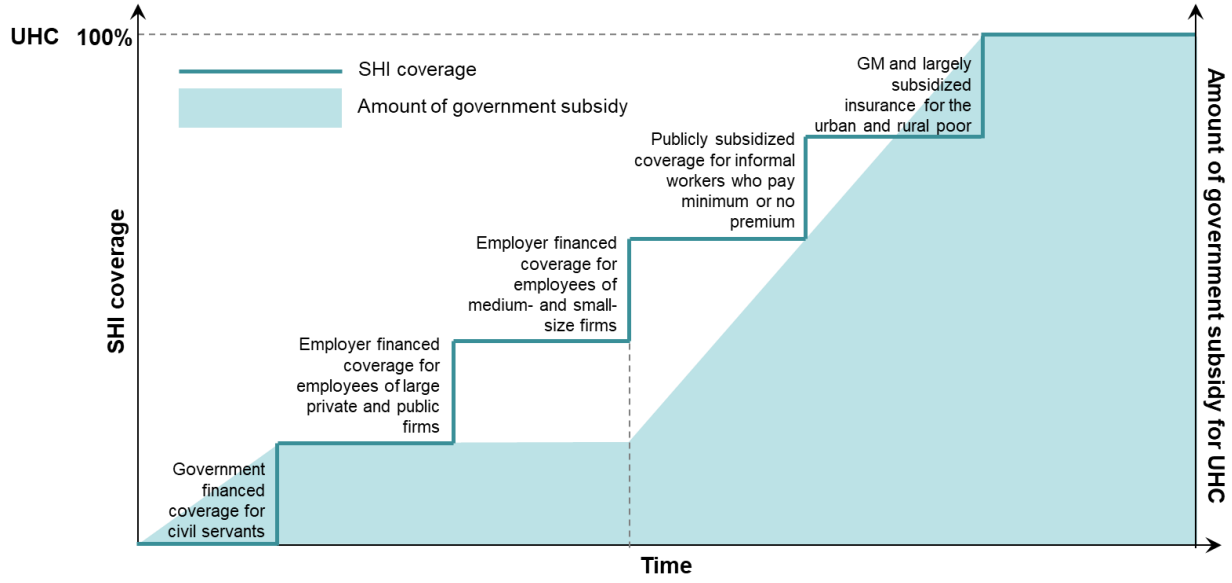
### *What are common strategies to pursue UHC?*

Most if not all the countries that have adopted SHI as their health financing model have taken an incremental approach to coverage expansion (see Figure 8). Countries such as Korea, Thailand, Indonesia, China, Philippines, and Vietnam, have followed, or are currently following, this pattern. Coverage typically begins with formal sector workers, from whom income assessment and the collection of mandatory contributions is administratively easier in comparison with workers from the informal sector. Among formal sector workers, civil servants generally stand out as the first target group to enroll under SHI. This is so because CSs are government employees and therefore the employer's contribution to SHI –where required by law– is paid for by government as the employer. Thus, a government seeking to launch SHI may find it politically easier to start making its SHI mandatory contribution to cofinance CSs'' enrolment than getting private sector firms to do so. CSs are also a powerful political force, and the performance of government services, including public education and health, are sensitive to the working conditions of this important group. Consequently, offering them health insurance constitutes a significant improvement in work benefits.

SHI coverage continues following the passage of a legal mandate to enroll for employees of large corporations, with financing coming from the employer and sometimes also the employee. This mandate is subsequently extended to mid-size and small firms. The following large groups to be enrolled were the nonpoor informal sector and the poor. Whereas many among the nonpoor informal sector workers can in principle pay for their enrollment premium, the international evidence has systematically shown that the vast majority choose not to do so, even when subject to legal mandate to enroll (Bitran 2014a; Annear, Comrie-Thomson, and Dayal 2015). The response by most government has been to subsidize in full or a large part of their premium in order to induce this group to enroll in SHI. For the poor, governments worldwide subsidize their enrollment through different mechanisms, either via demand subsidies to poor families that use the money to pay for coverage, or via supply subsidies paid to public, and sometimes also private providers who are then required to deliver health care to the poor at no direct cost.

There may be variations in the coverage expansion sequence. For example, in Chile –a country that achieved UHC in the 1980s– the indigent were the first group to be covered several decades ago (Ministerio de Salud 2022). Formal and informal sector workers followed. Similarly, in Bangladesh, the HCFS stipulates that the first group to be covered is that of the population living below the poverty line (BPL), through the government funded social health protection scheme known as SSK.

**Figure 8 SHI coverage progression and needs for government subsidization**

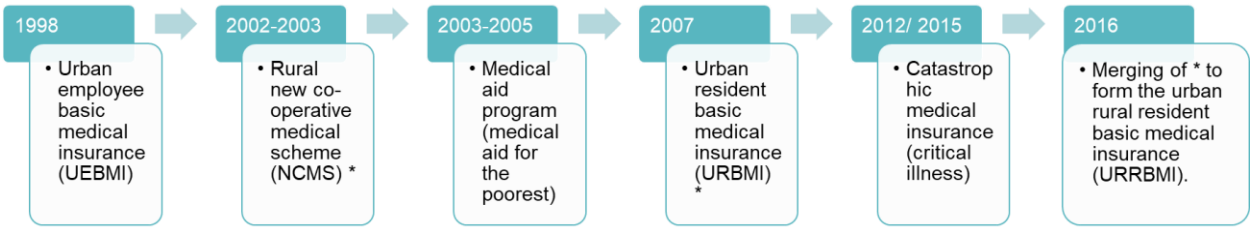



Source: Bitran (2005).

Figure 8, above, also represents the amount of public subsidies required along the coverage expansion path as the shaded area. Public financing is required to enroll CSs, but not to cover the employees of private or public firms. Once the entire formal sector is covered, government subsidies are needed to subsidize coverage for the nonpoor informal and the poor. The height of the shaded area represents the annual fiscal effort that government must make to sustain UHC.

China offers an example of this incremental approach to coverage expansion under SHI (Figure 9). It introduced legislation in the early 1950s creating the Government Insurance Scheme (GIS) and the Labor Insurance Scheme (LIS) for CSs and employees of large firms. It subsequently created new schemes, lumping some of those already in existence, and then expanding coverage for the poor, and the rural population. China is currently consolidating all schemes into one.

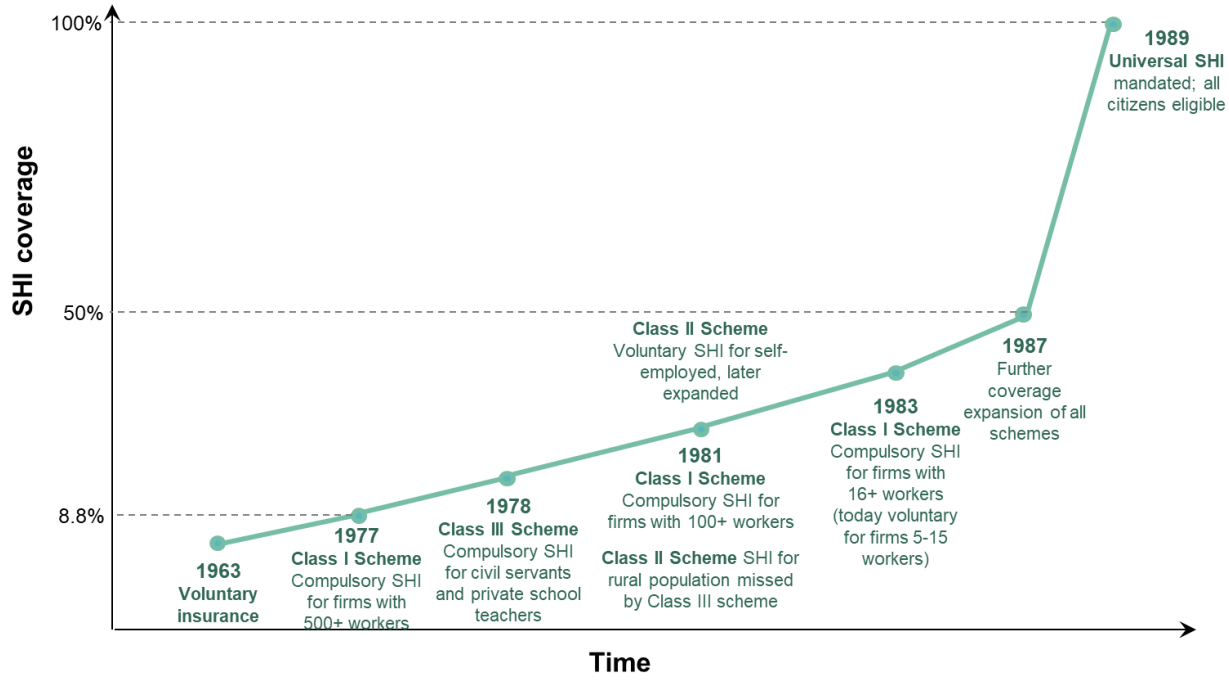
**Figure 9 Expansion path of SHI in China, 1998-today**




Source: Bitran (2014a).

Korea and Indonesia followed China, although Korea was able to achieve universal coverage with SHI before the two other countries (see Figure 10).

Figure 10 Expansion path of SHI in South Korea, 1963-1989




Source: Bitran (2014a).

## (b) UHC strategies in other countries

### *Summary*

We carried out an analysis of seven developing country case studies describing their health financing strategies to seek UHC. The cases were selected to encompass diverse financing strategies, from two-tiered SHI to national health systems financed by the public treasury. The countries are Brazil, Chile, and Colombia in Latin America, Ethiopia and Rwanda in Sub-Saharan Africa, Thailand in East Asia, and Sri Lanka in South Asia. Health policymakers in Bangladesh can learn from the enabling factors for these strategies, their pros and cons, and their policy and implementations challenges. The detailed write up of the cases can be found in 0. A summary of the country cases is presented below in the section "Findings". What follows is a series of lessons for Bangladesh emerging from these case studies.

***Brazil.*** Brazil underwent a significant shift in health policy with the introduction in 1988 of the Unified Health System (SUS). By providing free public and private health care to all citizens, SUS led to increased coverage and improved health outcomes. The relevance of Brazil's case study for Bangladesh is that the former first had for decades a two-tied SHI health system offering unequal access to care, with the population segmented in SHI sub-systems defined along socioeconomic lines. The setting up of SUS responded to policymakers' decision to put an end to segmentation and offer the same set of health services free of direct cost to all citizens irrespective of individual characteristics. The main challenge facing SUS, however, is considerable underfinancing.

***Chile.*** Prior to 1988, Chile, like Brazil, had a segmented SHI system where 80% of the population, including the poor, the nonpoor informal, and the formal, is covered by the public insurer FONASA (from its Spanish acronym for National Health Fund), while the 20% upper income, mostly formal, is covered by private SHI insurers known as *Isapres* (Spanish acronym for health providence institutions). To ensure that all Chileans would have access to the exact same health benefits package, irrespective of who their insurer was, a reform implemented in 2005, known as AUGE, defined a set of explicit health guarantees for all Chileans, including the priority diseases to be covered, the services that would be provided to prevent and treat them, the standard treatment protocols that would be used, the maximum waiting times by diagnosis, and the maximum OOPS. The relevance of Chile's AUGE reform to Bangladesh is that it is possible to operate a segmented national SHI system that can achieve significant levels of equity by guaranteeing the same health benefits package to all citizens and relying on differential public subsidization by segment.

***Colombia.*** Colombia implemented a broad SHI reform in 1994, known as Law 100, dividing the population into two groups based on their ability to self-finance social insurance. Colombia's health system is relevant for Bangladesh for the same reasons as is Chile's: a segmented SHI system, which is equivalent to a hybrid model combining a national health service for the poor and the low- and middle-income and a self-financed SHI system for the upper middle- and upper-income can lead to acceptable levels of equity by having a universal health benefits package.

***Ethiopia.*** This country set out to achieve UHC by implementing a hybrid system that combines SHI for the formal sector with CBHI for the poor and the nonpoor informal. CBHI coverage has expanded, but challenges remain in terms of sustainability and service delivery. Ethiopia may offer a lesson for Bangladesh, however, by having a dedicated agency, the EHIA, working exclusively and autonomously from the Ministry of health to manage reform implementation.

***Rwanda.*** This country's CBHI system, financed by member premiums, external funds, and the government, has achieved high enrollment rates and improved health outcomes. Performance-based financing (PBF) and decentralization reforms have also played a role in improved performance. Rwanda's health reform for Bangladesh is pertinent for Bangladesh considering the African country's reliance on CBHI for its large informal sector. Yet, it is the only developing country that has successfully covered its entire population through CBHI, and in so doing it has benefitted from considerable external technical assistance and funding. Policymakers in Bangladesh should keep in mind the unusually large external support and the special mindset of Rwandans after their Genocide as unique elements that may have led to the reform's success.

***Sri Lanka.*** Sri Lanka has a well-performing NHS-type of health system that provides universal and free access to publicly-financed government health services.[2] Its experience is pertinent for policymakers in Bangladesh. As an alternative design to the segmented health system envisioned in the HCFS 2012-2032, Sri Lanka features an NHS-type system offering equal

[2] With the COVID-19 pandemic a crisis unfolded in Sri Lanka's health system. The authors of this review have not sought to determine from the available literature if the crisis was temporary and caused by the pandemic or f it has structural weaknesses.

coverage to all citizens. Nevertheless, while this country is internationally admired for its system's efficiency and equity, households have to shoulder nearly one-half (45.6% in 2019) of total health expenditure through OOPS.

***Thailand.*** Thailand has implemented an incremental approach to achieve UHC, expanding health protections through separate public health insurance schemes which have significantly reduced OOPS and improved access to health care. Thailand's case is relevant for Bangladesh because coverage expansion relied on a combination of coverage schemes to achieve UHC. Its government used general taxation to finance the Universal Coverage Scheme (UCS) without relying on contributions from members, at the time when per capita income was a mere US$ 2,091 in current dollars. This may be a more realistic model in Bangladesh for the coverage of the nonpoor informal, particularly given the challenges involved in setting up CBHI for them.

Overall, these countries have implemented different approaches to achieve UHC, with varying levels of success. Bangladesh can learn lessons from their experiences in expanding coverage, improving health outcomes, and addressing challenges.

### *Introduction*

The HCFS 2012-2032 formulated a health financing strategy with the aim of achieving UHC that considered three separate mechanisms for three distinct population groups, SSK, CBHI, and SHI. This section reviews the international experience with health financing reform by focusing on a diverse set of countries which, individually and collectively, may shed light on the strengths and weaknesses of the HCFS 2012-32 and offer useful lessons for policymakers in Bangladesh if they choose the revise its HCFS.

### *Two broad health system designs: the National Health System and the Social Security System*

In broad terms, two common health system designs are the National Health System (NHS, also known as the Beveridge model) and the Social Security System (SSS, also referred to as the Bismarck model, or SHI). Their main characteristics and described in Table 6. From a health financing standpoint, two main features distinguish these designs: (1) the main source of revenue –the NHS relies on government general tax revenue whereas the SHI draws its revenue from mandatory contributions by enrollees; (2) the payment method: –the NHS model pays providers through salary while the SHI model contracts out providers using various payment methods.

**Table 6 The two broad designs of health systems**

| National Health System (NHS, "Beveridge model") | Social Security System (SSS "Bismarck model", or SHI) |
|---|---|
| • Predominantly financed through taxes<br>• Universal access<br>• Health care is based on a general practitioner who controls the derivation to specialists and is responsible for an assigned population<br>• Doctors paid by salary/capitation | • Financed by mandatory fees paid by employers and workers or through taxes<br>• The financial resources go to the "funds", which are nongovernmental entities regulated by law which manage these resources<br>• The "funds" contract out from hospitals, family doctors, etc. to provide the services to the |

| | |
|---|---|
| • Government control<br>• Existence of a certain private sector<br>• Involvement of the State in the management<br>• Existence of some copayments by users | insured through contracts based on a budget or through fee-for-service (FFS) or other payment methods.<br>• Reimbursement systems and some copayments by users |

Source: Ministerio de Sanidad (2019).

In Europe these two models are widespread, as is shown in Figure 11. They are also prevalent in developing countries, although several distinguishing features of these nations influence the way in which the models have been implemented and operate. Developing countries with the NHS model, such as Brazil, Cuba, and Nicaragua, find themselves striving for public financing, particularly where per capita income, economic growth, and government tax revenue are low, and where constitutional or legal rules have resulted in a broad definition of citizens' health rights. Developing countries with the SHI model, such as China, Morocco, and Costa Rica, must deal with the challenges of a high prevalence of poverty and a large share of the working population being active in the informal sector. Consequently, the ability of these countries to finance health care from mandatory SHI contributions is limited.

The two models, as described, may not always for feasible, however, in low- and lower-middle-income countries (LLMICs). Hsiao and Yip (2023) assert that the international consensus on UHC "thus far lacks a clear mechanism to finance and deliver accessible and effective basic health care to the two billion rural residents and informal workers of the developing world. Importantly, the two preferred financing modes for UHC, NHS and SHI, are often infeasible for LLMICs."

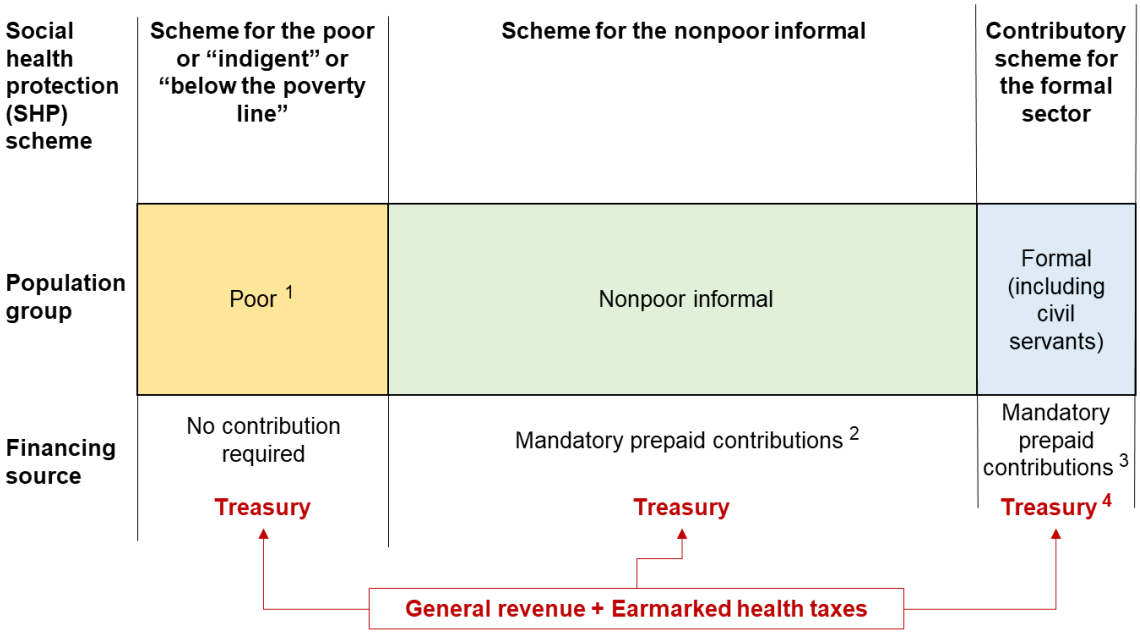
**Figure 11 Geographic distribution of the two broad health system designs in Europe**

Source: Ministerio de Sanidad (2019).

### *National Health Insurance: A hybrid system for lower-middle income countries*

In light of the practical difficulties of raising sufficient revenue from contributions, developing countries seeking to adopt the SHI model, have devised the so-called "national health insurance schemes (NHI)", whereby contributions bring in only part of the revenue for health and the rest comes in the form of subsidies from the government's treasury or earmarked health taxes, for those unwilling or unable to contribute. (Often in the developing country context, NHI systems are also referred to as SHI systems.) For example, Ghana's National Health Insurance Scheme (NHIS) is financed through 2.5% payroll deductions from formal sector employees, a 2.5% tax on certain goods and services, and premiums for informal sector workers ranging between $8 and $53. A growing number of other developing countries, such as Malawi, Madagascar, and Zambia, are also considering the adoption of NHI schemes (Friebel et al. 2020). A general description of the sources of revenue used to cover different population segments used by NHI systems is shown in Figure 12.

**Figure 12 Financing in national health insurance (NHI) systems**




Notes:
1. Generally, a means testing, or equivalent mechanism exists to categorize individuals as officially below the poverty line.
2. There may be variations in the way these contributions are defined. They may be a fixed amount per individual or family, or a percentage of the worker's salary or income. There is broad variation in the schemes regarding the enforcement of contributions.
3. Generally, they are defined as a percentage of the worker's salary.
4. In some countries, the mandatory contribution by formal sector workers and their employers is insufficient to finance the stated health benefits, and therefore government may provide additional financing from the treasury.

Source: Constructed by the authors.

### *Country selection*

The terms of reference for this assignment call for a selection and review of diverse country cases which can offer useful insights to Bangladesh policymakers regarding any needed revisions to its HCFS and its UHC strategy. In consultation with his government counterparts,

national consultants, and client (the WHO Dhaka), the author of this report came up with a selection of 9 developing countries (Table 7), in alphabetical order:

- Bangladesh
- Brazil
- Colombia
- Chile
- Ethiopia
- Rwanda
- Sri Lanka
- Thailand

They encompass a broad range of per capita income, from Ethiopia's $ 2,182 (purchasing-power-adjusted –PPP– international dollars of 2017) to Chile's $24,817. Health status indicators vary broadly among the selected countries and correlate very closely with their per capita income (Sri Lanka is an outlier, with an infant mortality rate as low as Chile's but with a per capita income about half as large).

Government health expenditure, as a share of GDP, is the lowest in lowest in Bangladesh (0.5%), followed closely by Ethiopia (0.7%). It is highest in Colombia (5.5%). The fiscal capacity (government revenue raising from taxes as a share of GDP) of the selected countries varies widely as well. Two African countries, Ghana and Rwanda, feature an ability to raise government revenue from taxes as high as the significantly richer Latin American countries of Brazil, Colombia, and Chile.

As a source of health financing OOPS is by far the highest in Bangladesh (68.5% in 2020). It is interesting to note that two case study countries, Rwanda and Thailand, whose governments spend on health an amount representing a relatively small share of GDP (2.6% and 2.7% respectively), have managed to achieve low OOPS as a source of health financing (11.7% and 8.7%). This suggests that governments need not allocate large amounts of financing to the health sector to be able to relieve households from the need to finance health care mostly out-of-pocket. It is surprising to see that in Sri Lanka, a country internationally admired for its mostly public and efficient health system, households have to shoulder nearly one-half (45.6% in 2019) of total health expenditure.

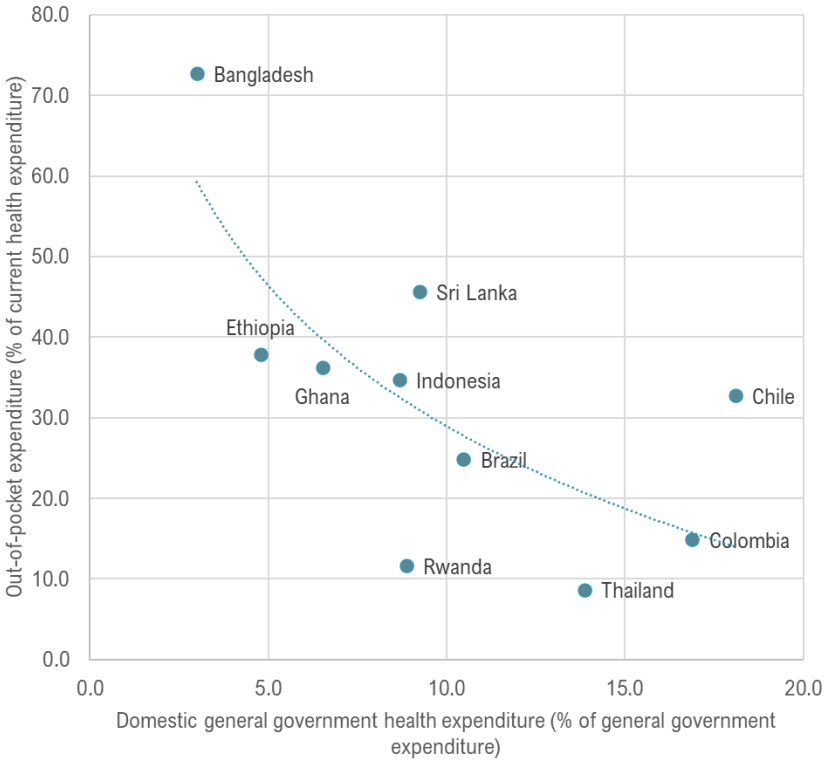
The share of the government's public budget allocated to health varies widely among case study countries as well. On one extreme is Bangladesh, whose government allocates only 3% of its budget to the health sector (see Figure 13). This small allocation results in a situation where households must resort to OOPS to pay for a large part of their health care. On the other extreme are countries like Thailand and Colombia, whose governments allocated 13.9% and 16.9% of the public budget to health. Owing to this high prioritization of the health sector, health financing relies only to a small extent on household OOPS in these two countries.

**Table 7 Selected economic and health indicators, Bangladesh and country cases, 2019**

| Indicator | Ethiopia | Rwanda | Ghana | Bangladesh | Indonesia | Sri Lanka | Colombia | Brazil | Thailand | Chile |
|---|---|---|---|---|---|---|---|---|---|---|
| GDP per capita, PPP (constant 2017 international $) | 2,182 | 2,191 | 5,346 | 5,467 | 11,858 | 13,639 | 14,616 | 14,685 | 18,004 | 24,817 |
| Average per capita GDP growth last 15 years (%) | 6.90% | 4.60% | 3.90% | 5.50% | 3.90% | 4.10% | 2.30% | 0.90% | 2.10% | 2.00% |
| Tax revenue (% of GDP) | 6.7 | 14.6 | 12.0 | 7.6 | 9.8 | 10.9 | 15.1 | 13.7 | 14.7 | 17.9 |
| Current health expenditure (% of GDP) | 3.2 | 6.4 | 3.4 | 2.5 | 2.9 | 4.1 | 7.7 | 9.6 | 3.8 | 9.3 |
| Current health expenditure per capita, PPP (current international $) | 75 | 146 | 193 | 123 | 358 | 570 | 1,204 | 1,498 | 731 | 2,424 |
| Domestic general government health expenditure (% of general government expenditure) | 4.8 | 8.9 | 6.5 | 3.0 | 8.7 | 9.2 | 16.9 | 10.5 | 13.9 | 18.1 |
| Domestic general government health expenditure (% of GDP) | 0.7 | 2.6 | 1.4 | 0.5 | 1.4 | 1.9 | 5.5 | 3.9 | 2.7 | 4.8 |
| Domestic general government health expenditure (% of current health expenditure) | 22.7 | 39.9 | 40.2 | 18.6 | 48.9 | 47.2 | 71.9 | 40.7 | 71.7 | 50.9 |
| Out-of-pocket expenditure (% of current health expenditure) | 37.9 | 11.7 | 36.2 | 68.5* | 34.8 | 45.6 | 14.9 | 24.9 | 8.7 | 32.8 |
| Mortality rate, infant (per 1,000 live births) | 36.6 | 31.2 | 34.5 | 25.3 | 20.1 | 6.2 | 11.8 | 13.4 | 7.7 | 6.1 |
| Maternal mortality ratio (modeled estimate, per 100,000 live births) | 401 | 248 | 308 | 173 | 177 | 36 | 83 | 60 | 37 | 13 |
| Life expectancy at birth, total (years) | 65.8 | 66.4 | 64.7 | 72.8 | 70.5 | 76.0 | 76.8 | 75.3 | 79.0 | 80.3 |
| Literacy rate, adult female (% of females ages 15 and above) | 96.3 | 95.3 | 71.2 | 93.4 | 44.4 | 74.5 | 94 | 69.4 | 90.8 | 92.4 |
| Access to electricity (% of population) | 100.0 | 98.5 | 91.8 | 99.7 | 44.9 | 80.4 | 98.5 | 37.0 | 99.6 | 99.8 |
| People using at least basic drinking water services (% of population) | 100.0 | 97.3 | 97.6 | 98.9 | 48.1 | 84.7 | 91.6 | 60.4 | 92.2 | 100.0 |

* OOP as per BNHA 2020

**Figure 13 Health share of the public budget and out-of-pocket spending on health, selected countries, 2019 (%)**




Source: Constructed by the author from World Bank Databank.

Probably the most interesting set of facts behind the selection of case study countries is the varied nature of their health policies. For example, Sri Lanka's National Health Service system has managed to achieve an infant mortality rate of 6.2 per thousand life births, nearly as low as Chile's and lower than Thailand, even though those two countries are much richer than Sri Lanka and have adopted fairly different policies to move toward UHC. This suggests that when it comes to health policy to achieve UHC, there is no such thing as a one-size-fits-all strategy. A same strategy can produce good results in one country and poor ones in another, depending on a multitude of political, cultural, social, and economic factors.

### *Findings*

***Brazil.*** Brazil underwent a significant shift in health policy with the introduction in 1988 of the Unified Health System (SUS), which by providing free health care to all citizens, led to increased coverage and improved health outcomes. The system combines public and private subsystems. The relevance of Brazil's case study for Bangladesh is that the former first had for decades a two-tied SHI health system with the population segmented in SHI sub-systems defined along socioeconomic lines. Thus, the low-income informal population had access to an implicit and reduced set of health benefits financed by the national and local treasuries, with rationing through demand deflection and waiting lines; the nonpoor informal were uncovered and could obtain publicly financed health care in government facilities or pay for private care; and the formal sector

had SHI coverage financed through their and their employers' mandatory payroll contributions for health. The setting up of an integrated system such as SUS reflected the desire by policymakers to put an end to segmentation and offer the same set of health services free of direct cost to all citizens irrespective of individual characteristics. The main challenge facing SUS, however, is considerable underfinancing.

***Chile.*** This other Latin American country has, like Brazil prior to 1988, a segmented SHI system where 80% of the population, including the poor, the nonpoor informal, and the formal, is covered by the public insurer FONASA (from its Spanish acronym for National Health Fund), while the 20% upper income, mostly formal, is covered by private SHI insurers known as *Isapres* (Spanish acronym for health providence institutions). Policy efforts to put an end to the segmentation failed in the mid-2000s and led to an alternative strategy seeking to achieve higher levels of equity in access despite the segmentation. It involved the design and implementation of the Universal Access with Explicit Guarantees program (AUGE), a policy that defined an explicit health benefits package with legal guarantees for access and quality, for all SHI beneficiaries, irrespective of income or coverage. The AUGE policy has succeeded in improving access and reducing disparities. But the breath of the AUGE benefits has forced FONASA, the public insurer, to rely increasingly on public financing from the treasury such that the 7% mandatory payroll contribution currently accounts for only one-fourth of all financing. The relevance of Chile's AUGE reform to Bangladesh is that it is possible to operate a segmented national SHI system that can achieve significant levels of equity by guaranteeing the same health benefits package to all citizens and relying on differential public subsidization by segment.

***Colombia.*** Colombia implemented a broad SHI reform in 1994, known as Law 100, dividing the population into two groups based on their ability to self-finance social insurance. Like Chile's, the reform in Colombia improved access and reduced inequalities, ensuring equal access to the national Mandatory Health Plan, known as POS. A problem facing Colombia's health system was the growing number of legal challenges to the exclusion of certain health benefits from the POS, and the decisions by courts to force SHI insurers to deliver and finance services outside of POS. Colombia's current government is seeking to put an end to Law 100 and to set up a universal health system that would rely solely or more heavily on public financing from the treasury. Colombia's health system is relevant for Bangladesh for the same reasons as is Chile's: a segmented SHI system, which is equivalent to a hybrid model combining a national health service for the poor and the low- and middle-income and a self-financed SHI system for the upper middle- and upper-income can lead to acceptable levels of equity by having a universal health benefits package.

***Ethiopia.*** This country set out to achieve UHC by implementing a hybrid system that combines SHI for the formal sector with CBHI for the poor and the nonpoor informal. CBHI coverage has expanded, but challenges remain in terms of sustainability and service delivery. SHI implementation has been delayed, however. A national body, known as the Ethiopian Health Insurance Agency (EHIA), has the implementation responsibility for both SHI and CBHI. Ethiopia's

policy is relevant for Bangladesh because it shares key features with the latter country's HCFS 2012-2032. Both designs rely on SHI and SBHI, although in Ethiopia the poor are expected to be covered by CBHI, whereas in Bangladesh their coverage will be achieved through the SSK, a dedicated publicly financed scheme Also, while both countries expect to implement SHI, they have put off implementation for years partly owing to the complex politics of reform and questions about the feasibility of SHI. Ethiopia may offer a lesson for Bangladesh, however, by having a dedicated agency, the EHIA, working exclusively and autonomously from the Ministry of health to manage reform implementation.

***Rwanda.*** This country's CBHI system has achieved high enrollment rates, contributing to improved health outcomes. The program is supported by member premiums, external funds, and the government. Performance-based financing (PBF) and decentralization reforms have also played a role in health care improvement. The pertinence of Rwanda's health reform for Bangladesh is evident considering the latter country's reliance on CBHI for its large informal sector. Rwanda is the only developing country that has successfully covered its entire population from CBHI, however, and in so doing it has benefitted from considerable external technical assistance. The importance of PBF in the success of its reform cannot be overlooked, however. Policymakers in Bangladesh should keep in mind the unusually large external support and the special mindset of Rwandans after their Genocide as unique elements that may have led to the reform's success. They should also keep in mind WHO's (2000) conclusion that low-income countries seeking UHC often view CBHI as a promise to cover the poor and the nonpoor informal populations. In practice, evidence suggests that the impact of CBHI on financial protection and access to needed health care is moderate for those enrolled. Further, most CBHI schemes have low participation levels and the poorest people usually remain excluded. CBHI thus has played only a limited role in helping countries move towards UHC. However, they can have other positive impacts such as community development and local accountability of health care providers.

***Sri Lanka.*** Sri Lanka has a well-performing public health care system that provides universal and free access to government-provided health care services.[3] Despite the current economic crisis, Sri Lanka has achieved good health outcomes through investments in social and human development policies. Bangladesh's large informal sector, accounting for 94% of its population, makes the establishment of SHI a challenging policy proposition, as it will be difficult to raise sufficient funds from the formal minority to cross-subsidize the informal majority. Thus, it is pertinent for policymakers in Bangladesh to consider an alternative to SHI, and neighboring Sri Lanka, with its national health system, offers a possible model.

***Thailand.*** Thailand has implemented an incremental approach to achieve UHC, expanding health protections through public health insurance schemes. These schemes have significantly reduced OOPS and improved access to health care. Challenges remain in preparing for an aging society

[3] With the COVID-19 pandemic a crisis unfolded in Sri Lanka's health system. The authors of this review have not sought to determine from the available literature if the crisis was temporary and caused by the pandemic or f it has structural weaknesses.

and addressing non-communicable diseases. Thailand's case is also relevant for Bangladesh because coverage expansion relied on a combination of coverage schemes to achieve UHC. Thailand's government used general taxation to finance the Universal Health Coverage Scheme without relying on contributions from members, at the time when per capita income was a mere US$ 2,091 in current dollars. This may be a more realistic model in Bangladesh for the coverage of the nonpoor informal, particularly given the challenges involved in setting up CBHI for them.

Overall, these countries have implemented different approaches to achieve UHC, with varying levels of success. Bangladesh can learn lessons from their experiences in expanding coverage, improving health outcomes, and addressing challenges.

# 4. HEALTH FINANCING IN BANGLADESH: IMPLICATIONS FOR UHC

## (a) Summary

This section reviews basic health financing indicators for Bangladesh and all other countries in the South Asian region. Its aim is to assess the current sources of health financing in the country, to compare their magnitude with other regional countries, and to assess from a health financing standpoint, whether Bangladesh is in a position that is consistent with the coverage objectives set forth in the country's HCFS 2012-2032.

The ambitious goals of Bangladesh's HCFS 2012-2023 appear inconsistent with the country's low overall current health expenditure (CHE), at 2.5% of GDP in 2019. This modest figure contrasts with a twice as high regional average of 5.04%. In fact, in 2020 Bangladesh featured the lowest CHE-to-GDP share of all countries in its region. Nations with significant progress toward UHC, such as Sri Lanka and the Maldives, exhibit a much higher THE-to-GDP share (4,08% and 8.04% respectively). Bangladesh's low THE partly results from a small health share in the government's budget (around 5%)) a share that was one-half the regional average.

Bangladeshi households are required to finance the lion's share of their health care to make up for limited public financing. With OOPS at 68.5% of current health financing in 2020, Bangladesh has the second highest share of household health financing in the South Asian region, after Afghanistan.

UHC tracking data shows that Bangladesh belongs to the least favorable of all country groups, featuring low service coverage combined with high catastrophic OOPS. In 2022, it was the sample country with the worst performance in UHC, with the highest (24.9%) share of households experiencing catastrophic OOPS and a (51%) service coverage indicator that was below the median.

Bangladesh's government exhibits the lowest tax collection rate, as a share of GDP, of all South Asian countries, limiting its ability to spend on health and other social sectors. While poorer than Bangladesh, Nepal and Pakistan managed to collect more than twice the amount of tax revenue in relation to GDP than Bangladesh.

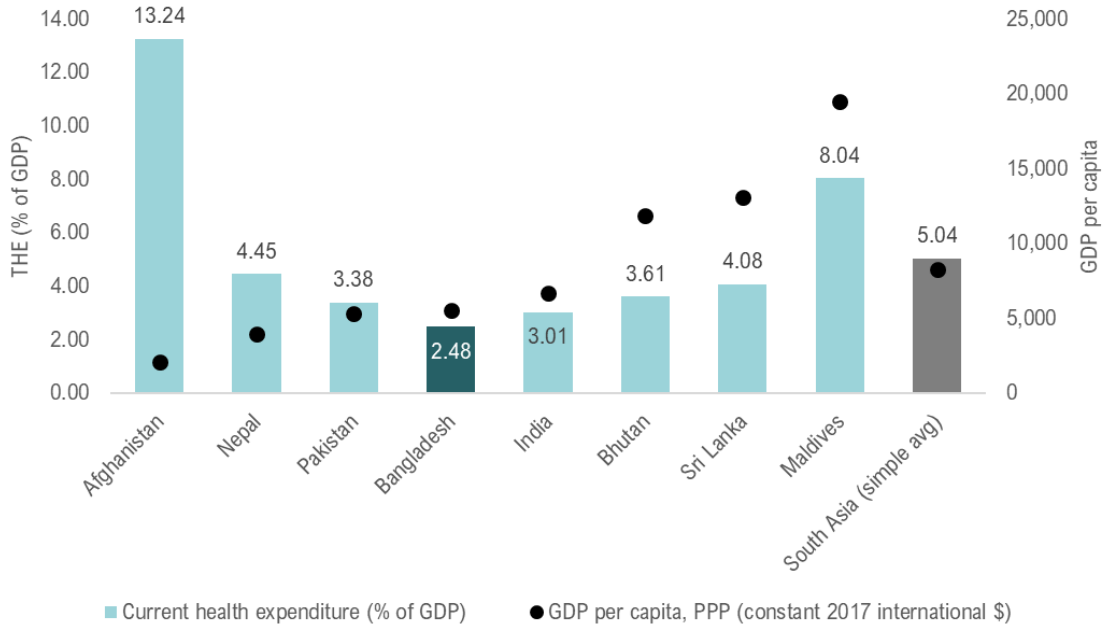
Bangladesh's low tax revenue does not fully justify the low share of the government's budget going to health. Indonesia, China, and Sri Lanka also draw a low tax revenue yet they assigned a much greater importance to the health sector in their budgets. For example, the government of China's tax revenue is 9.05% of GDP (versus Bangladesh's 7.73%) yet the share of its budget going to health 8.85% (versus Bangladesh's 2.98%).

What follows after this summary is a detailed analysis on the sources of health financing in Bangladesh.

## (b) Total health expenditure

With 2.5% of GDP spent on health in 2020, Bangladesh had the lowest total expenditure on health of all countries in its region (Figure 14). The regional average of 5.04% was more than twice as high. It is a general empirical fact that, as countries grow richer, they devote a growing share of their economy to health. The countries of Figure 14 are organized in ascending order of per capita GDP, depicted by the black dot.[4] Excluding Afghanistan, an outlier country because of its political instability, war, and the large amount of foreign financing for health, countries that were poorer than Bangladesh, like Nepal and Pakistan, spent more in total on health care than Bangladesh. Sri Lanka, internationally praised for its well developed and performing social programs, spent 4,08% of GDP on health, a significantly higher share than Bangladesh, while the Maldives allocated 8.04% of its GDP to health, more than three times as much as Bangladesh.

**Figure 14 Total health expenditure (THE) as % of ascending order of per capita GDP, 2019, PPP (constant 2017 international $)**




Source: Constructed by the author from World Bank DataBank https://databank.worldbank.org/reports.aspx?source=health-nutrition-and-population-statistics

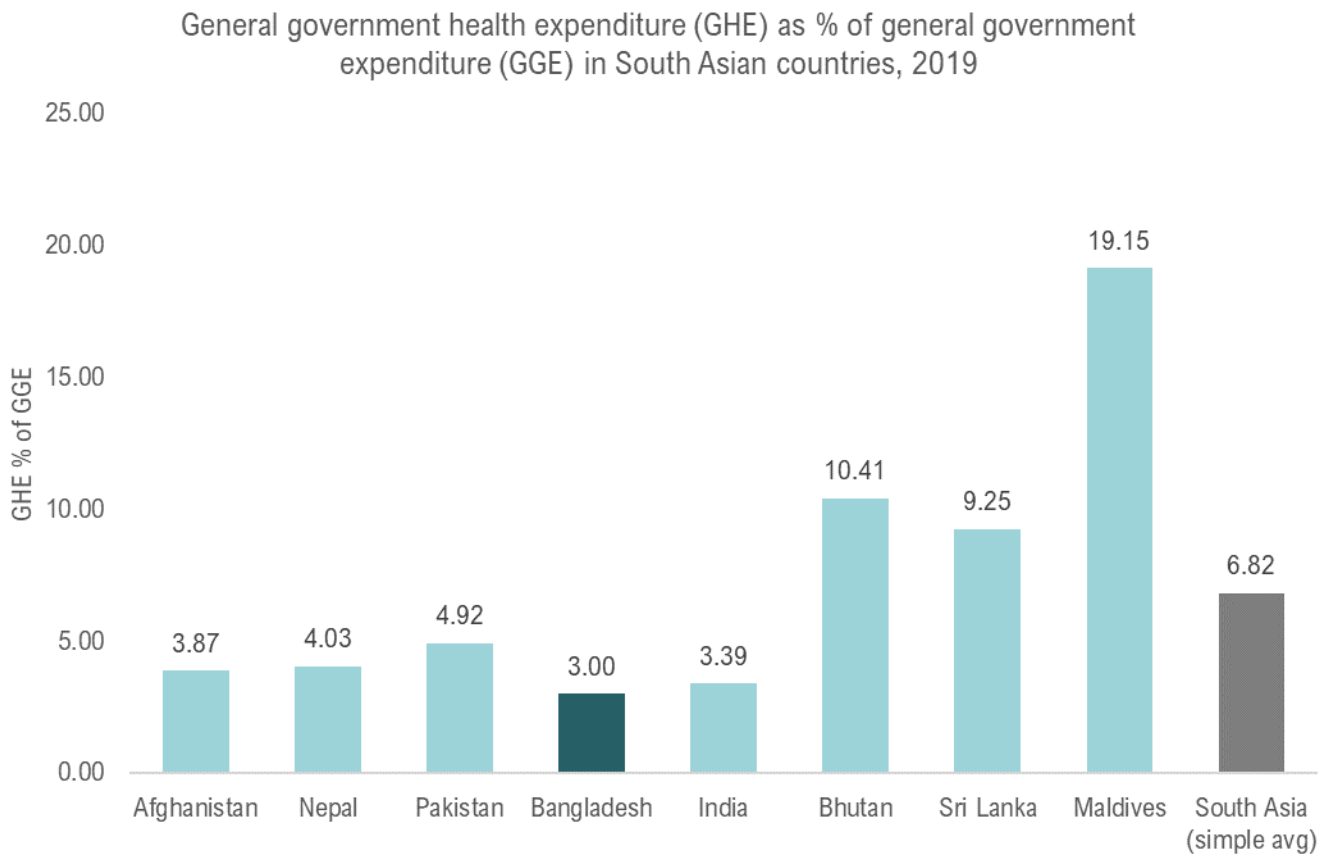
## (c) Health share of the government's budget

Annually, governments face the difficult task of assigning their limited budget among competing sectors. In Bangladesh, the health sector received just under 3% of the public budget in 2022-23, more than Afghanistan and similar to India, but a share that was one-half the regional average of 6.8%. Sri Lanka allocated nearly 10% of its government's budget to the health sector while the

[4] Per capita GDP is measured in purchasing-power-parity adjusted international dollars of 2017.

Maldives allocated 19.2%. In Sub-Saharan Africa, the target share is 15% as per the so-called Abuja initiative (World Health Organization 2011).

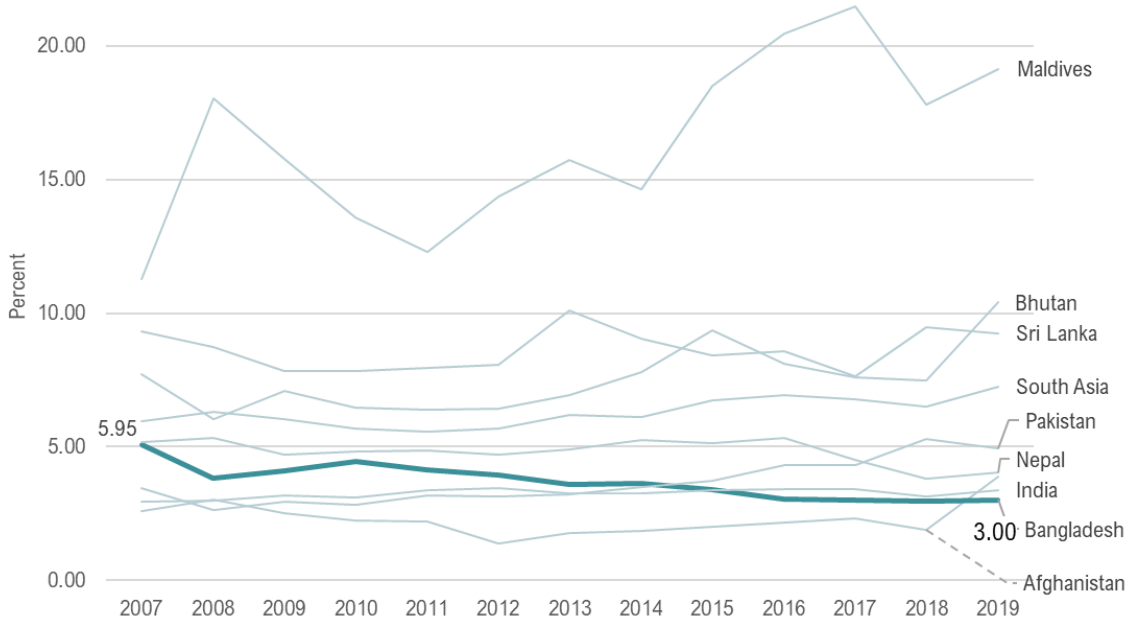
**Figure 15 General government health expenditure (GHE) as % of total health expenditure (THE) in South Asian countries, 2019**




Source: Constructed by the author from World Bank DataBank https://databank.worldbank.org/reports.aspx?source=health-nutrition-and-population-statistics

In Bangladesh, the health sector's share of the public budget was not only relatively small in 2020 but it has actually been stagnant over the years (Figure 16). The ambitious goals of the HCFS 2012-2023 seem inconsistent with the actual volume of financing that the health sector is getting from the public budget.

**Figure 16 General government health expenditure (GHE) as % of general government expenditure (GGE) in South Asian countries, 2007-2019**

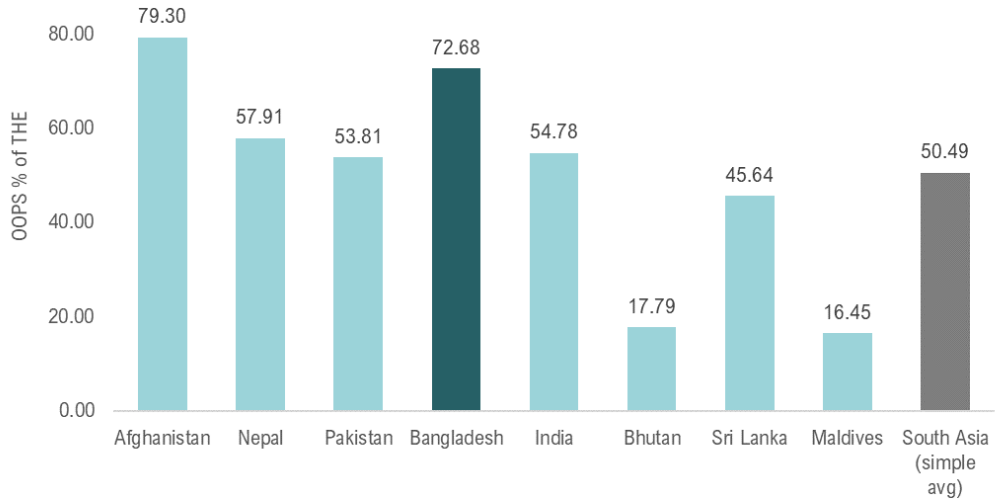



Source: Constructed by the author from World Bank DataBank https://databank.worldbank.org/reports.aspx?source=health-nutrition-and-population-statistics

## (d) Out-of-pocket financing of health care

With such a low share of Bangladesh's public budget going to health by 2023, it is not surprising to see that OOPS, at 72.68% of total health financing, was the second highest in the South Asian region, after Afghanistan. Stated differently, Bangladeshi households were required to finance the lion's share of health care consumed in the country to make up for the limited public financing.

**Figure 17 Out-of-pocket health expenditure (OOPS) as % of current health expenditure (CHE) in South Asian countries, 2019**

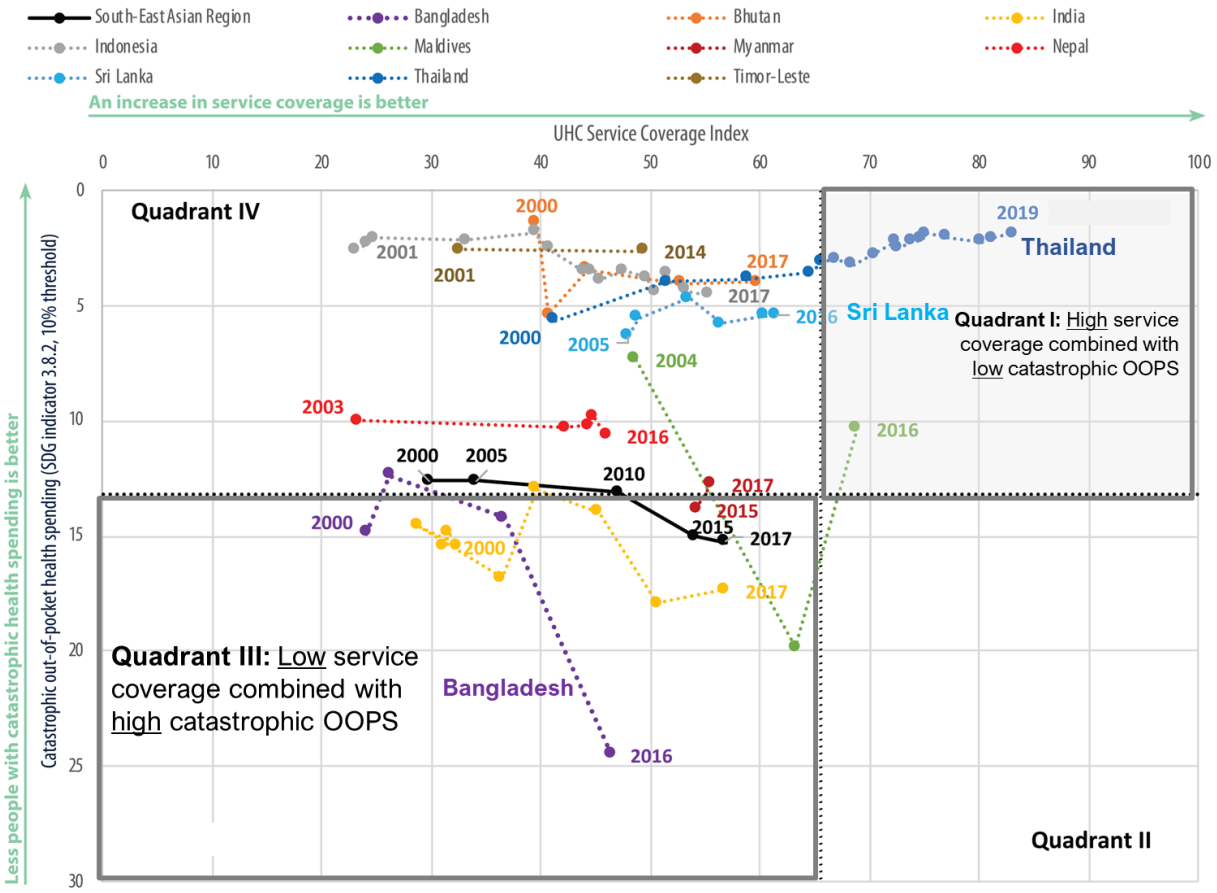



Source: Constructed by the author from World Bank DataBank https://databank.worldbank.org/reports.aspx?source=health-nutrition-and-population-statistics

## (e) Progress toward UHC

Considerable differences in health financing patterns account to a large extent for differences in countries' progress toward UHC, as can be in Figure 18. The figure shows the trajectory that selected Asian countries have followed over the past 8 years in terms of two UHC progress indicators: a service coverage index and a catastrophic health spending index. Thailand belongs to Quadrant I, which contains countries with high service coverage combined with low catastrophic OOPS. Within this quadrant, Thailand's trajectory toward UHC has been improving over time, with growing service coverage and decreasing incidence of catastrophic OOPS. Sri Lanka has also been showing a marked improvement as it approaches Quadrant I. In contrast, Bangladesh belongs to the least favorable of all quadrants, Quadrant III, containing countries with low service coverage combined with high catastrophic OOPS. In 2016, it was the sample country with the worst performance in UHC: it had the highest (24%) share of households experiencing catastrophic OOPS and a relatively low (46%) service coverage indicator that was below the median.

**Figure 18 Trends in UHC service coverage index (SDG indicator 3.8.1) and incidence of catastrophic health spending (SDG indicator 3.8.2,10% threshold) for selected countries in the WHO South-East Asia Region, 2000–2017**

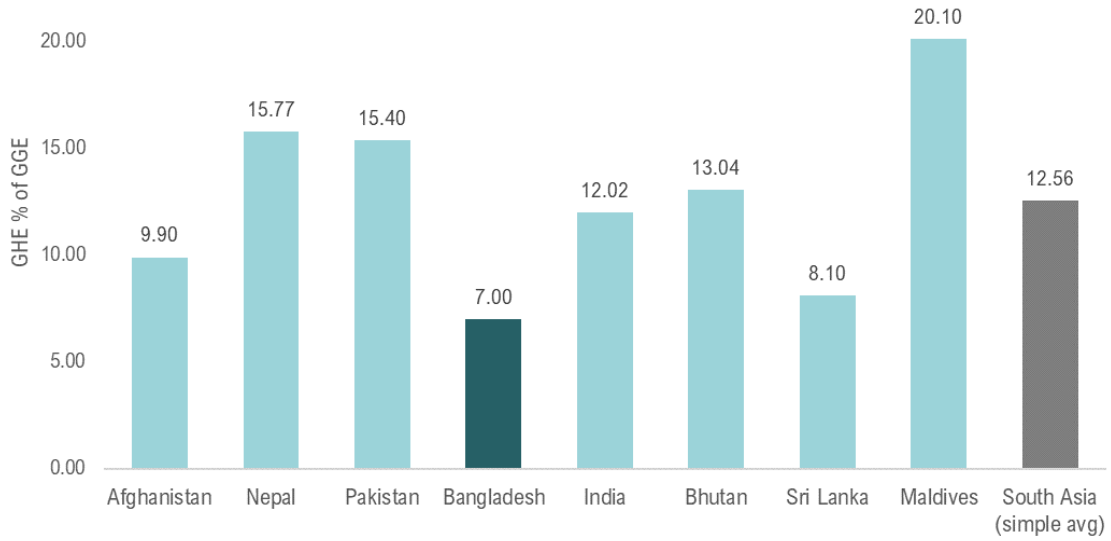



Source: The World Bank and World Health Organization (2021).

## (f) Government tax revenue collection

A government's long-term spending ability naturally depends on its capacity to raise tax revenue. Bangladesh's government exhibits the lowest tax collection rate, as a share of GDP, of all South Asian countries (Figure 19). Nepal and Pakistan are both poorer than Bangladesh, yet in 2017 they managed to collect a more than twice the amount of tax revenue in relation to GDP than Bangladesh.

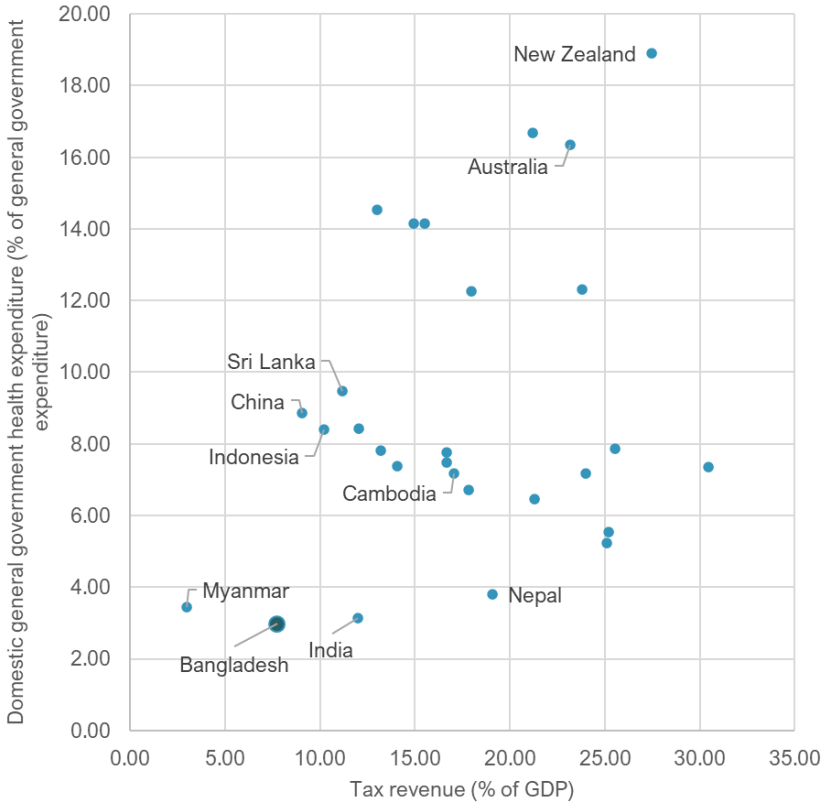
**Figure 19 General government tax revenue as a share of Gross Domestic Product (GDP) in South Asian countries, 2019**




Source: Constructed by the author from World Bank DataBank https://databank.worldbank.org/reports.aspx?source=health-nutrition-and-population-statistics

Is Bangladesh's low tax revenue collection an explanation for the low share of the government's budget going to health? In part, yes. The governments of India and Myanmar have in common with that of Bangladesh that the also collect a relatively small about of tax revenue and they allocate a low fraction of their public budget to health (Figure 20). Yet there are other countries which, while exhibiting a low tax revenue, have assigned a much greater importance to the health sector in their budgets. Three prominent examples are Indonesia, China, and Sri Lanka. China, in particular, draws tax revenue equivalent to 9.05% of GDP (versus Bangladesh's 7.73%) yet its government assigns to the health sector 8.85% of its budget (versus Bangladesh's 2.98%).

**Figure 20 Domestic general government health expenditure (% of general government expenditure) versus tax revenue (% of GDP)**




Source: Constructed by the author from World Bank DataBank https://databank.worldbank.org/reports.aspx?source=health-nutrition-and-population-statistics.

## (g) Fiscal space for health

According to the WHO, fiscal space for health may be defined as room in a government's budget that allows it to provide resources for a desired purpose within the health sector without jeopardizing the sustainability of its financial position or the stability of the economy (WHO 2017). A study of fiscal space in Bangladesh's health sector by the World Bank stated the following:

> *Fiscal space for health is a particularly important policy challenge for Bangladesh because it currently has one of the lowest levels of government health spending in the world. At present it spends just 0.8% of GDP (or $6.20 per capita) on health, or slightly over half the South Asia regional average of 1.3% of GDP, which is itself lower than the average of 1.6% of GDP among lower middle-income countries. Low government spending translates into inadequate service coverage for key interventions that would improve population health and a high reliance on out-of-pocket expenditures (OOP). These payments account for 63 percent of total health spending in Bangladesh, a higher share than regional or lower middle-income country (LMIC) averages. As a result, a large number of households fall into poverty*

*each year due to medical costs. Without increases in the government health budget, improvements in service coverage are likely to stall and OOP will continue to rise in line with growing demand for health care services, thus making the attainment of the Sustainable Development Goal (SDG) of achieving universal health coverage (UHC) an ever more elusive objective. (The World Bank 2016)*

The World Bank study concluded the following:

- *Economic growth*. Whereas Bangladesh has experienced high economic growth, government tax revenue collection is low and should increase to ensure that sustained economic growth does translate into additional public revenue for the social sectors, including health.
- *Reprioritization*: The government's allocation to the Ministry of Health and Family Welfare (MOHFW) dropped to 5% of the total government budget in 2013-15, after many years in the 6-7% range. These are much lower values than the 8-10% that other South Asian and low-income countries allocate to the health sector. Increasing the share of the public budget to health is necessary to gain fiscal space and is has significantly larger potential source of fiscal space for the country than economic growth and improved tax collection alone.
- *Development assistance*: This is the least likely way to generate significant fiscal space, considering the exodus of some international donors providing development assistance and an expected steady decline of net assistance to the health sector over the medium term.
- *New sources of health financing:* The country's HCFS 2012-2032 envisions that significant revenue for health will be raised from the nonpoor informal sector. The international evidence to date does not support this expectation.
- *Efficiency gains*: Bangladesh's health system appears relatively efficient because it has achieved good outcomes at low cost (Balabanova, McKee, and Mills 2011). It also seems to continue improving efficiency in certain areas. While there are also inefficiencies, overcoming them does not represent a significant source of additional fiscal space.

# 5. PROGRESS TO DATE ON BANGLADESH'S HCFS, FACTORS FACILITATION OR IMPEDING IMPLEMENTATION, AND DESIGN ELEMENTS THAT MAY WARRANT REVISION

## (a) Summary

This section contains two parts. The first presents main findings from FGDs and KIIs held by the review team from late 2021 to early 2023 regarding the contents of the HCFS, the progress to date in its implementation, and how implementation could be accelerated. The second part presents in summary form the findings from an evaluation of pilot tests of the SSK scheme carried out in three districts of the country.

***FGDs and KIIs.*** Study authors interviewed key informants in Bangladesh about progress to date in the implementation of the country's HCFS 2012-2032, the factors facilitating and impeding progress, and elements of the reform that might warrant revising. They found that the proposed health financing reform is considered to have valuable design elements but also ones that appear not appropriate for Bangladesh. The interviews revealed that a government subsidized regime for the BPL population, SSK, is considered a good feature of the reform, while the adoption of CBHI for the nonpoor informal is seen as unsuitable for that large population segment. A contributory SHI system for the formal sector was seen as feasible but could result in a two-tier health system that would perpetuate inequities in access to health care in the country. Weak leadership and governance, as well as the assignment of implementation duties to the HEU, are impediments for the successful execution of health financing reform. Insufficient public financing for health is inconsistent with the country's expressed desire to achieve UHC. Finally, rigid PFM and weaknesses in the supply side of the health system need to be overcome for a health financing reform to succeed.

***Evaluation of SSK pilots.*** The authors also analyzed a recent evaluation of SSK pilots managed by the HEU and a scheme operator called Green Delta. Three pilots were conducted in Tangail district, with upazila hospitals serving as the primary contact facilities for SSK enrollees. The SSK scheme covers a range of inpatient conditions and provides benefits up to BDT 50,000 per household per year. The pilot evaluation focused on several key outputs, including reducing financial hardship, improving access to inpatient care, establishing quality standards, and enhancing efficiency and transparency in hospital management. The evaluation used methods such as community assessments, facility assessments, treatment protocol reviews, patient exit interviews, and record reviews. Findings revealed that SSK cardholders experienced significantly lower OOPS, but there was no poverty reduction effect. The availability of equipment and supplies in SSK facilities was generally good, although some areas lacked functional generators and communication equipment. Compliance with treatment protocols was moderate and did not improve over time. Community engagement activities were weak, and there were challenges related to staffing, specialist availability, and the referral system. Patient satisfaction varied, with positive feedback on privacy and negative feedback on information sharing by providers. The evaluation made several

recommendations, including scaling up the SSK scheme to additional areas in Tangail district and eventually to all districts in Bangladesh. It recommended strengthening operational components, improving collaboration between relevant institutions, enhancing monitoring and supervision, increasing provider motivation through non-financial incentives, and expanding the SSK model to urban areas. The establishment of the NHSO was also proposed for effective management of the SSK scheme.

## (b) Review of findings from focus group discussions (FGDs) and key informant interviews (KIIs)

Team members were tasked with the review of existing documents related to HCFS implementation and the gathering through interviews of the opinions of key health sector stakeholders and informants about HCFS design and implementation to date. This section presents the findings of a series of FGDs and KIIs that members of the study team held between late 2011 and early 2023. Annex B contains a list of key informants interviewed. Main findings follow and are organized around the six core elements of the health care financing strategy. Selected statements made by participants in these events are presented verbatim in box, by subject.

### *Overall*

***Optimistic plan with limited implementation capacity.*** Several interviewed stakeholders stated that the HCFS was optimistic, especially in the context of the several constraints that included existing supply side barriers to the provision of quality care to the country's population; a large informal sector, which challenges the feasibility of SHI; and limited MOHFW capacity to design and implement the strategy's three financing schemes.

**Box 1. HCFS time horizon**

"Usually, the health care financing strategies are designed for 5 or 10 years, not much longer than that [...]. Now is the time to take stock and revisit the strategy and figure out how to come up with a more realistic and feasible strategy."

–Representative of Development Partners

"Earlier, people working in the MOHFW did not have a clear idea about generating resources for health care. This strategy has made everything a lot easier. MOHFW are pioneers of many significant policy reforms. The HCFS strategy was a major milestone that gave us a way forward. That document was essential in guiding us nationally. I think we need some changes, however, since there has been a hold on the implementation of the HCFS. It needs discussing in the broader government sphere."

–Former high government official

### *Resource mobilization*

***Limited public financing for health.*** As was shown above, Bangladesh's government collected a relatively small amount of revenue as a share of GDP in comparison with other regional countries, and this limits its ability to finance the social sectors, including health. In 2017 the tax-to-GDP ratio in Bangladesh was 7.00%, the lowest among all countries in the South Asian region and almost 5 percentage points below the regional average of 11.75%. Participants in FGDs and KIIs highlighted this lack of public financing for health as a key obstacle to HCFS

implementation. Respondents also underscored the comparatively small share of the public budget allocated to health, at 3.00% in 2017.

***Complicated and rigid public financial management (PFM) rules.*** Deficiencies in PFM ware identified as another key challenge resulting in the slow implementation of the HCFS. Respondents reported that public providers are overburdened by the excessive demands of existing PFM rules, thus restricting their ability to deliver timely and quality health care. Further, PFM constraints delay the availability of public funds, the recruitment and retention of human resources, and the procurement of drugs and medical supplies. Additionally, current PFM rules impose rigid rules for the allocation of operational funds in health facilities. Interviewees reported that health facility managers are unfamiliar with PFM rules, including those related to public procurement, and that the responsibility for budget execution is frequently shifted among public officials. Also, current PFM practices result in fragmented reporting, weak monitoring, and limited accountability, thus hindering HCFS implementation.

**Box 2. Public financial management**

"If we need to fix health spending then the main issue observed is the capacity and financial management, and we need to fix the public financial management. The Ministry of Finance makes rules that are very hard for the Ministry of Health and its institutions to implement, and they say, 'you cannot spend your money, so we cannot give you more.'"

–International health economist

"The main challenge for the implementation of the tax-financed system will be the lack financial management capacity. For resource mobilization, we need the umbrella act, which would allow resources to flow locally and greater utilization of the budget. We have made very little progress so far, and therefore we might need a longer time for HCFS implementation. There are some training programs for improving public financial management, but they are not enough. All these shortcomings make HCFS implementation challenging."

–Health system expert

"It is not that the other ministries are ahead when compared to the health ministry. This is a generic and universal problem. Nationally, the number of people able to comprehend and continue to work with public financial management issues is very limited. Employee turnover is frequent. Yet, the employees in charge of budget and finance are properly trained. The problems in PFM arise due to the lack of ownership. There is not enough manpower nor is the appropriate amount of time required to understand these issues. […] It takes 5-7 years of working experience for public staff to be able to finally comprehend how the Ministry of Finance functions, and it may take them up to 10 years to start functioning appropriately."

–Ministry of Finance technical staff

***Inefficient and inequitable allocation of government health resources.*** FGD and KII participants acknowledged that, over the years, government has taken multiple initiatives to increase efficiency in resource use by channeling resources to PHC, investing in preventive care and cost-effective interventions, and reducing underspending of resources. But they complained that the MOHFW's budget allocation was centralized and unresponsive to the local needs and demands because it was based on the number of health staff and health facility beds. This input-based budget allocation mechanism also leads to inequity, with large differences in the availability of government health financing among districts. They also reported insufficient technical skills among health staff and the persistence of a wrong mix of health inputs leading to great inefficiency in the resource use. For example, while the MOHFW had deployed doctors and nurses

around the country, recruitment of support staff such as lab technicians, midwifes remained insufficient. A sizable investment in infrastructure had not been accompanied by the needed allocation of staff, medicine, and equipment. Inefficiency was further the result of a centralized decision-making process, staff turnover, and weak monitoring and supervision systems.

Some experts explained that the MOHFW's budget is based on a Medium-Term Budgetary Framework (MTBF) with a three-year rolling budget prepared by its two divisions. The operating budget is based on the number of staff in post (for salary) and the number of beds at facilities (for drugs and diets), and not based on health or health care needs across districts, thus leading to geographic inequity in resource allocation. The following example, included by the authors of this review, illustrates the possible inequities in budget allocation cited by respondents: in 2020, per capita government public spending was highest in the Dhaka division (BDT 2,827) and lowest in the Sylhet division (BDT 747) [HEU (2020) [Public Expenditure Review 1997-2020. MOHFW]. While the concentration of high/complexity public hospitals in Dhaka may partly justify the difference in per capita public spending, greater poverty and limited access to Dhaka for the residents of Sylhet suggest that the budget is inequitably allocated. The absence of needs-based budget allocation rules, results in an inequitable allocation of government health spending.

The budget execution rate of MOHFW dropped from 84% in 2018 to 78% in 2022 and was lower for the development budget (76%) than for the operating budget (79%) (World Bank 2023). In the MOHFW, there is no mechanism to analyze budget execution levels in previous years while preparing the budget, particularly the one for development. There is an inadequate analysis of the expenditure by the economic codes/line items to identify the items with efficient use of the funds, with funding deficits, or with unspent funds in the past. Instead, budget managers usually follow an incremental approach using the previous year's budget. Therefore, the budget distribution among line items does not consider the evidence, capacity, or needs. The budget proposed thus becomes impractical, and some line items remain underutilized (World Bank 2019).

There are several weaknesses in the execution phase including: a lengthy procurement process, delays in the release of funds for the development budget, limited capacity of health managers in budget execution and compliance with PFM, frequent turnover of health managers, and insufficient clarity and rigidity in delegating of financial authority (World Bank 2019). Usually, Line Directors (LDs) of operational plans start preparing procurement plans after receiving the budget at the beginning of the fiscal year, thus delaying the implementation of the plan. Having the procurement plans ready by cost center when receiving the funds would expedite the implementation process. Weak procurement processes and delays in receiving drugs result in inefficiency in budget execution and service delivery. Delays in the release of funds is another cause of underspending of the development budget. The Statement of Expenditure (SOE) is required to request the release of funds for the third and fourth quarters of each year. Inadequate knowledge by health managers about PFM rules and the delegation of financial authority is causing back and forth in decision-making related to disbursement. Moreover, frequent transfer of LDs and health managers hinders the timely utilization of the fund (World Bank 2019).

### *Risk pooling*

***A design partially sound, partially unsuitable.*** As noted several respondents considered the SSK as an appropriate vehicle to cover the BPL population. Yet, they raised questions about the appropriateness and feasibility of a contributory SHI scheme in a country like Bangladesh, where a small formal sector may have limited potential to raise revenue with which to cross-subsidize coverage for the rest of the population. Additionally, they expressed their concern about creating a two-tiered health system like those common in several like Latin American countries, where formal sector workers can finance with their contributions a relatively generous benefits package while the informal sector and the poor have access to a narrower benefits package mostly financed by government. Such a design in Bangladesh could institutionalize inequality. Further, most respondents questioned the feasibility of CBHI for the nonpoor informal, given weak empowerment by communities to run such schemes and mistrust of the population about health insurance.

**Box 3. Scaling up of SSK**

"If we want to achieve UHC, we have to think about scaling up the SSK or doing something else. In the case of SSK, we are planning to slowly cover the entire country. NHSO must be formed before scaling up of SSK because the HEU cannot scale up and DGHS cannot do it either."

–Government official

### *Purchasing*

***Rigid PFM rules and lack of strategic mechanisms to purchase services from the private sector.*** Currently, Bangladeshi citizens obtain 14.4% of health services from public health facilities, 25.2% from formal, private health care providers, and 59.9% from informal health care providers (HIES 2016). Some experts interviewed stated that the private sector should be brought into the reformed system via *public-private partnerships* (PPP). Some also stated that the MOHFW should divest itself from the direct provision of health services and adopt a *purchaser-provider split*. This would require a major shift for the MOHFW, by moving away from its traditional role as the manager of providers to a new role as a purchaser of health services, where it holds others contractually accountable for health care delivery. This shift would require new skills at the MOHFW, including contract management, legal, finance, risk management and monitoring and evaluation.

However, the MOHFW is unable to purchase services from private health care providers due to the current PFM rules. Consequently there is a lack of strategic purchasing initiatives in health by government and few PPPs for health care delivery, especially in rural areas. There are a few examples of PPP in health in Bnagladesh. One of them is the urban PHC project known as MOLGDC, which contracts out NGOs to provide PHC to the urban population.

Regulation and supervision of the private sector are also crucial for strategic purchasing and successful public private partnerships. The importance of this issue has been uttered in the 4th Health, Population and Nutrition Sector Programme (HPNSP), MOHFW. It was planned to develop a comprehensive private health act (to replace the old 1982 ordinance) and to establish a National

Accreditation body for the accreditation of hospitals and diagnostic facilities in private sectors by 2022. However, these plans are yet to be implemented.

**Box 4. Health benefits package**

"We are now treating 110 diseases under SSK. The SSK facilities are not ready to provide protocol-based services to treat those 110 diseases. It is a challenge for us to provide protocol-based services, which we have not been able to do yet."

–Focus group participant

***Insufficient experiences in results-based financing (RBF).*** A couple of respondents mentioned the Maternal Health Voucher Scheme (MHVS) in the context of the lack of public arrangements linking health providers' output with their financing. In line with the reform agenda of the Health Sector Programs (SWAp) in Bangladesh, in 2004 WHO and the MOHFW agreed to pilot the innovative initiative known as the Maternal Health Voucher Scheme (MHVS). This RBF scheme was formally inaugurated in 2007 and is currently running in 55 sub-districts (WHO 2020). In 2012, this demand-side financing (DSF) program became an integral component of the HCFS 2012-2032. However, the DSF program could not be scaled up to other sub-districts to move towards achieving universal coverage in maternal care. The experts who brought up the MHVS suggested that this project's experience could help trigger further initiatives of this sort in the country.

### *Benefits package*

***Coexisting benefits packages.*** FGDs and KIIs participants noted that there are at least two different health benefits packages in the country and wondered whether they would eventually converge into one or remain separate for different health financing schemes. They noted that, in addition to the Essential Services Package (ESP), the recently piloted SSK scheme has its own benefits package offering coverage of inpatient services for 110 diseases, including necessary medicines, diagnostics, and transport costs. The scheme covers benefits up to BDT 50,000 per household per year (about US$ 461 at the current exchange rate of 108.45 BDT per US dollar). However, the facilities are facing challenges in providing the services under SSK.

The SSK benefits package currently does not cover outpatient care or PHC services. One expert interviewed stated that these exclusions may explain the rather low overall use outpatient services, particularly in more remote sub-district locations where the ambulatory services contained in the ESP are not readily available. The already planned extension of the SSK package to outpatient services will be important in strengthening the scheme although assessing the cost and implications of doing so requires further planning. It will likely improve access to care, from the PHC level up, and may also improve access to hospital services through the referral system. This is a point made by Ensor [2018] in his review of SSK.

### *Leadership and governance*

**Box 5. Leadership and governance**

***Weak leadership and governance.*** Bangladesh has a pluralistic health system where multiple entities engage in health service provision: the MOHFW, the MOLGRDC, private for profit, and private nonprofit (non-governmental organizations, NGOs) engage in health service provision. Strong leadership and governance are required to coordinate, monitor, and regulate this diverse network of health providers. To date, the private sector remains largely unregulated, while service quality vary widely across different types of providers.

"The main objective of establishing the NHSO is to achieve UHC. And, once created, the NHSO's mandate would be to cover the entire population of the country […] It is not possible to cover the whole country in just one step. So we have to start with the BPL population with SSK and then progressively expand coverage to the rest of the population. Still, we spent too much time piloting the SSK scheme for the BPL. We now need to expand this scheme faster."

–Government official

"I do not think the entity responsible for implementing the HCFS needs to be a separate institution; you can quite easily make it part of the MOHFW, provided that it has some kind of genuine autonomy within the Ministry, meaning that it has some sort of authority over the funding, so there is clear funding for that office. Not just to run it, but it has the authority for spending the insurance scheme or whatever you call the system […]. If you cannot do that within the Ministry of Health, then I guess that is why some countries have chosen to make it separate and maybe a subordinate of the ministry."

–International health systems expert

The HEU became the de facto entity responsible for the implementation of the HCFS, including the piloting of SSK. Yet, several participants in the FGDs and the KIIs believe that the HEU should not be given that responsibility because it is not part of its mandate and it lacks the required skills. Rather, the HEU could assist in generating evidence and policy advocacy related to HCFS implementation. Insufficient coordination between the HEU and other implementing bodies, in particular the MOHFW and development partners, has also been accounted for delays in implementation of the HCFS.

Additionally, some experts interviewed stated that the HCFS was fine on technical grounds, but lacked political support across different ministries and offices, including the Prime Minister's Office, the Ministry of Finance, implementing bodies under the MOHFW (DGHS, DGFP) and development partners.

Whereas the HCFS called for the creation of the National Health Security Office (NHSO), to manage the SSK and the contributory regime of formal workers, respondents had mixed opinions about the merits or the feasibility of such an initiative. Those in favor argued that health service providers were overburdened with financial management responsibilities and that a different body should be in place to manage the finances of the reformed system. However, some stated that the NHSO would fail due to existing weaknesses in governance and accountability.

**Box 6. Leadership and governance (continued)**

"The capacity of the HEU to go ahead with the strategy implementation also needs to be looked into. Since the reviewing process has started, we need to understand where we stand now, how far we can go, and whether it is at all achievable within 2021. These are some general observations from my side. The MOHFW is now bigger than before. It has two divisions, there will be difficulties from the policy side, and there might be some organizational issues."

– Former high government official

"It is the responsibility of all the stakeholders working in the health sector to evaluate, monitor, and follow up on the implementation of the HCFS. However, in reality, there is limited political buy-in of the HCFS, which is a major constraint in implementing the HCFS."

–Representative of development partners

"The HCFS was a product of the HEU, so it is the responsibility of the HEU to provide an update on the progress and to regularly evaluate the program progress. The concerned ministries and departments should sit and discuss what needs to be done to ensure implementation of the HCFS. There can also be consultations with stakeholders from different levels to facilitate changes in the strategy."

–Former high government official

Indeed, there is a need of dedicated body who will oversee the health financing activities and monitor the implementation and provide guidance to the implementing bodies. But the MOHFW has not been able to establish such a body.

On the other hand, stewardship role over the health sector is much weaker for establishing effective and efficient health services delivery arrangements by both public and private sector in terms of organizational effectiveness, facility management, , transparency and accountability in the procurement process, human resource management and regulatory functions and control.

While 77% of expenditure of health is private, a strong stewardship role of the government over the private sector is crucial to contain the excessive price of health services and ensure the quality as well. Indeed, government regulatory functions are much weaker to oversee and control the vast private sector of the country.

### *Supply side readiness*

***A weak supply-side system.*** There were multiple references by participants in FDGs and KIIs to pervasive deficiencies in the public network of health facilities. Some respondents even stated that the most important policy action required, even before a health financing reform, was the

strengthening of public supply (Box 7). Bangladesh has an extensive network of government hospitals at community, upazila (sub-district), and district levels. Participants noted that despite significant annual budget allocations for infrastructure development and equipment procurement for these facilities, only about one-fourth of them have basic equipment while only one out of five upazila health complexes has functioning x-ray machines. Public hospitals are not equipped with oxygen and ventilators, two medical inputs essential for the COVID-19 response.

Interviewees also reported that alongside a deficit of essential equipment are extensive workforce shortages. Emergency services in public facilities are dysfunctional and services are provided for limited hours at the upazila and district levels. Demotivation of the existing health workforce resulting from the lack of a clear career path had been identified as a major challenge in the health sector. Other key problems include weak retention of health staff in rural areas, absenteeism, large vacant posts, and absence of public health experts.

**Box 7. Supply-side readiness**

"Supply side readiness in the public sector is not up to the standards. Additional investment would be needed there to strengthen the health system and those initiatives should be funded well."

–International systems expert

"'Whichever health financing strategy you want to implement, we first need to ensure that we have quality health care providers at the service points. Otherwise, it would not be possible to implement any strategy."

–Academician

'What I understand is that the main problem is the readiness of the health system to have such a health protection scheme (SSK). We have facilities, but we lack in human resource and equipment."

–Health system expert

"Whether it will be a tax financed health system or a social health insurance system, quality providers are essential. We should put more emphasis on capacity development of health care providers."

–Health system expert

'There has been implementation of SSK in a small manner which has not progressed after a certain time. We need to explore the roles and activities of the other stakeholders concerned. The role of Directorate General of Health Services particularly needs to be explored. Besides, the performance of health facilities and other stakeholders involved in the process could be evaluated.'

–Former high government official

They also mentioned the lack of medicines and supplies in public facilities (only 3% of the drugs consumed by households are obtained from government health facilities; HIES 2016). High cost of the drugs, and diagnostic tests are major reasons behind high OOPS. More generally, high OOPS for drugs and diagnostic tests results from multiple factors, including the absence of a structured referral system, the sale of drugs without prescriptions, and unregulated private sector, and aggressive marketing of the pharmaceutical industries. The absence of referral system also creates unnecessary pressure on secondary and tertiary care, leading to inefficiency of resource use.

One respondent stated that a comprehensive health information system is crucial for proper planning and progress monitoring among health care providers. The MOHFW has launched the digital platform known as Demographic and Health Information System 2 (DHIS2) to gather

patient-level data from both public and private providers. However, population level data is scarce, and there are no real time data sources. A robust system with regular flow of quality data should be in place for successful implementation of the HCFS. The iBAS++ is still evolving and needs to be aligned with the analytical needs of the MOHFW.

### (c) The piloting of SSK: Design and evaluation

Greater pooling of health finance is pivotal to the extension of UHC in Bangladesh. The HCFS 2012-2032 focused on an insurance approach to extending pooling first to the population below the poverty line (BPL) and later to groups in employment. The SSK scheme, which aims to cover the country's estimated 30% of BPL households was implemented in 2016 in three pilot upazilas in Tangail district.

The SSK scheme is pool funded through an HEU operational plan. The scheme began operation in Kalihati upazila in March 2016 before being rolled out to Ghatail and Modhupur in September 2017. In each of the pilot sub-districts, the 50-bed upazila hospitals, which have referral linkage with the Tangail district hospital, function as the first contact facilities for SSK enrollees. The SSK cell in the HEU contracted out and SSK scheme operator (SO, Green Delta) to register BPL households and to process health care provider claims. The SSK also engaged private pharmacies, diagnostic centers, and suppliers of support staff to facilitate the smooth functioning of the scheme. The SO visits all households previously identified in a census and registers those that qualify. The SSK health benefits package currently covers 78 inpatient conditions. Patients seeking treatment initially visit the SO desk at the upazila hospital before an outpatient consultation or inpatient referral. Facilities bill the SO periodically for inpatient services rendered based on a case-based payment system. The SSK covers benefits up to BDT 50,000 (US$ 474.20) per household per year.[5] An SSK Cell was established to function as a management, planning, implementing, and review body to verify claims made under the SSK scheme. A high-level national steering committee headed by the Secretary of the MoHFW's Health Services Division (HSD) is responsible for inter-ministerial and policy decisions in support of the scheme's successful implementation.

Chowdhury, Hasan, and others (2021) carried out an evaluation of the SSK pilots focusing on the pilot's following key outputs: (a) reduced financial hardship among the poor due to out-of-pocket health care spending (OOPS); (b) increased access to inpatient health care services among the poor; (c) establishment of health care quality standards; and (d) improved efficiency and transparency in hospital management. The SSK evaluation had the primary objectives of assessing SSK's effectiveness in reducing OOPS among the scheme's beneficiaries, as well as catastrophic and impoverishing health expenditure. Secondary objectives aimed to assess the readiness of the SSK facilities for providing the selected SSK services; patient load and referral patterns at the SSK facilities; compliance with and the correctness and completeness of treatment protocols; patient satisfaction with utilization of SSK services; the challenges related to scheme implementation from

[5] At the exchange rate of March 9, 2023.

both demand- and supply-side perspectives; the claim settlement process through a review of financial records.

Evaluation methods included a community SSK assessment by comparing intervention with control areas, an assessment of SSK health complexes and referral hospitals, a review of treatment protocols, patient exit interviews, and a review of patient and financial records at SSK facilities.

Main findings from the SSK pilot evaluation are as follows:

- ***Community assessment.*** BHP households using their SSK cards had significantly lower OOPS but he SSK intervention had no effect on the reduction of impoverishment. In the intervention area, almost 80% of the selected villages had been provided with SSK cards although one-fifth (18/90) of the sampled villages were not covered by the SSK intervention. There was a significant targeting error, however, in the granting of SSK cards: about 58% of the SSK households were confirmed as true BPLs, while the remaining 42% were found to be non-BPLs.
- ***Facility assessment***. SSK facilities were well endowed with equipment and supplies except for the availability of functional generators and communication equipment some upazila health centers.
- ***Treatment protocol review.*** Overall compliance with the treatment protocol was 70% and did not improve over time.
- ***Qualitative assessment.*** Weak community engagement activities resulted in insufficient motivation among SSK cardholders to seek services at SSK facilities. Also, the scheme was impacted by the difficulty of retaining doctors, although this problem was recently addressed in part by posting fresh doctors. However, about 80% of consultant posts remain vacant in the SSK upazila health centers and in the referral hospital. A lack of specialist providers and their absence at night in upazila health centers led to the direct referral of emergency patients were directly sent to the referral hospital, causing delayed care and patient dissatisfaction. Generally, the SSK districts failed to adopt a performing referral system. All service providers felt overburdened and demotivated to care for SSK patients partly because of the required management burden and the lack of incentives. Gaps in the supply of medicines and diagnostic services to SSK patients were also reported. Claims management was more demanding than anticipated. Moreover, there was insufficient collaboration between the HEU with the Directorate General of Health Services (DGHS) and the Health Services Division of the MoHFW for the successful implementation of SSK. Thus, no effective performance monitoring and supervision system was implemented to detect and overcome problems. Also, there were undue HEU delays in claim settlement owing largely to a shortage of at the HEU.
- ***Exit interviews.*** Overall satisfaction of SSK beneficiaries was between good to moderate. Patients were most satisfied with their privacy during diagnostic tests and

least satisfied with providers sharing information about treatment. About 80% of beneficiaries received all prescribed medicine from the SSK pharmacy, while about 90% received all recommended diagnostic services under the scheme. Patients reported dissatisfaction with the availability of drinking water and being satisfied with the overall cleanliness of the health care center.

- ***Record review.*** Overall utilization of inpatient care increased in SSK facilities throughout the review period, but SSK scheme utilization decreased slightly in the first semester of 2019.

The reviewers of the SSK pilot recommended the following:

- ***SSK scaling up.*** Within the next three years SSK should be expanded to all 12 upazilas of Tangail district. Over the next six to ten years, the final SSK model should be scaled up to all 64 districts in Bangladesh in a phased manner. Poor and difficult-to-reach upazilas with relatively deficient health service infrastructure should be targeted first.
- ***Strengthening of SSK's operational components.*** Improvements should be made to the BPL identification process; information dissemination among SSK cardholders; the computerized system supporting the treatment of comorbidities; the dispensation of medicine to follow-up patients; the readiness of the SSK facilities; the non-clinical facilities and services; the referral system from SSK UHCs to higher-level facilities through improved ambulance support services related management procedures; services at contracted pharmacies and diagnostic centers; the transportation for inpatients to contracted diagnostic center. The SSK 78-disease list should be modified based on local needs and the collection of bedside specimen should be adopted for critical patients.
- ***Improving joint institutional work.*** Collaboration should be improved between the HEU and DGHS should jointly work on the development and improvement of the information technology system for the management of BPL card holders, patients at SSK facilities, and financial documents; and function as strategic partners for policy research and service delivery, respectively, in support of a nationwide scale-up of SSK. Collaboration should also improve between the HSD and the MoHFW to fill consultants' vacant posts at both the SSK UHCs and the referral hospital.
- ***Strengthening of monitoring and supervision.*** The HEU should develop and implementing a monitoring framework.
- ***Increasing provider motivation.*** The HEU develop innovative models such as non-financial incentives for doctors and nurses and non-practicing allowances for consultants. Local level hiring of consultants using the SSK funds could also be a possible strategy for reducing the shortage of consultants.
- ***SSK scaling up in urban areas.*** Government agencies should develop an SSK model that caters to the health care needs of the BPL population in urban settings, particularly those living in large cities.

- ***Institutional strengthening.*** Setting up of National Health Security Office (NHSO). For effective SSK management of the SSK, such a body be established for regulatory and management-related activities.

However, the participants of the FGD reported several operational challenges in scaling up SSK. The organizational capacity of HEU needs to improve further for scaling up SSK in other districts. The IT platform for SSK is yet to be functional, and HEU has taken initiatives to develop IT automation. Currently, there is no provision for updating the SSK card to include a new member of the BPL household. The claim management and verification process, in most cases, becomes difficult and inappropriate as the treatment of patients and claim documents are not provided following the disease protocol of SSK. There is no clear path of transition of SSK from the pilot stage to the full implementation stage. The respondents urged the need for establishing NHSO before scaling up SSK. However, any notable progress in establishing such a regulatory and management body is yet to be seen.

# 6. DISCUSSION

***The strategy.*** Ten years ago Bangladesh's MOHFW of released its Health Care Financing Strategy for the next 20 years, calling for the creation of three separate schemes designed for three different population segments. PHC facilities would be reinforced through public financing to ensure that they would be able to respond with quality services to demand for covered services. Treatment protocols, including referral criteria, would be developed and implemented to set up a medically appropriate journey for patients between primary and hospital care. A payment system was devised for SSK to pay providers for services rendered to its beneficiaries. To ensure that enough financing would be available to create and support the operations of these three schemes, a new, autonomous public agency, named Health Equity Fund or National Health Security Office (NHSO) would "handle the financing of the social protection program".

***Progress to date.*** To date only one of the three of the strategy's schemes –SSK for the BPL population– has been initiated in the form of three pilot tests. These tests have been evaluated with rather encouraging results and the current recommendations by the evaluators is to scale up this scheme to the entire country (Chowdhury, Hasan, and others 2021). Specifically, they recommended that within the next three years SSK should be expanded to all 12 upazilas of Tangail district. Over the next six to ten years, the final SSK model should be scaled up to all 64 districts in Bangladesh in a phased manner. Poor and difficult-to-reach upazilas with relatively deficient health service infrastructure should be targeted first. The CBHI scheme for the nonpoor informal population has not yet been implemented or piloted. The SHI scheme proposed for the formal population has been the subject of debate in the country and has not yet been initiated. Much of the discussion on SHI has focused on a particular segment of the formal sector, namely, civil servants. An actuarial study about the financial feasibility of SHI for civil servants was carried out (Hamid 2014). Additionally, the WHO commissioned a policy brief on the subject (Bitrán 2021a). A World Bank note on SHI for civil servants in developing countries was circulated among national decisionmakers and experts (Smith 2018).

The limited implementation of the HCFS to date has led to discussions within government regarding the appropriateness of the strategy, and the factors that explain its delayed implementation. The current study, commissioned by the WHO/Bangladesh, sought to address those issues and to recommend, where appropriate, changes in strategy design and mechanisms to ensure effective implementation.

***Reasons for slow and partial implementation.*** There seem to be two kinds of reasons behind the strategy's limited implementation. *First, there's is a lack of consensus among national policy makers about the appropriateness of some of the strategy's central elements*. Specifically, there are questions about the suitability and feasibility of CBHI as the primary mechanism to cover the largest share of the population, comprising the nonpoor informal sector. The review of country experiences provided in this report shows that aside from Rwanda –a country that has benefitted from huge external assistance in health–, no other developing country has managed to cover its

entire population through an array of CBHI schemes. It is therefore doubtful that Bangladesh would succeed where so many others have failed. Additionally, there a questions about the rationale for and merits of SHI. SHI would cover only a small share of the country's population (about 15% or less). An actuarial study showed that SHI could be feasible for civil servants and a policy note showed that many other developing countries have started their SHI regime by first covering civil servants (Bitrán 2021a). Still, some experts believe that the creation of SHI for this population segment could set the basis for a two-tier health system, with a few covered by a regime that would confer a broader and better financed package of health benefits of better quality, and the remaining large majority of the population getting more limited health benefits. Of the three social protection schemes proposed in the HCFS, only one, the SSK, has shown some progress by conducting the already mentioned pilot tests and by planning its national expansion.

*The second apparent cause of the delay in implementation seems to be the limited operational capacity of the MOHFW, specifically of its HEU, which de facto has been given the responsibility of implementing the entire HCFS*. The recently-conducted study that evaluated the SSK pilots also concluded that the scaling up of SSK would benefit from institutional strengthening. Specifically, they recommended that the NHSO be set up for effective scaling up and management of the SSK scheme. The establishment of such a body was also a part of the financing strategy but has been delayed up until today.

The remainder of this section discusses the main problems related to the design and implementation of the HCFS. The discussion is organized according to the six policy levers or core health financing functions introduced in the conceptual framework of section 3: Resource mobilization, pooling, purchasing, benefits package, leadership and governance, and supply side readiness. The section is followed by a final section offering a set of concrete recommendations for the way forward with health financing reform in Bangladesh.

### (a) Resource mobilization

***Limitations in public financing.*** A common impediment to the achievement of UHC in any country is the lack of public financing to pay for the cost of coverage for the large share of the population which cannot not defray those costs with their own resources. In this respect, Bangladesh finds itself in a particularly challenging position. It is a country that has shown high economic growth over the past decade, yet this growth had not translated into an increase in the amount of public financing allocated to health. This is so for two main reasons.

The first is that the country's treasury collects only a comparatively small share of its GDP in the form of taxes. Indeed, the fiscal capacity of Bangladesh's government is very constrained. The analysis presented in section 4 of this report showed that among South Asian countries, Bangladesh is the one that has the lowest fiscal capacity. Its government collects only about 7% of GDP through taxes. This contrasts with the much greater fiscal capacity of other countries in the region, such as Nepal (15.8%), Pakistan (15.4%), India (12.0%) the Maldives (20.1%) and the regional average (12.6%). This limitation, which apparently is structural, will remain a major

impediment to the country's UHC ambitions. Unless this barrier is overcome, efforts to advance toward UHC will face weak prospects for success.

But it is not only the limited fiscal capacity of the country that gets in the way of UHC; it is also the nature of the government's prioritization of its budget toward the health sector. Here, too, the analysis presented in this report reveals that of all countries in South Asia it is Bangladesh the one whose government spends the smallest share of its total public expenditure to the health sector, 3%%. This is a relatively small amount that contrasts with Nepal's 4.5% Pakistan's 3.4% and Sri Lanka's 4.1% It is just under one-half of south Asia's average of 5.0%.

Strengthening the government's fiscal capacity may take time and should not be counted on as the short- or medium-term solution. In contrast, what could be remedied in the short-term is, in principle, the share of the public budget going to the health sector. This is the same conclusion that the World Bank's report on fiscal space for health (also reviewed here) reached.

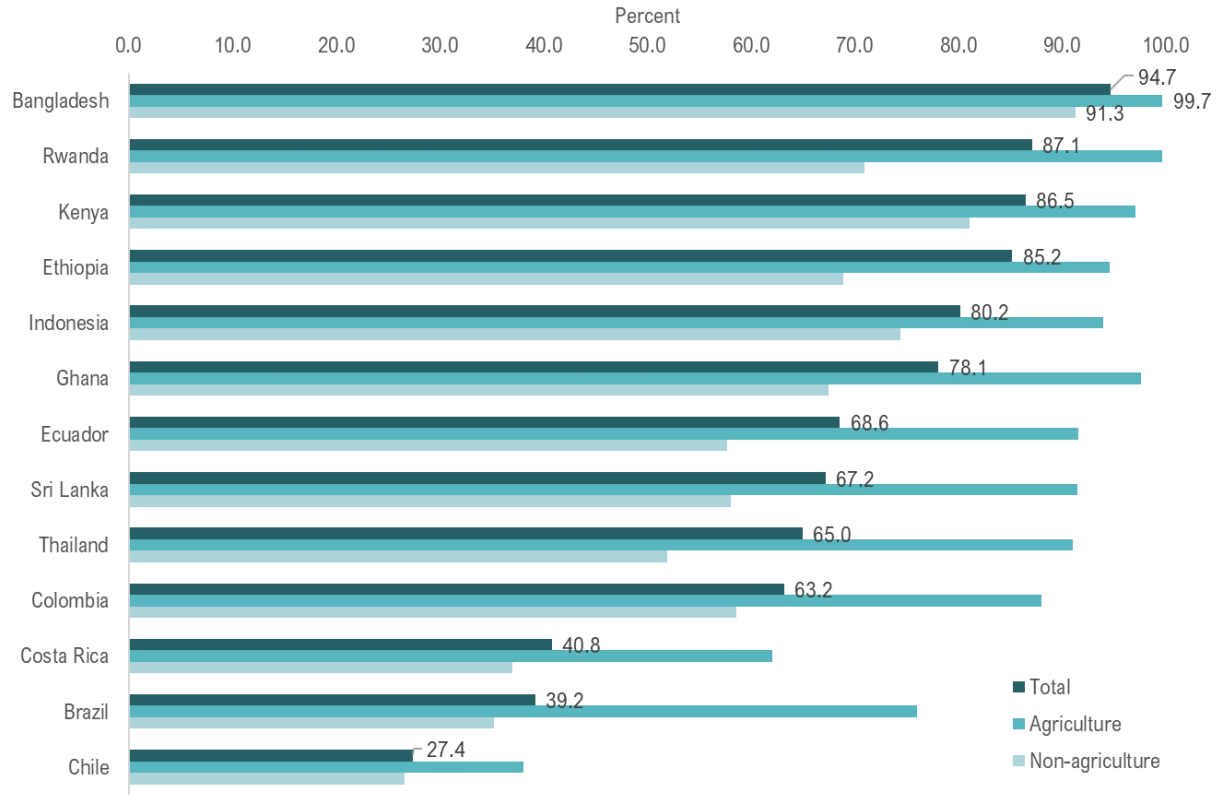
In sum, Bangladesh will swim against the tide when attempting to make significant progress toward UHC without solving the public financing problem, no matter which financing strategy it chooses. Expanding SSK will consume large volumes of public financing based on the amount of resources used to conduct the SSK pilots, and on estimates of the financing required to overcome the weaknesses detected through the pilots' evaluation. It would be possible to estimate the additional total volume of financing necessary to scale up SSK to the entire BPL population of the country. It would therefore be relatively simple through this exercise to determine the total incremental public financing needed for SSK implementation, and the required share of the public budget that should be incrementally allocated to health to make SSK possible.

***Coverage for the nonpoor informal.*** What to do with the large sector of nonpoor informal workers and their families remains an unsolved issue in Bangladesh. The review of the country case studies presented in this report showed that those nations that have achieved UHC through SHI have done so thanks to massive public subsidization of coverage for the nonpoor informal. That is the case of Chile, Colombia, and Costa Rica in South America as well as that of Thailand and Vietnam in Asia, and that of most if not all developing and industrialized countries that have adopted the SHI approach. Gertler (1998) showed that the Asian countries that were able to achieve UHC through SHI in the 1980s and 1990s, such as Singapore, Korea, and Taiwan, were ones that experienced high and sustained economic growth for two or more decades and that consequently were able to draw on additional tax revenue generated by their economic bonanza to subsidize coverage for the poor and the nonpoor informal.

Any developing country envisioning health care reform to move towards UHC should consider the key features of its population, including the distribution and level of income, the geographic distribution of the population in urban and rural areas, the population's familiarity with the concept of insurance, the readiness of supply of public and private health care services, and the employment status of the population, among other factors. Bangladesh stands out for the large size of its informal sector. The most recent employment statistics available from the International

Labor Office show that 94.7% of Bangladesh's population lives in households with informal employment. As can be seen from Figure 21, this is the largest percentage of informality of all countries included in the case study review of section 5.[6]

**Figure 21 Proportion of informal employment in total employment by sector for selected countries (%)**




Source: Constructed by the authors from ILO employment database, SDG indicator 8.3.1 - Proportion of informal employment in total employment by sex and sector (%)

This feature of Bangladesh limits the options available for health financing reform. To date, the international experience has shown unambiguously that where labor informality is high, a national SHI system financed partly by contributions by the informally employed is infeasible as a mechanism to achieve UHC. The reason for this is that no country to date has successfully managed to get the nonpoor informal sector workers to contribute a financially relevant amount to an SHI scheme, even if contributions are mandated by law (Bitran 2014b).

This is a fact that those designing Bangladesh's HCFS have clearly understood and explains why they did not recommend as part of the HCFS that the nonpoor informal participate in SHI. That was the correct design decision, but what was formulated instead, a social protection scheme based on CBHI, is not backed empirically as a policy option that has proven its broad feasibility. Only a few developing countries have attempted to set up a national system of CBHI as the means

[6] The discrepancy between the ILO figures for informality in Bangladesh and those estimated in the HCFS 2012-2032 Health Economics Unit (2012) must be sorted out.

to reach UHC. The most prominent and successful example to date is that of Rwanda, whose experience was reviewed in section 5 of this report. Another African country that is actively implementing a CBHI model similar to Rwanda's is Ethiopia, also described in section 5. Nevertheless, Ethiopia has not yet succeeded in achieving broad implementation of CBHI, and it is unclear is the government of that country will have the financial resources necessary to subsidize CBHI nationally, considering the poverty levels of the country and constraints in its health care delivery system. It is worth mentioning, however, that Ethiopia has set up an institution responsible for implementing UHC. It is not a Ministry of Health unit but rather a separate public institution – the Ethiopian Health Insurance Agency–, whose exclusive mandate is the support of efforts to advance UHC.

The recent policy proposals in Bangladesh about expanding of SSK to the informal population have merits, in light of the international experience reviewed here and other familiar to these authors. But its feasibility, or the significance of such a policy if adopted, as measured by increased access to quality health care, greater financial protection, and improved health status will largely depend on the amount of public subsidies backing this policy option.

***Is SHI the way to go in Bangladesh?*** Some experts are contrary to the setting up of SHI in developing countries. Prominent opponents have recently published two papers where they express their reviews about the drawbacks of SHI (Yazbeck et al. 2020; Yazbeck et al. 2023). One of their criticisms is the large size of the informal sector, and the near impossibility are collecting mandatory premiums from them. Another argument of SHI detractors in the developing country context is that payroll taxes have a distortionary effect on the cost of labor. These arguments are to be considered seriously in Bangladesh. However, in light of the constrained public finances, SHI for the formal sector offers the prospect of injecting fresh resources into the health financing stream. SHI appears as a possible solution for the entire formal sector, and not just only for civil servants.

In previous sections of this report, the authors described the incremental approach that several developing countries have adopted to achieve UHC via the SHI model. As shown, incremental coverage expansion efforts have begun with civil servants, followed by the employees of large, firms to then move towards other segment of the formal population. Rich countries which set up SHI systems, such as Japan, Singapore, and South Korea, followed this expansion path.

Critics of this approach argue that creating different coverage schemes for different segments of the population under SHI results in a two-tier system characterized by inequity in access. They argue that putting an end to the two-tier system and integrating the various schemes is difficult. The experience of several Latin American countries, including Chile, Colombia, Argentina Ecuador, the Dominican Republic, and others shows that it is indeed difficult to put an end to a two-tier SHI system

It is not impossible, however. There are several examples of developing countries that followed the SHI coverage expansion approach through two tier SHA system, which years later decided to

integrate those different systems into a single one. A recent publication by the International Labor Office reviewed the experience of Costa Rica, Indonesia, Lao, PDR, Rwanda, and Vietnam with the integration of social health protection schemes. The authors of the report demonstrate that it is possible to progressively put an end to segmented SHI system overtime and that doing so calls for incremental public financing.

China is an example of a country that expanded coverage via three separate and different SHI schemes, one for the poor rural, another for the informal rural, and a third one for the formal urban. For years, the three schemes had three separate health benefit packages. The schemes for the poor and the informal received a sizable public subsidy, whereas the scheme for the formal sector, self-financed with contributions by workers and employers. China is now attempting to integrate is three systems. It will require significant public resources to do so.

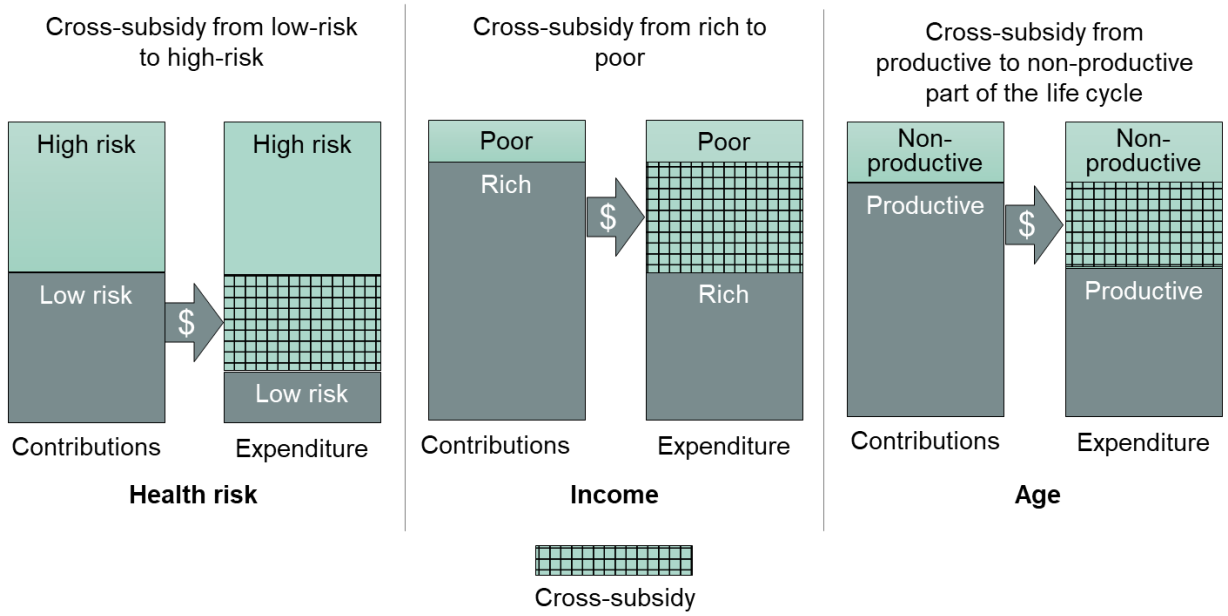
Indeed, the lack of flexibility of public financial management system in Bangladesh and inefficient financial management are considered as bottleneck for effective health spending. Evidence showed that health budget planning and allocation sometimes cannot meet the national health policy objectives and even public investment for health fails to make impact to the society at a satisfactory level[1]. On the other hand, underspending of health budget, particularly development budget, is a persistent problem in health financing, which even weakens the stance of MOHFW for demanding higher share of national budget for health from the Ministry of Finance.

### (b) Risk pooling

In health, risk pools are established to spread the financial risk of infrequent and expensive health events among a large number of individuals. Bangladesh, being a country of 169 million people, could easily set up multiple risk pools, each large enough to prevent its financial collapse owing to catastrophic health events. There are, however, additional reasons why risk pools are established in health, and that is for equity and solidarity reasons. This is explained below with the help of the Figure 22.

In a system where financial contributions for prepayment are set independent of a person's current or expected health status, those with low health risks end up subsidizing with their contributions the health expenditures incurred by those with higher health risks (left panel of Figure 22). This is possible if individuals with varying levels of health risk are pooled together. A second kind of cross-subsidy occurs when the poor and the rich are pooled together and the contributions made by the rich are higher than those made by the poor (or only the rich contribute and the poor get a waiver) (center panel of the figure). Thus, the rich end up subsidizing the health care costs of the poor. Finally, a third cross-subsidy arises when the young (or productive) and the old (unproductive) share a risk pool. The young, who are economically active, are required to make greater contributions than the old, who are retired, and therefore the former confer a health subsidy to the latter (right panel).

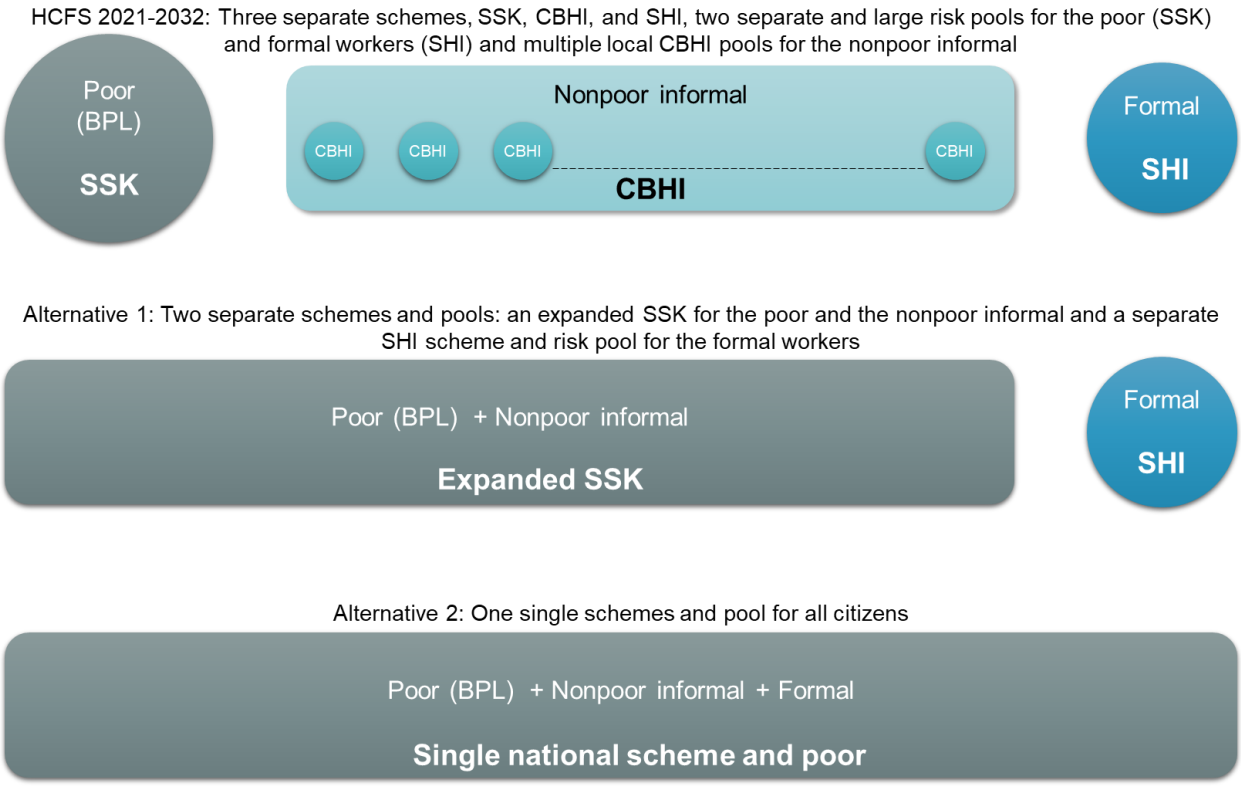
**Figure 22 Pooling of revenues implies transfers (a) from healthy to sick (b) from rich to poor and (c) across life cycle**




Source: Adapted by the authors from Smith and Witter (2004).

The above framework facilitates a discussion of the strengths and weaknesses of alternative health care financing designs in Bangladesh. The HCFS design considered three separate schemes (SSK, CBHI, and SHI), two separate and large risk pools (SSK and SHI), and multiple local CBHI pools for the nonpoor informal (top panel of Figure 23). These three separate schemes would likely have different health benefits packages, because of the inevitable differences in per capita revenue among the schemes, and this would be inequitable: The SHI scheme would likely have the greatest amount of financing per beneficiary while either the SSK or the CBHI would have the smallest amount of financing. In addition, some of the CBHI pools, if they were created, could be too small to remain financially viable, or they could go bankrupt because of adverse selection (those with poor health would be more willing to join CBHI), as the national and international evidence shows (Wang et al. 2006; Parmar et al. 2012; Ahmed et al. 2018).

**Figure 23 HCFS: Alternative designs**




Source: The authors.

An alternative design is that already being proposed by some experts in Bangladesh: a single scheme –an enlarged SSK– that would cover both the poor and the nonpoor informal (center panel of the above figure). In the authors' view, it would be a more viable design and also a more equitable one if the two population groups obtained the same set of health benefits.

Finally, a third possible design is that depicted at the bottom of the figure, with a single national health scheme covering all citizens and offering the same set of health benefits to all, to improve equity in access. Such a unified scheme may be technical viable but may face resistance by some stakeholders, particularly formal sector workers who have a greater ability to contribute to health insurance and who may expect a benefits package in accordance with the contribution, and greater than that given to the BPL and the nonpoor informal.

There are several other possible financing designs not worth discussing here; the issue of the institutional architecture, or policy design, is further addressed in the final section of this report. In the authors' view, the second and third options shown above may be technically more viable in practice (they may be susceptible of implementation) although the third one may face greater political opposition by some stakeholders. Two factors will determine the success of whichever design is chosen: the amount of public financing available for health and the capabilities of the entity responsible for the strategy's implementation.

### (c) Purchasing

Bangladesh's health care system faces several challenges, including inefficiencies in resource allocation, the near absence of strategic purchasing, and a lack of strategic mechanisms for purchasing services from the private sector. The allocation of government financing across regions and among public providers is not based on health care needs but instead on the current configuration of supply capacity (staff numbers, facility beds), leading to geographic inequities.

The government's ability to purchase services from private health care providers is restricted due to current financial rules. This hinders strategic purchasing and public-private partnerships (PPPs) in health care delivery, particularly in rural areas. To enable such partnerships, the MOHFW may consider introducing strategic purchasing initiatives. These may prove necessary as part of the health care financing reform being considered.

The experience of other countries with new purchasing methods as part of their health financing reform is worth considering. For example, the success of Rwanda's policy relied in part on a major reform in provider payment methods. For years Rwanda implemented a system of performance-based financing for public health care providers which has been an integral part of that country's UHC reform.

### (d) Leadership and governance

Leading a major health care financing reform, starting with its clear formulation and followed by its implementation, calls for a specialized organization endowed with considerable human and financial resources. The HEU does seem not fit that role.

The HEU has taken on the responsibility for implementing the HCFS and piloting the SSK scheme, but some experts consulted for this review believe it lacks the mandate and capabilities for this role. Instead, they suggest the HEU could focus on generating evidence and policy advocacy related to HCFS. Further, reportedly there has been Insufficient coordination between the HEU, the MOHFW, and development partners, and this has caused delays in HCFS implementation.

It is these reviewers' view that the HEU should not take on implementation responsibilities for a revised HCFS. That is not the role this organization was created for; the HEU is essentially an institution created to provide analytical support for health policymaking.

While the HCFS proposed the creation of the National Health Security Office (NHSO) to manage the SSK and the contributory regime for formal workers, opinions about its feasibility and merits are mixed. Advocates argue that a separate body would relieve health service providers of financial management burdens, while others believe existing governance and accountability weaknesses could lead to the NHSO's failure. A study by the Institute of Health Economics (2023) offers arguments in favor of the creation of the NHSO. It notes that "the HCFS 2012-2032 suggested establishing the National Health Security Office (NHSO) to manage social health protection schemes." This study views the NHSO's role as the entity responsible for purchasing health care

from both public and private sectors to ensure health care access according to the needs of the people.

These reviewers believe that the effort required to implement a major health care financing reform in a country as large and diverse as Bangladesh calls for a specialized organization. It could be an entity functioning within the MOHFW or one set up as a body with management authority outside of the MOHFW. Setting up a single or large public purchaser may be a required feature of the revised HCFS if a decision is made to split the purchaser and provision functions currently in the hands of the MOHFW. But HCFS implementation is an effort that goes well beyond the setting up of a large public purchaser of health services. The following is a list of typical implementation activities required under a major health care financing reform like that envisioned for Bangladesh (some of the listed activities have already been completed in the country, partially or full):

1. The formulation, costing, and financing plan for the single or multiple health benefits packages
2. Formulation of standard treatment protocols for the services in the benefits package(s)
3. Health staff training on the use of treatment protocols
4. Assess availability of human, pharmaceutical, and infrastructure resources to be able to deliver the package(s) in accordance with quality standards (providers readiness assessment)
5. Invest in needed resources among health care providers, including the training of health workers (supply-side strengthening)
6. Set up and implement new provider payment systems for public and private providers delivering covered services at ambulatory and inpatient levels
7. Set up and implement a system for the accreditation of health care providers
8. Design and implement computerized information system for beneficiary identification
9. Set up social services offices around the country to enroll beneficiaries
10. Carry out a baseline and a follow up survey to assess the performance of the health care financing reform
11. Legal creation, staffing, and training of national health insurer(s)
12. Design and implement information campaign to explain the new health financing scheme to the population
13. Begin operations including the collection of any required contributions by members and by government
14. Begin provision of covered services
15. Concurrent performance assessment on a monthly basis to fine tune operations

The government of Bangladesh, through its MOHFW, will need to define who will be responsible for the successful execution of all these implementation activities.

### (e) Supply-side readiness

Key to the success of a health financing reform is the existence of a well-endowed and well-functioning health care delivery system. Yet, Bangladesh's health care system faces numerous challenges. Despite recent public investments in infrastructure and equipment, only a quarter of government hospitals have basic equipment, and only one in five upazila health complexes has functioning x-ray machines. Public hospitals lack essential medical inputs like oxygen and ventilators crucial for responding to COVID-19.

The health care system also suffers from extensive workforce shortages, dysfunctional emergency services, limited service hours, and demotivated health workers due to a lack of clear career paths. Retention of health staff in rural areas is weak, absenteeism is common, and there are numerous vacant posts, including a shortage of public health experts.

In addition to equipment and workforce shortages, there is a lack of medicines and supplies in public facilities. The majority of households obtain drugs from non-governmental sources due to high drug costs and limited availability in government health facilities. This leads to high Out-of-Pocket Spending (OOPS) for drugs and diagnostic tests, influenced by factors such as the absence of a referral system, unregulated private sector drug sales, and aggressive marketing by pharmaceutical industries. The absence of a structured referral system results in unnecessary pressure on higher-level health care facilities, leading to inefficiency in resource usage.

For proper planning and progress monitoring in the health care sector, a comprehensive health information system is crucial. The implementation of the public digital platform DHIS2, which gathers patient-level data from both public and private providers, is an important step forward, but population-level data remains scarce, and there are no real-time data sources. To successfully implement the health care financing strategy, a robust system with regular flow of quality data is essential.

If the above deficiencies of in health care supply, any health care financing strategy in Bangladesh will fail. Success occurs when citizens obtain more timely and better quality health care and they do so without having to incur catastrophic or impoverishing health expenditures. The increase in health system's reliance on OOPS since the HCFS 2012-2032 was formulated suggests that public health care delivery has progressively deteriorated. Higher OOPS in part reflects greater use by the public of private health care providers and pharmacies. This calls for policy efforts to consider greater collaboration with private providers and to regulate them to ensure that they deliver quality and safe health services. Strengthening the supply-side of Bangladesh's health system must become an important component of a revised HCFS.

### (f) Benefits package

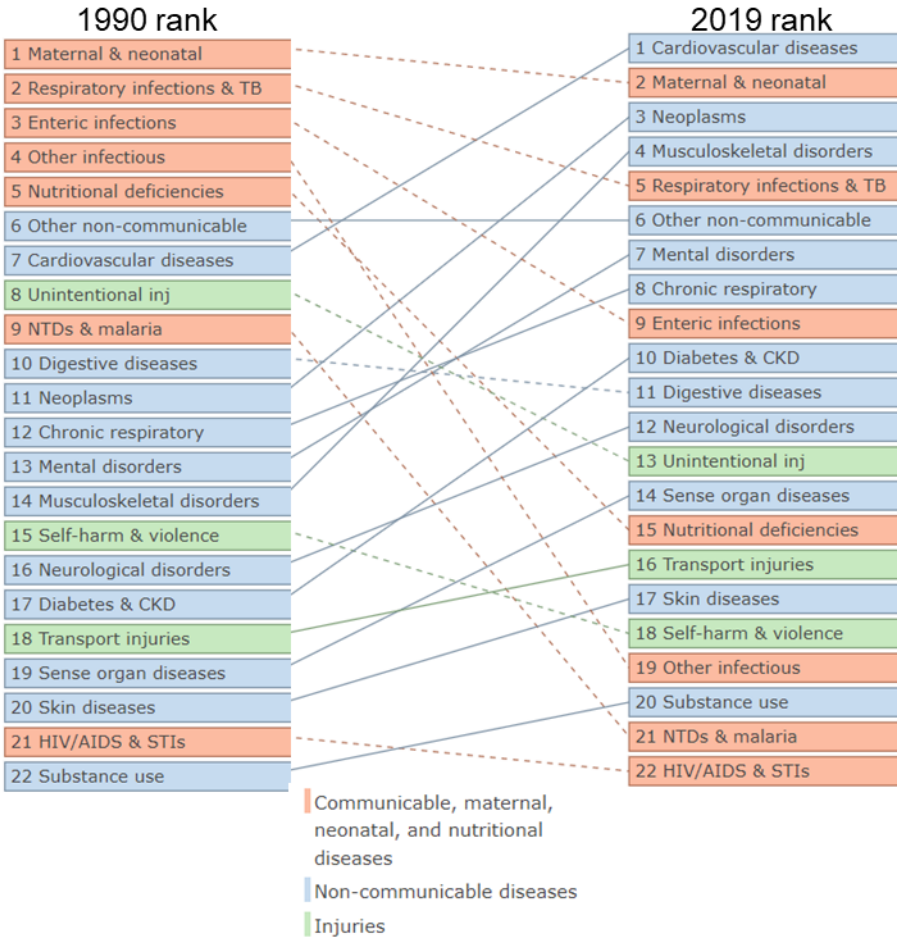
The government has carried out various initiatives to prioritize health spending. The MOHFW constructed the Essential Service Package (ESP) comprising 234 interventions for which detailed standard treatment protocols have been defined (Ministry ofHealth and Family Welfare 2016). The

MOHFW also estimated the cost of delivering the ESP (Unit 2018). Additionally, the HEU formulated a separate benefits package for the SSK pilot. Since in principle most outpatient services were already provided free or subsidized as part of the ESP, SSK was designed to complement the ESP to protect people from catastrophic health expenditure for inpatient services. Therefore SSK was designed with only hospital inpatient services at its initial stage (Health Finance and Governance 2005). The SSK scheme, piloted and set for expansion, provides inpatient services for 110 diseases, covering medicines, diagnostics, and transport costs up to BDT 50,000 per household yearly. The potential expansion of SSK to cover also the nonpoor informal may call for a unification of the two existing benefits packages, ESP and SSK. This is an analytical effort that should accompany such a policy, if adopted.

Successful delivery of a benefits package depends critically on the existence of a strong health care delivery system. Yet, as was discussed above in this section, there remain important deficiencies on the supply-side of the country's health system. Addressing and overcoming these challenges is a requisite for the successful implementation of the HCFS.

Setting priorities in health, as the government has done through the formulation of the ESP and the SSK benefits packages, is at the heart of a health financing strategy. To keep the reformed health system financially feasible and sustainable, government must define health benefits packages that are coherent with the financing available. If packages are too generous, then available financing will be insufficient to pay for them, and the reform will get discredited. Eventually, a reformed health system that attempts to provide health benefits packages that are too broad may fail because of a lack of financing and the existence of a weak supply-side system. The shifting epidemiological patterns taking place in Bangladesh and in much of the developing world will place increasing pressure on the social protection schemes –whichever they are– to expand the set of health interventions included in the health benefits packages, given their rising frequency and unit costs. Figure 24 shows the considerable change in Bangladesh's burden of disease between the three decades from 1990 to 2019, with non-communicable diseases (NCDs) emerging as significant contributors to the burden of disease. Thus, keeping benefits packages lean, to the extent possible, will be a priority.

**Figure 24 Bangladesh: Change in the burden of disease, 1990-2019 (disability-adjusted life years, DALYs)**




Source: IHME https://vizhub.healthdata.org/gbd-compare/

# 7. POLICY RECOMMENDATIONS

HCFS implementation has been slow due to lack of consensus on the current HCFS which has represented a major constraint for progress and there appears to be a need to revise the strategy's contents, its timeline and also its implementation plan. This final section discusses potential revisions to the strategy based on the current review and recommends basic elements of an implementation plan. Actions are categorized as short term (to occur between this report's release and December 2024, medium term (2025 and 2026) and long term (2027-2030).

## (a) Revisions to the HCFS

This review has concluded that the following 11 main areas contained in the HCFS 2012-2032 warrant revising:

***1. CBHI for the nonpoor informal is unfeasible.*** Possibly the most salient conclusion made by experts interviewed for this review was that a national network of CBHI schemes was not a feasible or desirable solution to the challenge of covering the nonpoor informal.

***2. A new dedicated entity is essential for HCFS implementation.*** The second most frequent recommendation heard was that the HEU or the MOHFW were not designed for, and lacked the means to implement the HCFS, and that a separate agency, such as the one commonly referred to as the NHSO should set up with that exclusive mandate.

***3. More public financing for health is a requisite.*** The third frequently-cited criticism from experts was that Bangladesh's health sector is underfinanced. They stated that government health spending is unusually low in comparison with other countries in the region and with developing countries elsewhere that have made progress toward UHC. This low level of public financing for health necessarily translates into high levels of OOPS leading to catastrophic and impoverishing health spending. These experts asserted that any HCFS design would fail in its implementation unless government made a sizable increase to the share of its public budget going to health.

***4. Strengthening the public network of health providers is indispensable.*** A frequent remark was that any HCFS would fail in Bangladesh so long as public health care providers remain understaffed and underfinanced. Thus, strengthening the public supply of health care services was indispensable for the success of any HCFS.

***5. Improving efficiency in PFM and budget execution is urgent.*** A recurring comment by respondents during this review was that PFM rules are inadequate for the fair and efficient allocation of the government's health budget to public providers, and for the efficient spending of these resources by providers. Besides, unrealistic budget planning, low capacity of health managers, delayed in preparing procurement plan, delay in procurement, unclear delegation of power, frequent transfer of budget managers lead low budget execution. The budget execution rate of MOHFW reduced

from 84% in FY2018 to 78% in FY2022. The budget execution rate was lower for the development budget (76%) compared to that of the operating budget (79%) of MOHFW (World Bank 2023).

***6. Purchaser-provider split advisable in public subsystem.*** An idea often heard was that a purchaser-provider split would be desirable in the MOHFW, with the MOHFW retaining its policymaking capacities but giving away its ownership, management, and financing of government health care providers. A special policy would have to be defined to pay health care providers while systems would have to be set up to formulate and sign contracts between the MOHFW and both public and private providers, establish payment methods, implement them, and put in place the necessary control mechanisms.

***7. Divided opinions about the merits of SHI in the formal sector.*** A common reflection on the HCFS was on the need and merits of setting up SHI for the formal sector. Opinions were divided on this question. Some respondents thought that it was a desirable strategy, particularly to improve access to care by civil servants, but also to inject further financing into the health system and to relieve pressure from public providers. Other experts interviewed through that the setting up of SHI would establish a two-tier health system that would give rise on the one hand to a better endowed system offering superior access to quality care for the better off (those working in the formal sector and their families) and, on the other hand, a less well financed public system for the large majority of the population that is either BPL or nonpoor informal.

***8. Adopt a uniform health benefits package.*** A frequent comment was that the existence of two separate health benefits packages, the ESP on one side, designed as the national benefits package, and the SSK package on the other side, designed as the SSK package, was confusing and led to limited access to needed care for SSK beneficiaries, in part because of the limited availability of ambulatory ESP services among public providers.

***9. Set up monitoring and evaluation for HCFS.*** Several respondents thought that the M&E capabilities of the MOHFW were limited and reflected a culture that paid little attention to the importance of this function in health. They indicated that a revised HCFS should contain and be accompanied by a strong M&E plan.

***10. The HCFS 2012-2032 was overly ambitious and lacked consensus.*** Several experts consulted for this review thought that the original HCFS was too ambitious as it did not anticipate all the implementation challenges that would arise. Furthermore, they cast skepticism about the degree of consensus reached within government and with national experts about the strategy's design.

***11. HCFS lacks focus on curbing private expenditure and on promoting strategic purchasing from private providers.*** At present, only around 15% of country's population receive health care from the public facilities and 77% of health expenditure in private facilities. Government has limited regulatory control on private sector prices and quality. While government providers cannot meet the health care demands of the population, it has not shown a clear interest in engaging in strategic purchasing of services from the private sector to address the gap.

The remainder of this section discusses institutional design questions and implementation issues.

## (b) Institutional design: Health system architecture with a revised HCFS

The review of international country cases showed convincingly that there is no such thing as a unique correct way of financing health care or of organizing a health system (with existing and new institutions) to move toward UHC. Very different strategies, including financing methods and institutional designs, have produced good results in the reviewed countries.

It is therefore difficult to recommend a unique financing strategy or a preferred institutional design for Bangladesh. What follows is one of several possible options and is used only to illustrate the kinds of design decisions government must make. Reaching those decisions should be the result of upcoming policy reform discussions, for which this review is an input. Deciding on a HCFS and its associated institutional design involves answering the following questions:

***Health care financing strategy***

- Where will the money come from to cover the costs of health insurance, including both the administrative costs of the insurer(s) and the health care delivery costs of the providers?
- How many different risk pools will there be in the country and for which population groups?
- What purchasing methods will the insurers managing the risk pools to compensate providers for the health care services delivered to the insured?

***Institutional design***

- Which institutions will collect the contributions to health insurance?
- What entities will manage the risk pools (that is, who will be the insurers)?
- What will be the hierarchical relationship between the various institutions operating in the reformed health system?
- Will there be a single or multiple health benefits packages and who will define their contents?
- Will health care providers be only those owned and operated publicly or will private providers also be able to deliver the services from the benefits package?
- Who will regulate health insurers and providers? What will be the aspects of health insurance and health care delivery that will be regulated and how will regulation take place?
- Who will formulate various needed regulations such as: the contents of the benefits package, including the standard treatment protocols; the conditions for being a health insurance beneficiary; the provider accreditation and certification standards; the health care quality standards; the instruments in which health insurers must

invest their surplus funds; the regulatory requirements for health insurers; and so on.

- Who will control fraud?
- How will health system performance be defined and measured and who will be responsible for and who will finance M&E?

The possible design envisioned here is offered solely as illustrative. It takes as a starting point the current system and what the HCFS intended to achieve, and considers the recommendations made by experts consulted for this review, and summarized as the 10 points presented above. This illustrative design is offered both to pinpoint the common institutional needs that arise with health financing reform and to highlight the challenges of any design. The reformulated HCFS should consider these challenges and, consequently, formulate a strategy and an implementation mechanism that are pragmatic and consistent with the nature and magnitude of the challenges.

The design presented in Figure 25 considers the existence of a NHSO, or an otherwise- named agency responsible for implementing the revised HCFS (for expediency we will maintain the now familiar name of NHSO). This degree of autonomous of this agency would have to be defined, in particular the nature of any subordination to the MOHFW. The agency's role would be to implement and then manage the reconfigured health system –including both insurers and providers– proposed in the new strategy.

The NHSO would receive its own budget from the Ministry of Finance. A small share (about 5-10%) of this budget would be intended to finance the agency's management costs while the bulk of the budget (90-95%) would be provided to pay for the coverage costs of the insured (or covered) population. The magnitude of the "coverage budget" would have to be calculated on the basis of the per capita cost of delivering the national health benefits package (which we will continue to call ESP) times the number of individuals covered. The latter could include only the BPL population or also the nonpoor informal population.

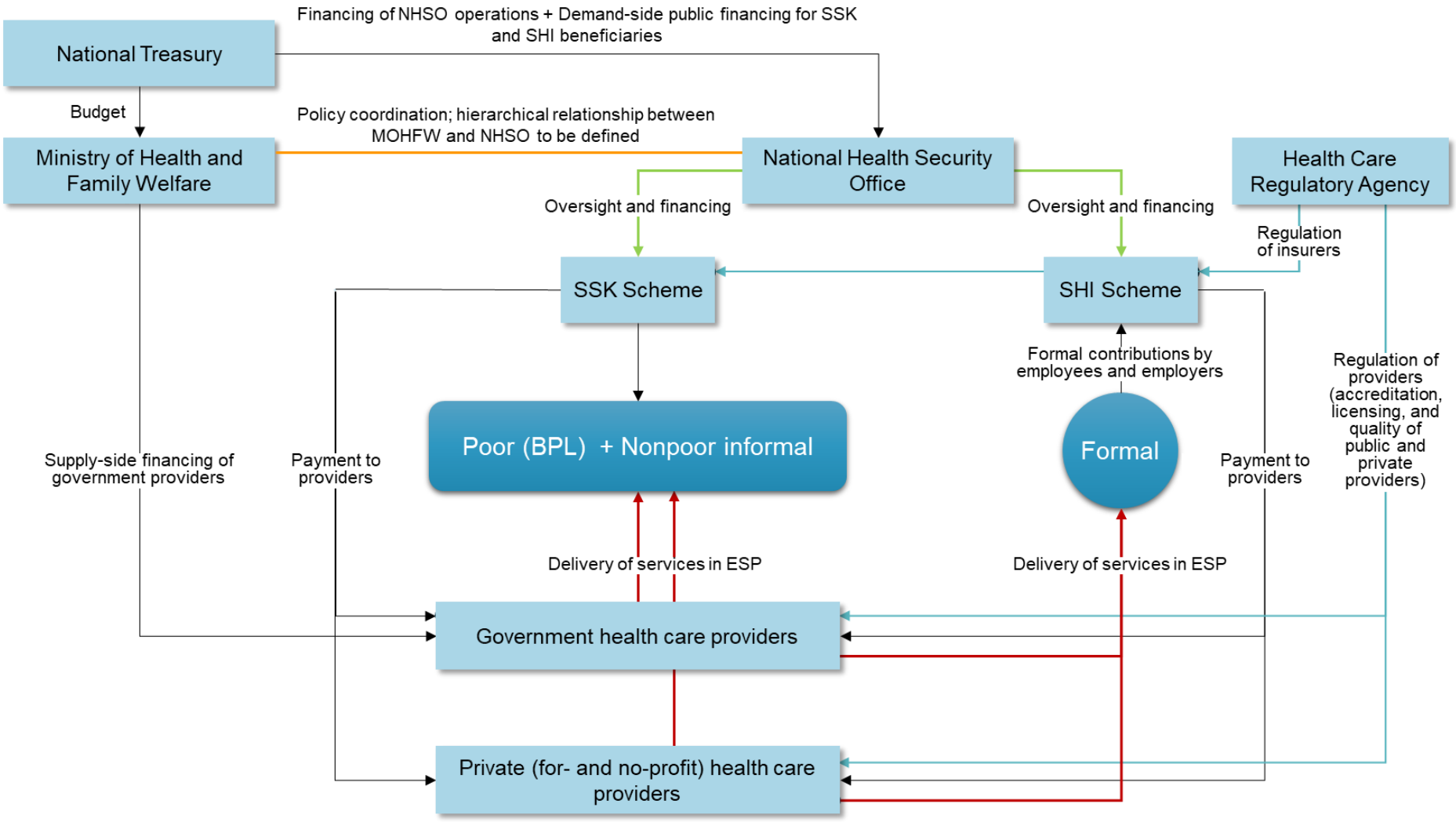
The illustrative design also shows the existence of a social health insurer for the formal population, covering both civil servants and the employees of large and medium size firms, both private and government-owned.

The NHSO could manage both insurance regimes, SSK and SHI. Managing these regimes would involve both raising revenue, pooling it, and paying providers. The revenue needed to finance SSK would come from government in the form of subsidies, while the revenue of SHI would come from contributions by employers and employees. We call this *demand-side financing* because it would finance the demand for health care by the insured. Government could also partially subsidize the operations of SHI, as is the case in many countries around the world. NHSO could operate two large risk pools, one for SSK and another for SHI. NHSO could also become a single public purchased of health services, setting up strategic contracts with public and private providers.

The hypothetical design shown here assumes that government health care providers would continue to receive a publicly-subsidized budget, called *supply-side budget* in the figure, but they could also draw further revenue from selling their services to the NHSO.

A regulatory agency would be necessary, to regulate the operations of both insurers and providers, thus ensuring that they comply with the law. By necessity this agency would be autonomous from the NHSO since it would be regulating the NHSO's operations as a health insurer. Likewise, this agency would be autonomous from the MOHFW because it would be regulating government health care providers (as well as private ones).

**Figure 25 One of many possible institutional designs of the HCFS**




Source: The authors.

## (c) Implementation strategy for the revised HCFS

Many of the activities that need to be undertaken to put together and implement a reformed HCFS can be carried out by the MOHFW. For example, no other institutions is better positioned in the country to design the contents of a health benefits package or to formulate its standard treatment protocols. Likewise, only the MOHFW can come up with the accreditation, certification, and quality standards for health care providers. The MOHFW may also lead the revisions to the HCFS.

Yet, there are activities required as part of the strategy that the MOHFW was not designed to take on. Chief among them is the role of strategy implementation. The Ministry's Health Economics Unit cannot fulfil that role either. Its mandate would have to be drastically modified and its organization revamped. The entity doing so must play the equivalent role of an orchestra director, ensuring that all the parts are in place when needed and that each actor fulfills its role according to plan. The implementing agency must manage the transition from the current to the reformed system and, under the steady state, act as the national health financing agency.

This is the role that those interviewed for this review assigned to the NHSO. We concur with those experts that a separate implementing agency should be set up to fulfill the role previously described.

### *Reform revision and implementation timeline*

***Revising the HCFS.*** This should be a short-term action, starting in the remaining months of 2023 and be completed by no later than June 2024.

***National Health Security Office.*** This entity's institutional design could begin concurrently with the revision of the HCFS, but should be completed some months later, to incorporate the changes in the revised financing strategy. Thus, the NHSO's design could start in the remaining months of 2023 and be completed in December 2024. NHSO operations could begin in early 2025.

***Securing increased public financing.*** The MoHFW should negotiate with the MOF and increase in the share of the government budget allocated to health. Additional revenue sources may be considered, such as health taxes, along the lines of the World Bank's recommendations (The World Bank 2016). The MOHFW should commit to certain measurable short- and medium-term milestones linked to the implementation of the reformed HCFS. The MOHFW and the MOF should reach a long-term financing pact during 2024.

***Improving PFM and efficiency gain:*** The PFM seem to have been well-documented. Making PFM both less bureaucratic and efficient should be the task of a joint committee with the participation of the MOHFW and the MOF which should begin operations in the second half of 2023. An action plan should be ready by mid-2024 and its implementation should begin in the second half of 2024.

***SSK.*** The expansion of SSK and to include the nonpoor informal sector was discussed as a potential way-out, it is not construed as the definitive recommendation at this juncture. Despite the interviews and focal group discussions highlighting the scale up of SSK schemes, the ultimate decision regarding the SSK should rest with the upcoming revision of the current HCFS. It is imperative to acknowledge that this review has already identified a lack of consensus around the existing HCFS, as well as significant supply-side challenges that could impede the scaling up of SSK. Therefore, any decision made should be through a consensual process that considers what is practically achievable in the short to medium term., However, the government is scaling up the SSK to cover selected districts. The speed of this expansion should be carefully defined considering the amount of financing that will be required and available for it. So, the SSK model should be strengthened in what remains of 2023 and throughout 2024 in response to the recommendations made by SSK's reviewers (Chowdhury, Hasan, and others 2021). If a decision is made to also cover the informal under SSK, then the cost and expansion effort will be greater, and this must be considered in the implementation plan. It is too early and there's insufficient information for these reviewers to recommend the speed of SSK's territorial expansion.

***Supply-side strengthening.*** Weakness in the government health care delivery system have been well documented. Current efforts to strengthen public supply should continue and accelerate. The MOHFW should formulate an investment and implementation plan for supply strengthening even in the face of insufficient human resources. The guiding principle to strengthen public supply should be to ensure that government providers can deliver a subset of the services contained in the ESP by the end of 2024 and a larger subset by the end of 2026. The MOHFW should also take actions aimed at expanding the national supply of human resources for health, keeping in mind that this is a long-term effort that will take one to two decades.

***Strengthening regulatory control over the public and private sectors.*** Governance and regulation of public and private sectors are crucial for implementing the health care financing strategy. It is evident from the literature that government could not establish strong regulatory control over both the public and private sectors. Indeed, the government's regulatory bodies are not capacitated in terms of manpower and internal capacity; and have limited authority to take action against irregularities. The absence of a proper regulatory mechanism deters the health sector to translate the investment into health gains effectively. Regulation and supervision of the private sector are integral parts of strategic purchasing and successful public private partnerships. The importance of this issue has been uttered in the 4th Health, Population and Nutrition Sector Programme (HPNSP) and Strategic Investment Plan (SIP) of the 5th Health, Population and Nutrition Sector Programme (HPNSP). It was planned to develop a comprehensive private health act (to replace the old 1982 ordinance) and to establish a National Accreditation body for the accreditation of hospitals and diagnostic facilities in private sectors by 2022. However, these plans need to be implemented without any delay.

***Developing and implementing strategic public purchasing of private health care.*** Strong public reliance on private health care is the natural consequence of weaknesses in public supply. Expanding access to health care may call for public purchasing of quality private services. Doing so calls for an explicit policy and the development of purchasing capabilities. The framework for the health care purchasing system must be balanced, incorporating the different interests and proper provider payment and incentive mechanisms. The process of developing the framework should engage all stakeholders for convincing policy changes required to move towards more strategic purchasing. The framework should be ready by mid-2024 and its implementation should begin by the FY 2024.

# 8. REFERENCES


Health Economics Unit, Expanding Social Protection for Health: Towards Universal Coverage Health Care Financing Strategy 2012-2032. 2012, Ministry of Health and Family Welfare Government of the People's Republic of Bangladesh: Dhaka.

Welfare, M.o.H.a.F. Central Government Health Scheme (CGHS Mumbai),. 2022; Available from: https://cghsmumbai.gov.in/introduction.

Liang, L. and J.C. Langenbrunner, The Long March to Universal Coverage: Lessons from China. 2013, The World Bank.

Turkey, G.o., Turkish Retirement Health Insurance and Acts, 1949-50. 1950.

López, A.C., R.G. Nieto, and Others, Historical and social perspective from the 64-65 Mexican Medical Movement. Revista Médica del Instituto Mexicano del Seguro Social, 2015. 53(4).

Humas. History of Social Security Journey in Indonesia. 2020; Available from: https://www.bpjs-kesehatan.go.id/bpjs/index.php/pages/detail/2013/4,.

Towse, A., A. Mills, and V. Tangcharoensathien, Learning from Thailand's health reforms. BMJ, 2004. 328.

Bazyar, M., et al., The experiences of merging health insurance funds in South Korea, Turkey, Thailand, and Indonesia: a cross-country comparative study. Int J Equity Health, 2021. 20(1): p. 66.

Bitran, R., Universal Health Coverage and the Challenge of Informal Employment: Lessons from Developing Countries, in HNP Discussion Paper. 2014, The World Bank: Washington, DC.

Annear, P.L., L. Comrie-Thomson, and P. Dayal, The challenge of extending universal coverage to nonpoor informal workers in low- and middle-income countries in Asia. IMPACTS AND POLICY OPTIONS, in Policy Brief. 2015, World Health Organization. Asia Pacific Observatory on Health Systems and Policies: Geneva.

Ministerio de Salud. Hitos de la Salud Chilena. 2022; Available from: https://www.minsal.cl/hitos-de-la-salud-chilena/#:~:text=En%201952%20se%20promulga%20la,hijos%20hasta%20los%2015%20a%C3%B1os.

Hamid, S., Designing an Health Insurance Scheme for Government Employees in Bangladesh: A Concept Paper, in Munich Personal RePEc Archive. 2014.

Hamid, S.A., et al., Civil Servants' Health Protection Scheme in Bangladesh. Concept Paper. 2015, Health Economics Unit Ministry of Health and Family Welfare of BangladeshWorld Health Organization Bangladesh Country Office: Dhaka.

Smith, O., A Note on Insurance Schemes for Civil Servants Around the World. 2020, The World Bank: New Delhi.

Nadu, G.o.T., G.O.Ms.No.160, Dated 29th June 2021 (MEDICAL AID – New Health Insurance Scheme, 2021), F.S. DEPARTMENT, Editor. 2021: Dhaka.

Bennett, S., Viroj, and Tangharoensathien, Health Insurance and Private Providers: A Study of the Civil Servants' Medical Benefit Scheme in Bangkok, Thailand. International Journal of Health Planning and Management, 1993. 8: p. 137-152.

Prakongsai, P., Lessons from Thailand in achieving universal health coverage: Contributing factors and key challenges, in 2nd Thailand Pacific Island Countries Forum. 2015.

Jindapol, N. and Others, Crisis of Health Insurance under Thai Civil Servant Medical Benefit Scheme (CSMBS). Srinagarind Med J, 2014.

Acharya, Arnab, Sukumar Vellakkal, Fiona Taylor, Edoardo Masset, Ambika Satija, Margaret Burke, and Shah Ebrahim. 2013. The Impact of Health Insurance Schemes for the Informal Sector in Low- and Middle-Income Countries. A Systematic Review. In Policy Research Working Paper. Washington, DC: The World Bank.

Ahmed S et.al (2021) Assessing the incidence of catastrophic health expenditure and impoverishment from out-of-pocket payments and their determinants in Bangladesh: evidence from the nationwide Household Income and Expenditure Survey 2016, International Health, Volume 14, Issue 1, January 2022, Pages 84–96, https://doi.org/10.1093/inthealth/ihab015

Ahmed, S., A. R. Sarker, M. Sultana, S. Chakrovorty, M. Z. Hasan, A. J. Mirelman, and J. A. M. Khan. 2018. "Adverse Selection in Community Based Health Insurance among Informal Workers in Bangladesh: An EQ-5D Assessment." Int J Environ Res Public Health 15 (2). doi: 10.3390/ijerph15020242.

Annear, Peter Leslie, Liz Comrie-Thomson, and Prarthna Dayal. 2015. The challenge of extending universal coverage to non-poor informal workers in low- and middle-income countries in Asia. IMPACTS AND POLICY OPTIONS. In Policy Brief. Geneva: World Health Organization. Asia Pacific Observatory on Health Systems and Policies.

Balabanova, Dina, Martin McKee, and Anne Mills. 2011. Good health at low cost 25 years on. What makes a successful health system? London: London School of Hygiene & Tropical Medicine.

Bazyar, M., V. Yazdi-Feyzabadi, A. Rashidian, and A. Behzadi. 2021. "The experiences of merging health insurance funds in South Korea, Turkey, Thailand, and Indonesia: a cross-country comparative study." Int J Equity Health 20 (1):66. doi: 10.1186/s12939-021-01382-w.

Bennett, Sara, Viroj, and Tangharoensathien. 1993. "Health Insurance and Private Providers: A Study of the Civil Servants' Medical Benefit Scheme in Bangkok, Thailand." International Journal of Health Planning and Management 8:137-152.

Bitran, R., L. Escobar, and P. Gassibe. 2010. "After Chile's health reform: increase in coverage and access, decline in hospitalization and death rates." Health Aff (Millwood) 29 (12):2161-70. doi: 10.1377/hlthaff.2010.0972.

Bitran, Ricardo. 2005. Health Insurance Issues in East Asia. Washington, D.C.: World Bank.

Bitran, Ricardo. 2013. Explicit Health Guarantees for Chileans: The AUGE Benefits Package. In Universal Health Coverage Studies Series (UNICO), edited by Daniel Cotlear. Washington, D.C.: The World Bank.

Bitran, Ricardo. 2014a. Universal Health Coverage and the Challenge of Informal Employment: Lessons from Developing Countries. In HNP Discussion Paper. Washington, DC: The World Bank.

Bitran, Ricardo. 2014b. Universal health coverage and the challenge of informal employment: Lessons from developing countries. In HNP Discussion Paper. Washington, DC: The World Bank.

Bitrán, Ricardo. 2021a. Policy Brief: Civil Servant Health Insurance In Bangladesh. Santiago: World Health Organization.

Bitrán, Ricardo. 2021b. Dhaka.

Bitrán, Ricardo, and Paula Arpón. 2021. Political Economy and Financial Sustainability of Social Health Insurance in Ethiopia. Santiago: Bitrán y Asociados for the World Bank.

Chemouni, Benjamin. 2018. "The political path to universal health coverage: Power, ideas and community-based health insurance in Rwanda." World Development 106:87-98. doi: 10.1016/j.worlddev.2018.01.023.

Chowdhury, Mahbub Elahi, Md. Zahid Hasan, and others. 2021. Evaluation of the Pilot Shasthyo Shurokhsha Karmasuchi (SSK).

Esteves, Roberto. 2012. "The quest for equity in Latin America: a comparative analysis of the health care reforms in Brazil and Colombia." International Journal for Equity in Health 11.

Friebel, Rocco, Erik Josephson, Rebecca Forman, and Severine Calza. 2020. "Challenges of Social Health Insurance in Lowand Lower-Middle Income Countries: Balancing Limited Budgets and Pressure to Provide Universal Health Coverage."

Gertler, Paul. 1998. "On the Road to Social Health Insurance: the Asian Experience." World Development 26.

Giedion, Ursula, and Oscar Cañón. 2014. "Colombia: The Compulsory Health Plan." In Health Benefit Plans in latin America: A Regional Comparison, edited by Ursula Giedion, Ricardo Bitrán and Ignez Tristao. Washington, D.C.: Inter-American Development Bank.

Giedion, Ursula, and Manuela Villar Uribe. 2009. "Colombia's universal health insurance system. The results of providing health insurance for all in a middle-income country." Health Affairs (Millwood) 28 (3):853-63. doi: 10.1377/hlthaff.28.3.853.

Gumber, Anil. 2002. Health insurance for the informal sector: Problems and prospects. In Working Paper No. 90. New Delhi: Indian Council For Research On International Economic Relations.

Hamid, S. 2014. Designing an Health Insurance Scheme for Government Employees in Bangladesh: A Concept Paper. In Munich Personal RePEc Archive.

Hamid, Syed Abdul, Rumana Huque, Ahsan Habib, Waliul Islam, and Abdur Rahman Khan. 2015. Civil Servants' Health Protection Scheme in Bangladesh. Concept Paper. Dhaka: Health Economics Unit Ministry of Health and Family Welfare of Bangladesh

World Health Organization Bangladesh Country Office.

Health Economics Unit. 2012. Expanding Social Protection for Health: Towards Universal Coverage Health Care Financing Strategy 2012-2032. Dhaka: Ministry of Health and Family Welfare Government of the People's Republic of Bangladesh.

Health Finance and Governance. 2005. The Essential Package of Health Services and Health Benefit Plans in Bangladesh.

Health Insurance System Research Office. 2012. Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010). Synthesis Report. Nonthaburi, Thailand:: Health Insurance System Research Office.

Hsiao, W. C., and W. Yip. 2023. "Financing and provision of healthcare for two billion people in low-income nations: Is the cooperative healthcare model a solution?" Soc Sci Med:115730. doi: 10.1016/j.socscimed.2023.115730.

Humas. 2020. "History of Social Security Journey in Indonesia." BPJS Kesehatan. https://www.bpjs-kesehatan.go.id/bpjs/index.php/pages/detail/2013/4,.

Institute of Health Economics. 2023. National Health Security Office (NHSO) in Bangladesh: Design and Structural Aspect Based on Learning from Success Countries. University of Dhaka.

International Labour Office. 2016. Progress towards Universal Health Coverage: Rwanda. Geneva.

Jeong, Hyoung-Sun. 2010. Expanding insurance coverage to informal sector populations: Experience from Republic of Korea. In World Health Report (2010)

Background Paper.

Jindapol, Nutthida, and Others. 2014. "Crisis of Health Insurance under Thai Civil Servant Medical Benefit Scheme (CSMBS)." Srinagarind Med J.

Kutzin, J. 2013. "Health financing for universal coverage and health system performance: concepts and implications for policy." Bull World Health Organ 91 (8):602-11. doi: 10.2471/BLT.12.113985.

Liang, Lilin, and John C. Langenbrunner. 2013. The Long March to Universal Coverage: Lessons from China. The World Bank.

López, Alejandro Cabello, Rodrigo Gopar Nieto, and Others. 2015. "Historical and social perspective from the 64-65 Mexican Medical Movement." Revista Médica del Instituto Mexicano del Seguro Social 53 (4).

Makaka, Andrew, Sarah Breen, and Agnes Binagwaho. 2012. "Universal health coverage in Rwanda: a report of innovations to increase enrolment in community-based health insurance." The Lancet 380. doi: 10.1016/s0140-6736(13)60293-7.

Ministerio de Salud. 2022. "Hitos de la Salud Chilena." Chile Ministry of Health. https://www.minsal.cl/hitos-de-la-salud-chilena/#:~:text=En%201952%20se%20promulga%20la,hijos%20hasta%20los%2015%20a%C3%B1os.

Ministerio de Sanidad, Servicios Sociales e Igualdad. 2019. Health care systems in the European Union countries. Health characteristics and indicators 2019. Government of Spain.

Ministry ofHealth and Family Welfare. 2016. Bangladesh Essential Health Service Package (ESP). Dhaka.

Mulat, A. K., W. Mao, I. Bharali, R. B. Balkew, and G. Yamey. 2022. "Scaling up community-based health insurance in Ethiopia: a qualitative study of the benefits and challenges." BMC Health Serv Res 22 (1):473. doi: 10.1186/s12913-022-07889-4.

Nadu, Government of Tamil. 2021. G.O.Ms.No.160, Dated 29th June 2021 (MEDICAL AID – New Health Insurance Scheme, 2021). edited by FINANCE [Salaries] DEPARTMENT. Dhaka.

Nga, Nguyen Thi Thuy, Gerard FitzGerald, and Michael Dunne. 2018. "Family-Based Health Insurance for Informal Sector Workers in Vietnam: Why Does Enrolment Remain Low? ." Asia Pacific Journal of Public Health. doi: 10.1177/1010539518807601?journalCode=apha.

OECD. 2021. OECD Reviews of Health Systems BRAZIL 2021. In OECD Reviews of Health Systems. Paris.

Parmar, Divya, Aurélia Souares, Manuela de Allegri, Germain Savadogo, and Rainer Sauerborn. 2012. "Adverse selection in a community-based health insurance scheme in rural Africa: Implications for introducing targeted subsidies." BMC Health Services Research.

Prakongsai, Prusit. 2015. "Lessons from Thailand in achieving universal health coverage: Contributing factors and key challenges." 2nd Thailand Pacific Island Countries Forum.

Rajapaksa, L, P De Silva, A Abeykoon, L Somatunga, S Sathasivam, Perera S, and Others. 2021. Sri Lanka Health System Review. In Sri Lanka Health System Review: World Health Organization Regional Office for South-East Asia.

Reich, Michael R., Joseph Harris, Naoki Ikegami, Akiko Maeda, Cheryl Cashin, Edson C. Araujo, Keizo Takemi, and Timothy G. Evans. 2016. "Moving towards universal health coverage: lessons from 11 country studies." The Lancet 387 (10020):811-816. doi: 10.1016/s0140-6736(15)60002-2.

Roberts, Marc, William Hsiao, Peter Berman, and Michael Reich. 2008. Getting Health Reform Right: A Guide to Improving Performance and Equity Oxford University Press.

Rusa, Louis, Miriam Schneidman, Gyuri Fritsche, and Laurent Musango. 2009. "Chapter 10. Rwanda: Performance-Based Financing in the Public Sector." In.: Center for Global Development.

Smith, Owen. 2018. Sri Lanka: Achieving Pro-Poor Universal Health Coverage without Health Financing Reforms. Washington, D.C.: The World Bank.

Smith, Owen. 2020. A Note on Insurance Schemes for Civil Servants Around the World. New Delhi: World Bank.

Smith, Peter C., and Sopie N. Witter. 2004. Risk Pooling in Health Care Financing: The Implications for Health System Performance. In HNP Discussion Paper. Washington, D.C.: The World Bank.

Tangcharoensathien, V., W. Patcharanarumol, A. Kulthanmanusorn, N. Saengruang, and H. Kosiyaporn. 2019. "The Political Economy of UHC Reform in Thailand: Lessons for Low- and Middle-Income Countries." Health Syst Reform 5 (3):195-208. doi: 10.1080/23288604.2019.1630595.

Tangcharoensathien, V., W. Witthayapipopsakul, W. Panichkriangkrai, W. Patcharanarumol, and A. Mills. 2018. "Health systems development in Thailand: a solid platform for successful implementation of universal health coverage." Lancet 391 (10126):1205-1223. doi: 10.1016/S0140-6736(18)30198-3.

Tangcharoensathien, Viroj, Rapeepong Suphanchaimat, Noppakun Thammatacharee, and Walaiporn Patcharanarumol. 2012. "How closed-end payment became the main mode of purchasing in Thailand's Universal Coverage Scheme?" Economic and Political Weekly XLVIIS.

The Lancet Regional Health (Southeast Asia). 2022. "Sri Lanka-Health in the middle of a crisis." The Lancet Regional Health - Southeast Asia 4. doi: 10.1016/j.lansea.2022.100067.

The World Bank. 2016. Fiscal Space for Health in Bangladesh: Towards Universal Health Coverage. The World Bank Group.

The World Bank, and World Health Organization. 2021. Tracking Universal Health Coverage: 2021 Global Monitoring Report. Geneva.

Torrado, Santiago. Feb. 2, 2023. "Los 5 reparos de Alejandro Gaviria a la reforma a la salud_ "Destruir el actual sistema sería un suicidio" " El País.

Towse, Adrian, Anne Mills, and Viroj Tangcharoensathien. 2004. "Learning from Thailand's health reforms." BMJ 328.

Turkey, Government of. 1950. Turkish Retirement Health Insurance and Acts, 1949-50.

Unit, Health Economics. 2018. The Costs of the Bangladesh Essential Health Service Package: Fourth Health Population and Nutrition Sector Programme. Dhaka: Health Services Division of the Ministry of Health and Family Welfare.

Wagstaff, Adam, and Wanwiphang Manachotphong. 2012a. Universal Health Care and Informal Labor Markets. The Case of Thailand. In Policy Research Working Paper: The World Bank.

Wagstaff, Adam, and Wanwiphang Manachotphong. 2012b. Universal Health Care and Informal Labor Markets. The Case of Thailand. In Policy Research Working Paper. Washington: The World Bank.

Wang, H., L. Zhang, W. Yip, and W. Hsiao. 2006. "Adverse selection in a voluntary Rural Mutual Health Care health insurance scheme in China." Soc Sci Med 63 (5):1236-45. doi: 10.1016/j.socscimed.2006.03.008.

Welfare, Ministry of Health and Family. 2022. "Central Government Health Scheme (CGHS Mumbai),." Government of India. https://cghsmumbai.gov.in/introduction.

WHO. 2017. Fiscal space for health. WHO.

WHO. 2020. "Community-based health insurance." https://www.who.int/news-room/fact-sheets/detail/community-based-health-insurance-2020.

WHO. , no date. "Universal Health Coverage." World Health Organization. https://www.who.int/health-topics/universal-health-coverage#tab=tab_1.

WHO. No date. "Universal health coverage." https://www.who.int/health-topics/universal-health-coverage#tab=tab_1.

WHO Regional Office for Africa. 2022. "Community-based health insurance drives Ethiopia's bid for universal health coverage." https://www.afro.who.int/countries/ethiopia/news/community-based-health-insurance-drives-ethiopias-bid-universal-health-coverage.

Woldemichael, Andinet, Daniel Gurara, and Abebe Shimeles. 2019. The Impact of Community Based Health Insurance Schemes on Out-of-Pocket Healthcare Spending: Evidence from Rwanda. In IMF Working Papers: International Monetary Fund.

World Bank. 2016. Ethiopia Public Expenditure Review 2015. Washington, D.C.: World Bank Group.

World Bank 2019, Ahmed S et al. Diagnostic Study of Public Financial Management: To Strengthen Health Financing and Service Delivery in Bangladesh, Discussion Paper, World Bank Group.

World Bank 2023, FY 2023-24, Health Budget Brief, Bangladesh, Health, Nutrition and Population Global Practice, World Bank, Bangladesh. June 05, 2023.

World Health Organization. 2011. The Abuja Declaration: Ten Years On. Geneva.

World Health Organization. 2019. "Brazil's march towards universal coverage."

Yazbeck, A. S., W. D. Savedoff, W. C. Hsiao, J. Kutzin, A. Soucat, A. Tandon, A. Wagstaff, and W. Chi-Man Yip. 2020. "The Case Against Labor-Tax-Financed Social Health Insurance For Low- And Low-Middle-Income Countries." Health Aff (Millwood) 39 (5):892-897. doi: 10.1377/hlthaff.2019.00874.

Yazbeck, Abdo S., Agnes L. Soucat, Ajay Tandon, Cheryl Cashin, Joseph Kutzin, Julia Watson, Sarah Thomson, Son Nam Nguyen, and Tamas Evetovits. 2023. "Addiction to a bad idea, especially in low- and middle-income countries: Contributory health insurance." Social Science & Medicine 320. doi: 10.1016/j.socscimed.2022.115168.

# ANNEX A. International consultants' terms of reference

## Background

This Agreement for Performance of Work will enable WHO SEAR and WCO Bangladesh to provide strategic and technical support to the Government of Bangladesh to prepare a consolidated and state of the art report, based on the Bangladesh Health Care Financing Strategy review. The report will provide evidence and policy advocacy to key stakeholders in Bangladesh on probable and suitable pathways to advance health financing progress in light of the global experience and the local context. It is expected that the review findings and recommendations will help to revise the proposed activities and better equip the country with the vision and operational objectives required to improve financial risk protection, promote efficiency and equity while strengthening health systems to achieve universal health coverage (UHC).

Bangladesh developed a Health Care Financing Strategy (HCFS) 2012-32 in 2012 by sketching a road map with a view of providing financial risk protection, promoting efficiency and equity, and strengthening health systems in the context of achieving universal health coverage (UHC). The strategy also provides a framework to gradually bring all citizens in Bangladesh under three different social health protection schemes - targeting three segments of population: people under below the poverty line, formal sector employees, and nonpoor informal sector workers). As well, the strategy set targets for increasing resource generation, heightening the public share on health expenditure, and reducing out of pocket expenditure over the 20 years of its adoption.

However, since 2012, the country has not been able to make significant progress in implementing the HCFS. The country actually moved in a reverse direction. At present, current health expenditure on health accounts for only 2.7 % of GDP, while domestic government health expenditure in relation to GDP remains at only 0.42%", placing Bangladesh among the countries that least spends on health globally. Public funds for health is the main source under the existing pre-payment mechanism for risk-pooling in Bangladesh which constitutes 23% of total health expenditure. Due to insufficient public financing, households pay out of pocket fees at the point of service which constitute the main source of financing for health in Bangladesh, comprising 68.5%' in 2020. As a consequence, 24.9 % people face catastrophic expenditure and around 11.4 million people are being pushed into poverty every year in Bangladesh due to health care expenditure.

Against this backdrop, the government, with support from the WHO Bangladesh Country Office initiated a review of the health care financing strategy in 2021 as the initial step for revising the current strategy. A team of national and international consultants reviewed the strategy and prepared reports in different thematic areas with the guidance of an international global expert. A national technical review committee (TRC) accepted the findings and recommended to consolidate the reports produced by the national consultants and extend the scope of the review incorporating up-to-date and robust global evidence on health financing reforms and implications for Bangladesh. As well, the TC advocated to further consult with key policy makers

and experts to validate the findings and to reach a consensus on the health financing strategic directions based on the findings of the consolidated report and come up with prioritized recommendations considering technical, financial, operational, and political feasibility. This consolidated report is expected to support the Government in revising the HCFS and prepare a pragmatic implementation plan of the revised strategy. The committee also recommended the development of a policy brief based on the consolidated report to be used for policy advocacy and policy dialogue sessions to secure key stakeholders' buy-in and commitment for successful implementation.

On this ground, the HEU of the Ministry of Health and Family Welfare requested WHO to lead the technical support and to engage an international reputed consultancy firm with strong knowledge of global health financing reforms but also sound understanding of the Bangladeshi context to take the review forward as per the guidance of the Technical Review Committee of HCFS review.

The consultancy firm will be engaged through this APW and will work in close coordination with the South-East Asia Regional Office of the WHO, the Bangladesh WHO Country Office and the HEU of MOHFW.

**Requirements: Work to be performed**

Objective 1:

To conduct review of health care financing strategy in 2 phases with extended scope of work:

a. Consult with HEU, Technical Review Committee, key policy makers and experts to validate the review findings in the first phase and identify health financing directions in light of political economy factors.
b. Consolidate the reports of national consultants on different thematic areas in a single report showcasing the current status of implementation, key areas for revision of the strategy and probable pathways to advance policy initiatives and stakeholder commitment on health financing in Bangladesh.
c. Prepare a separate session on 'global experience on health financing' in the report by synthesizing the global experiences and lessons on health financing approaches for UHC and their implications in the Bangladesh context.
d. Prioritize recommendations and conceptualize the way forward considering technical, financial, operational, and political feasibility.
e. Draft report circulation and holding technical consultations with key stakeholders for consensus building on the findings.
f. Develop a policy brief as a policy advocacy tool based on the review of HCFS
g. Revision and circulation of final version of the report.

Objective 2:

To conduct political sensitizing activities based on review to secure political commitment for health financing transformation, travel to Bangladesh for 10 days (including travel time) for following activities

a. Design workshops/ seminar and develop presentations for consultations and policy advocacy.
b. 2nd set of consultations with government counterparts and stakeholders.
c. Disseminate the review findings among key policy makers and stakeholders and provide policy advocacy through policy advocacy sessions/policy dialogues

**Approach:**

- Desk review of the thematic reports and scripts of key informant interviews conducted by national consultants
- Desk review of existing reports, articles, documents, and evaluation reports on health financing activities in Bangladesh
- Capture global experience and best practices on health financing through desk review of documents, reports and articles and illustrate their feasibility and implications to Bangladesh -
- Gather information through consultation with national consultants, WHO SEARO and country team and HEU
- Virtual consultations with national consultants, TRC, policy makers, experts and other key stakeholders to validate the findings and identify the health financing directions
- Draft report circulation and holding technical consultations with key stakeholders for consensus building on the findings
- Travel to Bangladesh for 10 days (including travel time) for following activities
  - Design workshops/ seminar and develop presentations for consultations and policy advocacy
  - 2nd set of consultations with government counterparts and stakeholders.
  - Disseminate the review findings among key policy makers and stakeholders and provide policy advocacy through policy advocacy sessions/policy dialogues
- Revision and circulation of final version of the report.

**Deliverables:**

1. A consolidated draft report of the health care financing strategy review with the following sections:

a. Executive summary
b. Introduction
c. Conceptual framework

d. Methods
e. Situation analysis of the Health Care Financing Strategy in Bangladesh
f. Progress and challenges in implementing the Health Care Financing Strategy
g. Experiences of low- and middle-income countries on health financing UHC and their implications for Bangladesh
h. Recommendations for key revision areas and way forward for advancing health financing progress towards UHC

2. A policy brief based on the findings and recommendations of HCFS review
3. Advocacy and policy dialogue using the findings of the Health Care Financing Strategy review and way forward:

- Design and development presentations for consultations and policy advocacy sessions
- Consultation with key stakeholders, government counter parts and policy advocacy to key policy makers based on findings

4. Final report of Bangladesh Health Care Financing Strategy review

## Requirements - Planning

| Activities (all in year 2022) | July | August | September | October | November | December |
|---|---|---|---|---|---|---|
| Contracting | | | | | | |
| Review of national consultants transcripts from several workshops and of their final report. As well review of existing reports, articles, documents, and evaluation reports on health financing activities in Bangladesh | | | | | | |
| Capturing the global experience and best practices on health financing through desk review of documents, reports and articles and illustrate their feasibility and implications to Bangladesh | | | | | | |
| Virtual consultations with national consultants, TRC, policy makers, experts and other key stakeholders to validate the findings and identify the health financing directions | | | | | | |
| Draft report circulation and holding technical consultations with key stakeholders for consensus building on the findings | | | | | | |
| Travel to Bangladesh for 10 days (including travel time) for face-to-face consultation and policy advocacy | | | | | | |
| Revision of final version of the report | | | | | | |

## Inputs

The Technical / Medical Officer indicate the contribution that the beneficiary will make to produce the outputs.

## Activity Coordination & Reporting

**Technical Officer:** Mohammad Touhidul Islam, NPO-Health Financing, Health Systems

Email: islammt@who.int

For the purpose of: Technical supervision and instructions - Reporting

Administrative officer: Thislay Dorji

Email: dorjit@who.int

For the purpose of: Contractual and financial management of the contract

### Payment schedule

| # | % | Deliverable(s) | Tentative date |
|---|---|---|---|
| 1 | 20% | On signing of the contract | 21 July 2022 |
| 2 | 40% | Submission of 1st draft of review report | 30 Sept 2022 |
| 3 | 40% | a. Completed facilitation of an in-person policy advocacy session<br>b. Final version of the review report, a policy brief based on inputs provided by key stakeholders, submission of invoices/bills and financial report | 31 Dec 2022 |

All data produced is the property of WHO and the expert cannot make use of accessed information for his or her personal and professional use outside this project without WHO's permission.

### Place of assignment

The assignment will be conducted both remotely and in Bangladesh (10 days travel to Bangladesh for conducting policy advocacy sessions).

# ANNEX B. LIST OF KEY INFORMANTS

## Interviewees and participants of FGD for this study

(Not in order of seniority)

1. Dr. Shamsul Alam, State Minister of Planning, Ministry of Planning
2. Prof. Dr. Habibe Millat, Member of Parliament, Sirajganj -2
3. Mr. Humayun Kabir, Former Secretary, MOHFW
4. Mr. Ashadul Islam, Former Senior Secretary, MOHFW
5. Mr. M M Reza, Former Secretary, MOHFW
6. Dr. Md. Enamul Haque, DG, HEU
7. Dr. Syeda Nawshin Pornini, Director (Research), HEU
8. Md. Sirajul Islam, Deputy Director, HEU
9. Dr. Md. Mostafizur Rahman, Deputy Director, HEU
10. Dr. Md. Abul Bashar Sarkar, HEU
11. Md. Azmal Kobir, National Consultant, HEU
12. Dr. Subrata Paul, Focal Point, UHC and NHA, HEU
13. Dr. Md. Samiul Huda, MO, HEU
14. Shadat Hossain, Research Officer, HEU
15. Gazi Golam Mehdi, Junior Consultant, HEU
16. Golam Rabbani, Junior Consultant, HEU
17. Dr. Afreen Mahmood, Director, Planning and Research, DGHS, MOHFW
18. Dr. Farida Yasmin, Director, Finance, DGHS, MOHFW
19. Dr. Shaikh Iftekhar Rahman, Deputy Director, Finance, DGHS, MOHFW
20. Mr. Chowdhury Morshed Alam, Assistant Director, Finance, DGFP, MOHFW
21. Dr. Shahadt Hosssain Mahmud, Former DG, HEU
22. Mohammad Abdus Salam Khan, Joint Secretary (Planning), MEFWD, MOHFW
23. Mr. Helal Uddin, Planning Wing, MOHFW
24. Dr. Oaliullah ndc, Planning Wing, MOHFW
25. Mr. Abdur Rahman, MOF
26. Dr. Nurul Amin, Former Director (Research), HEU
27. Dr. Md. Osmani, Planning Wing
28. Dr. Khairul Islam, Regional Director, WaterAid
29. Prof. Syed Abdul Hamid, University of Dhaka
30. Ms. Tahmina Begum, Consultant
31. Dr. Md. Abdus Sabur, health system expert
32. Prof. Tim Ensor, University of Leeds, UK
33. Prof. Abdo Yazbeck, John Hopkins Bloomberg School of Public Health, USA
34. Ms. Maya Vandenent, UNICEF
35. Dr. Zahirul Islam, Health Advisor, Embassy of Sweden,
36. Bangladesh. Dr. Riad Mahmud, USAID

37. Ms Atia Hossain, The WB
38. Dr. Owen Smith, The WB
39. Dr. Sangay Wangmo, WHO
40. Dr. Pallav Bhat, WHO

## List of Participants at Workshop on Health Financing Policy Options for Universal Health Coverage

1. Dr. Md. Enamul Haque
   Director General
   HEU, HSD, MOHFW
2. Md. Ashadul Islam
3. Shaifullahhil Azam
   Additional Secretary
   MOHFW
4. Ricardo Bitran
   Consultant
   WHO
5. Maqsura Noon
   Director general
   DGNM
6. Prof. Nahid Akhter Jahan
   IHE, DU & Consultant, WHO
7. Md. Jasim Uddin
   JS, LGD
8. Dr. Zahirul Islam
   Health Advisor
   Embassy of Sweden
9. Dr. Touhidul Islam
   WHO
10. Mehedi Hassan
    System Anlayst
    HEU
11. Dr. Pranab Kumar Roy
    MO (Attached)
    QIS, HEU, HSD, MOHFW
12. Md. Saidur Rahman Khan
    Program Manager (GNJPU)
    HEU, HSD
13. Dr. Md. Samiul Huda
    Assistant Surgeon
    HEU
14. Md. Ismail Hossain
    A.A.O, HEU
15. Fatema Zohara
    Senior Assistant Chief
    General Economics Division, Planning Commission
16. Dr. Mohammad Hossain
    Deputy Secretary
    iBAS++
17. Khan Md. Nurul Amin
    NCD Chief (Additional Secretary)
    GED, Bangladesh Planning Commission
18. Dr. Mohammad Altaf-Ul- Alam
    Additional Secretary
    FD, Ministry of Finance
19. Mohammad Rabiul Islam
    Joint Secretary
    Finance Division
20. Md. Osman Gani
    Superintend Engineer
    PWD, Sylhet Circle, Sylhet
21. Mollika Khatton
    Joint Secretary
    Medical Education & Family Welfare Division
22. Dr. Mohammad Shawkat Hossain Khan
    DPM, GNSPU, HEU, HSD
23. Md. Saiful Islam
    Deputy Secretary
    HSD
24. Md. Nasir Uddin

Director (Admin)
DGNM

25. Dr. Md. Farid Hossain Miah
Director (Health)
DGHS
26. Dr. Rawshan Zahan Akhter Alo
Assistant Director
DGHS
27. Dr. Abdullah-Al-Faisal
DPM (Monitoring)
PMR, DGHS
28. Md. Hafizur Rahman
Additional Secretary
MOC
29. Md. Shah Alam
Additional Secretary (Admin)
MEFWD
30. Kh. Md. Rezaul Karim
DD-1, HEU
31. Nazmul Haque Khan
Additional Secreatry
Health Services Division
32. Kazi Tasnim Ara Azmery
Joint Secretary
HSD
33. Tauhidul Islam
Project Associate
Azi Programme
34. Dr. Afsana Alargir Khan
Assistant Director
DGHS
35. Dr. Syed Abdul Hamid
Professor
IHE, DU
36. Md. Serajul Islam
Deputy Director
HEU
37. Dr. Sayeda Nowshin Parnini
Director (Research)
HEU
38. Md. Dabir Al Kader
Deputy Director
HEU
39. Marzia Haque
Director
Audit Unit, DGFP
40. Shaila Sharmin Zaman
Joint Secretary (Planning Branch)
HSD
41. Md. Kamruzzaman
Computer Operator
HEU
42. Dr. Rasheda Sultana
ADG (Admin)
DGHS
43. Md. Ashif Karim
Research Officer
HEU
44. Mohammad Mostafa Kamal
Accountant
HEU
45. Md. Hasnine Sharif
OS, HEU
46. Md. Zahurul Islam
HEU

# ANNEX C. OUNTRY CASE STUDIES ON UNIVERSAL HEALTH COVERAGE STRATEGIES

This annex contains seven country case studies describing their health financing strategies to seek UHC. The cases were selected to encompass diverse financing strategies, from two-tiered SHI to national health systems financed by the public treasury. The countries are Brazil, Chile, and Colombia in Latin America, Ethiopia and Rwanda in Sub-Saharan Africa, Thailand in East Asia, and Sri Lanka in South Asia. Health policymakers in Bangladesh can learn from the enabling factors for these strategies, their pros and cons, and their policy and implementations challenges.

## (a) Brazil: A drastic shift in health policy

Prior to 1988, Brazil had a two-tier SHI health system, similar to that of several other Latin American countries. Under it, one-half of the population lacked effective coverage to health care, a situation particular to Brazil. A new Federal Constitution approved in 1988 gave rise to a new system, currently in place, where all citizens are entitled to free health care under the Unified Health System (SUS for its acronym in Portuguese).

Several authors consider the establishment and roll-out of SUS is a success story in extending health care coverage to disadvantaged population groups that previously did not have access to health care services (OECD 2021). The current system is mixed and segmented into two subsystems: one public and one private, with separate financing streams.

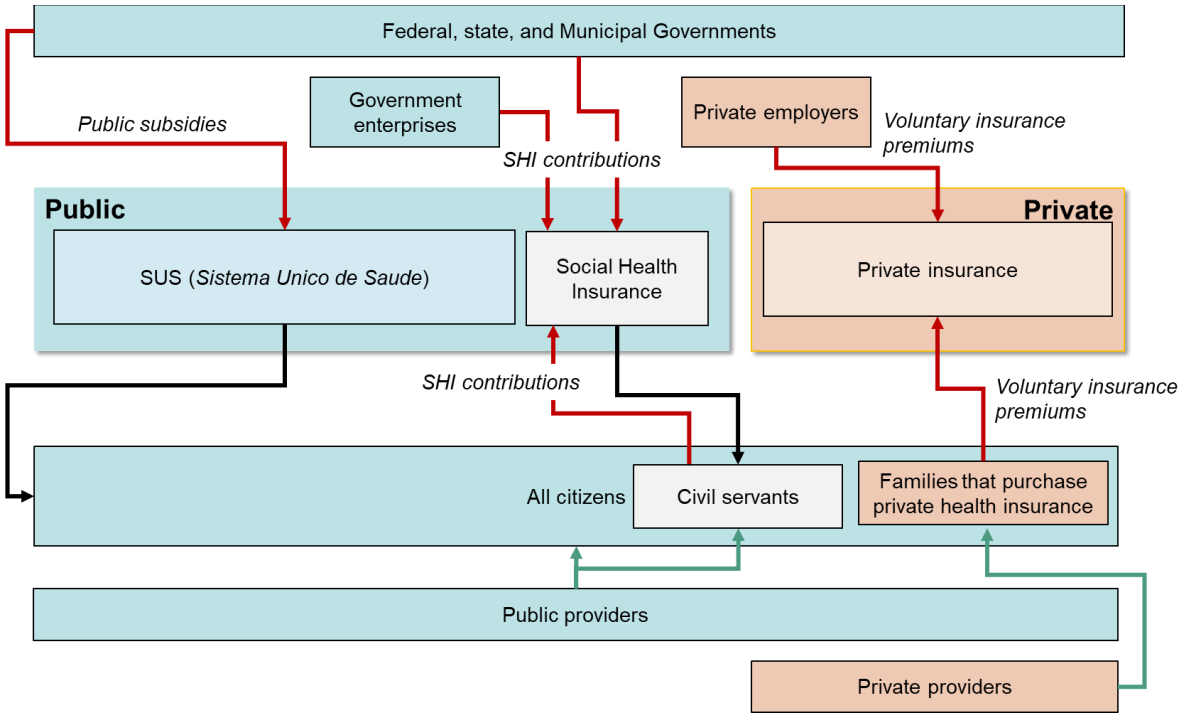
The *public subsystem* has two parts: one, called SUS, provides free universal access to all citizens and is fully publicly financed by the federal, state, and municipal governments. The other is SHI for the military and high-ranking civil servants, with financing from contributions by public employees and the federal government. SUS delivers health services mostly through public providers managed by State or Municipal Health Departments. Under special circumstances it can contract out to private providers, mainly nonprofit since for-profit providers face severe restrictions to provide care under SUS (Esteves 2012).

The *private subsystem* "also has two parts, both of which benefit from some form of fiscal incentive: the first is known as the supplementary system and encompasses several modalities of health insurance. Participation is voluntary, and it is financed either with resources from employers and employees (the rates of contribution are freely negotiated between the parties) or exclusively by individual families. The second segment offers direct access to private providers through out-of-pocket payments [17]. It is worth noting that the population covered by the private subsystem also benefits from the public network through public health activities (e.g. vaccination campaigns), and some also use it for more complex or costly procedures not covered by their private health insurance policies." (Esteves 2012)

"Virtually the entire population is formally covered by the public health sector, with equal benefits and equal financial protection. The reorganization and strengthening of PHC has been a key

component of this success. The Family Health Strategy, one of the largest community-based PHC programs in the world, has successfully increased population coverage, improved key health outcomes, and reduced health inequalities." (Esteves 2012)

**Figure 26 Organization and financing in Brazil's health system**



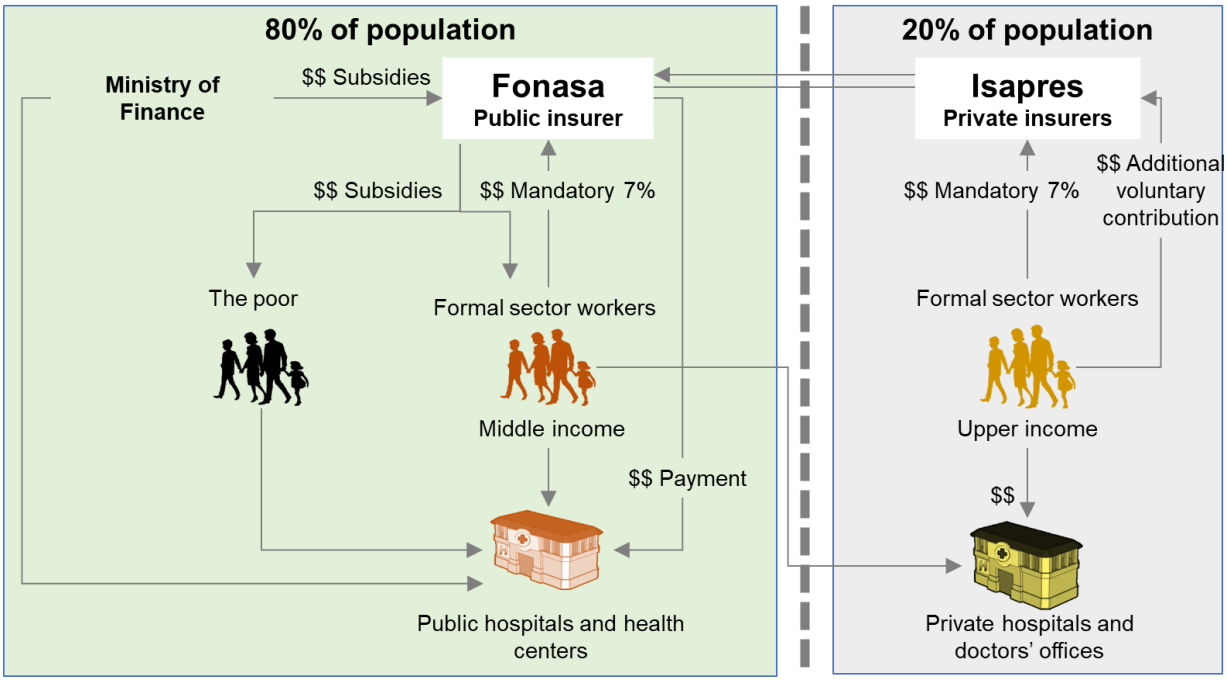

Source: Constructed by the author.

Brazil's SUS system is underfunded, however. The WHO reported that per-capita government health expenditure in 2007 was US$ 252, or US$ 100 less than what it needed that year to deliver quality health care to all the citizens that depended on it (World Health Organization 2019).

### (b) Chile: A Guaranteed HBP for all citizens with public subsidies for the poor

Chile's two-tier SHI system has long been criticized for having two separate subsystems: a large public insurer, Fonasa, covering the indigent and the middle and low-income population and providing health services mostly through public providers; and several for-profit private insurers, Isapres, that cover about one-sixth of the better-off population and providing services almost exclusively in the private sector. Until 2005 the SHI system lacked an explicit HBP, allowing for large differences in the content and quality of services between Fonasa and the Isapres. It has also made it possible for Isapres to engage in risk selection.

**Figure 27 Chile's social health insurance (SHI) system**




Source: Constructed by the author.

A reform implemented in 2005, known as AUGE for its Spanish acronym for *Universal Access with Explicit Guarantees*, defined a basic package for SHI consisting of guaranteed and explicit treatments for 56 priority health problems (see Box 8). In 2010, these were expanded to 69 priority problems and a current government initiative will further broaden the services covered in the package's current 87 health problems. This benefits package not only guarantees treatments, but also sets upper limits on waiting time and out-of-pocket payment for treatment. Coverage for the services left out of AUGE is not guaranteed by Fonasa, although the public insurer devotes more than one-half of its budget to finance non-AUGE services. Isapres provide coverage beyond AUGE, but this additional coverage varies from beneficiary to beneficiary depending on their premium contribution and the health plan purchased.

The AUGE reform has been accompanied by a sizable increase in total health spending in the country, both from public and private sources. Total real health spending per capita grew by 155% between 2005 and 2011, from US$542 to US$1,384), although it has stabilized as a share of gross domestic product at around 7.5%. OOPS has dropped 10 percentage points as a share of health financing in the country, from nearly 50% over the same period. AUGE has improved access to health services for all, including the poor and the other beneficiaries of Fonasa. In Fonasa, this phenomenon has not only been observed for AUGE-covered services, but also for other health services not included in the AUGE benefits package. The government has expanded public providers' capacity to meet the growing demand for AUGE and non-AUGE benefits. The generous benefits package offered by Fonasa to its indigent population (AUGE plus non-AUGE services) has led hundreds of thousands of individuals to underreport their income in order to qualify as indigent beneficiaries. Fonasa has recently taken measures to limit this abuse.

**Box 8 Making health guarantees explicit and legal for all citizens: Chile's AUGE health benefits package**

The 2005 AUGE in Chile law sought to ensure that all Chileans, irrespective of age, gender, income, ethnicity, and health insurance coverage have access to the same HBP. The contents of the HBP were formulated in terms of priority diseases and associated priority medical interventions, both preventive and curative. To ensure that there would be no differences in access to quality services, and that services would be timely for all, the AUGE reform stipulated in the law four guarantees for AUG: Access, quality, waiting time, and financial protection (see Figure 8). Government has been forced to make significant increases in health spending to ensure that all AUGE guarantees are met for the beneficiaries of the public insurer (Fonasa). To prevent cost escalation, a feature of the law, included at the request of the Ministry of Finance, is that the annual per citizen cost of the AUHE HPB cannot exceed a legally defined threshold linked to the national remuneration index. Thus, the contents of and therefore the cost this HBP cannot be expanded above a ceiling, to ensure that there is enough public financing available.

**Figure 28 The 4 guarantees of Chile's AUGE health benefits package**


Sources: (Bitran, Escobar, and Gassibe 2010; Bitran 2013).

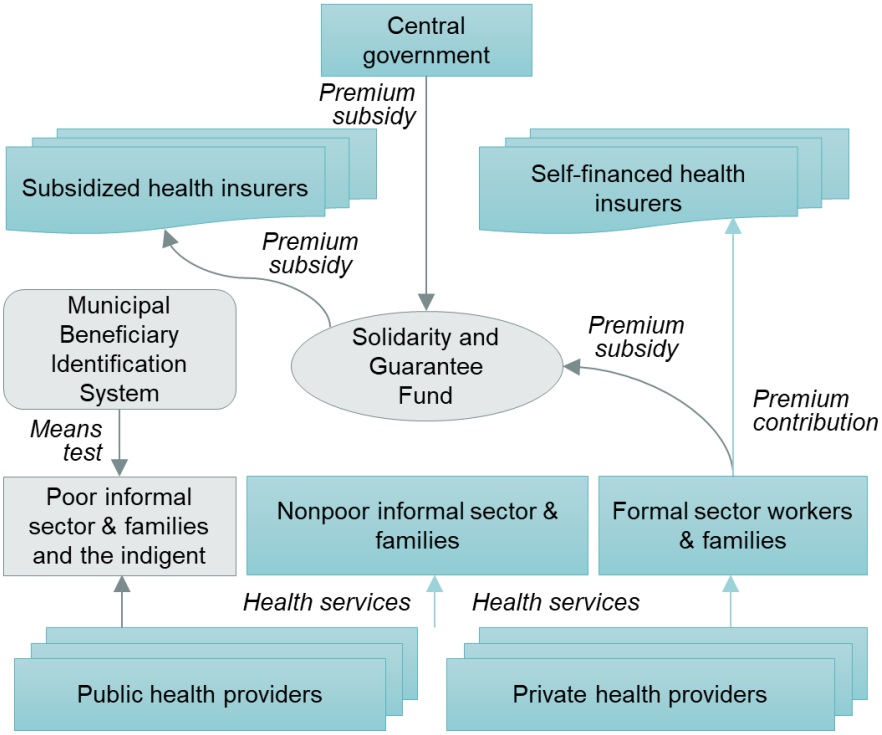
## (a) Colombia: A big-bang health reform currently being challenged

While Colombia's health system is facing an impending reform under the government of Gustavo Petro (Torrado Feb. 2, 2023), the mechanisms this country uses –and may still preserve– to target public and private subsidies for health toward the poor may contribute to the health policy debate in Bangladesh. Those mechanisms helped to improve overall access and equity in health in Colombia (Giedion and Uribe 2009).

A comprehensive SHI reform implemented in 1994 sought to introduce solidarity and competition in the provision of health insurance and health services in Colombia. The country's population was divided into two groups: (1) those that could self-finance health insurance coverage (mostly the formal sector) and (2) the low-income informal and the poor. The self-financing group made a mandatory SHI contribution of 12%, of which 1 percentage point was used as a private cross-subsidy to pay for part of the cost of providing SHI coverage for the poor (see

Figure 29). Additional funding to subsidize insurance for the poor came from the central government through general taxation.

**Figure 29 Solidarity in the Financing of Colombia's Subsidized SHI Regime**




Source: Constructed by the author.

Public and private funding for the subsidized SHI regime was centralized in the Solidarity and Guarantee Fund (FOSYGA). Municipalities were responsible both for identifying the low-income and the poor through an official means test and for enrolling them with a subsidized SHI insurer. The solidarity fund (FOSYGA) transferred financing to the chosen insurers.

Several evaluations of Colombia's health system reform have shown positive results. For example, Giedion and her colleagues concluded that the reformed system greatly increased access to and use of health services, even those that were free for all, and that it reduced the incidence of catastrophic health spending. They also found that the reform's impact was more dramatic among those most vulnerable to health shocks: those living in rural areas, the poorest, and the self-employed (Giedion and Uribe 2009). Giedion and Cañón (2014) note the following reform achievements: "(1) Today, the entire insured population enjoys the same HBP regardless of socioeconomic status and ability to pay. Among Latin American countries with an explicit HBP, only Colombia, Uruguay and Chile have made as much progress in this regard; (2) The reform allowed the country to coordinate different health system stakeholders, funding sources, and policies that universalized the explicit guarantees of rights for the population in a fiscally sustainable manner; and (3) By establishing rights and benefits through the mandatory HBP and paying for them with the capitation payment unit, the country was able to respond to different setbacks, such as rising unemployment, with the tax and macroeconomic adjustments necessary

to maintain the financing of the health care system. In addition, it has created a direct link between the cost of the HBP and the allocation of resources to service providers, something that rarely happens in Latin America".

### (b) Ethiopia: An approach to UHC similar to Bangladesh's

Sub-Saharan African countries face the challenge of raising sufficient revenue to finance the delivery of an essential package of health services to their population. In the face of this challenge, they have shown growing interest in two health financing mechanisms, Social Health Insurance (SHI) and Community-Based Health Insurance (CBHI). Ethiopia, Ghana, Kenya, Lesotho, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe are countries from the region that have launched or are in the process of launching SHI. Ethiopia has also been implementing CBHI schemes since 2001. This section describes the design, implementation, and achievements and challenges of Ethiopia's SHI and CBHI.

*CBHI*. The governments aims to scale up CBHI to cover 80% of Ethiopia's informal sector population. So far 32 million households, or about one-third of the country's national population of approximately 105 million, are enrolled in to CBHI schemes, according to the Ethiopian Health Insurance Agency (EHIA). The government's Health Sector Transformation Plan (HSTP 2015/16-2019/20)—an initiative cofinanced by the World Bank, the Global Financing Facility (GFF), other development partners, and the government of Ethiopia—has set a target of reaching 80% of household enrollment in CBHI by the end of the Health Sector Transformation Program (HSTP) period (Bitrán and Arpón 2021).

CBHI in Ethiopia is subsidized by the Ministry of Health and its development, as well as that of SHI, is coordinated by the Ethiopian Health Insurance Services. There is insufficient and contradictory information about the financing of CBHI. The World Bank (2016) reported that the government of Ethiopia subsidizes enrollment in both SHI and CBHI but that the subsidy for enrollment premium is more generous for SHI than CBHI. Further, it states that the effective coverage under SHI is likely to be more generous than CBHI, even if the benefits package of both schemes may appear similar on paper. As of 2015, the government subsidy for SHI enrollees (government employees) was approximately US$16 a year, while for CBHI enrollees it was only US$2.5 per year. Other authors report that the subsidy premium for CBHI is heavily subsidized by government.

The CBHI scheme was first piloted in 13 woredas (districts) in 2010 and has since expanded to cover almost all the 832 woredas in the country. Members pay a small yearly premium payment of 500 Ethiopian Birr (US$ 10), while there is a reduced fee of 240 Ethiopian Birr (around US$ 5) for dependents aged above 18 years. Between 2015 and 2020, about 7 million households containing 32 million people enrolled in CBHI. About 5.5 million of these households were members paying the yearly premium, while the remaining 1.5 million households were fully financed sponsored by the government. As of 2020, 1,920 health centers and 245 hospitals nationwide were contractually providing health services to CBHI beneficiaries. In addition, about

15% of these health facilities have established contractual agreements with third-party providers such as the Red Cross, Kenema Pharmaceutical Enterprise and other private and public pharmacies to fill gaps in the availability of essential medicines in health facilities (WHO Regional Office for Africa 2022).

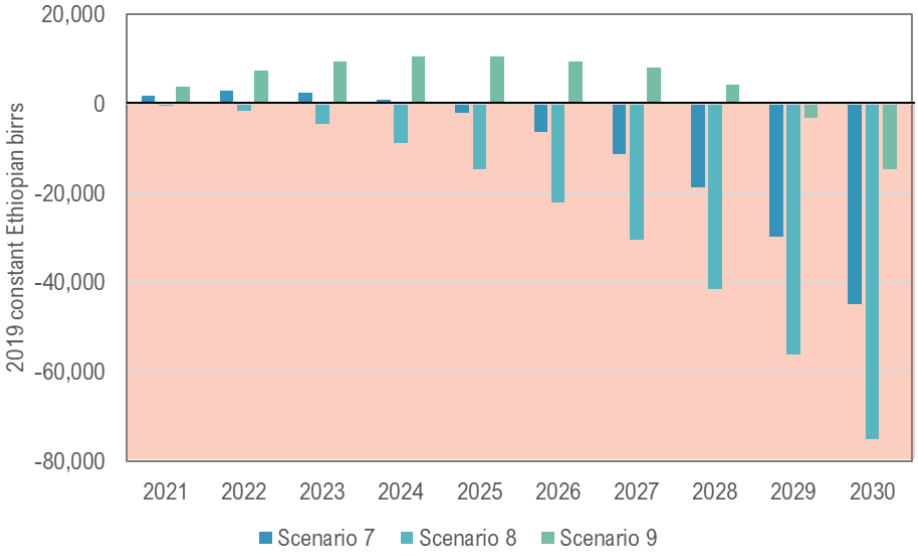
The World Bank (2016) also concluded that efficiency could be compromised from the perspective of insurance management and risk pooling. The coverage expansion approach with SHI and CBHI will result in one large pool for SHI enrollees who are relatively better-off and hundreds of small pools for CBHI enrollees.

Mulat et al. (2022) reviewed the challenges ahead for the expansion and sustainability of CBHI. They included: limited risk pooling and financial sustainability; lack of legal framework and poor institutional accountability; weak health service delivery system and limited engagement with the private sector; absence of political commitment at the sub-national level; constrained implementation capacity, especially at the woreda level; and weak information systems to support daily operation and informed decision.

*SHI*. In 2010, the House of People's Parliament of the Federal Democratic Republic of Ethiopia ratified the establishment of an SHI system. However, the kick-start of implementation of the proclamation has not yet happened for several reasons. In 2021 the EHIA decided to revisit the SHI agenda by generating all the necessary evidence with regard to the financial and operational prospects of the SHI model. This study fits within that initiative.

An analysis by Bitrán and Arpón (2021) commissioned by the World Bank concluded that a premium of 8% for formal workers, split between workers and employers, and a premium of 2% for pensioners, split between pensioners and government, would allow the SHI agency to break even during part or all of its first 10 years of life, except under the pessimistic macroeconomic scenario (Figure 30). These authors recommended, on equity grounds, not to increase government subsidization of the SHI premium for the formal sector. Formal sector workers and pensioners have on average incomes much higher than the rest of the informal working population. Government is supporting the expansion of CBHI for the poor and the nonpoor informal by cofinancing CBHI premium subsidies and offering technical assistance through EHIA to these insurance schemes. If government expanded its financial support of SHI for the formal sector, this would result in a regressive use of government subsidies, with higher-income formal workers receiving a significantly higher share of public subsidies than the less affluent nonpoor informal population and the poor.

**Figure 30 Ethiopia: Projected cumulative Social Health Insurance Fund, 2021-2030 (2019 constant Ethiopian birrs)**




Source: Bitrán and Arpón (2021).
Scenario 7: Base Macroeconomic Scenario and SHI Scenario with HBP as Defined in MOH (2019)
Scenario 8: Pessimistic Macroeconomic Scenario and SHI Scenario with HBP as Defined in MOH (2019)
Scenario 9: Optimistic Macroeconomic Scenario and SHI Scenario with HBP as Defined in MOH (2019)

In conclusion, CBHI coverage has expended to much of Ethiopia's poor and nonpoor informal population while, to the best of the author's knowledge, SHI continues to be evaluated and its implementation postponed. There are multiple challenges ahead for the CBHI scheme to become financial sustainable and to deliver quality care to its beneficiaries. Also, there may be a need for increased government subsidization of CBHI, a fact which will strain public finances but which may help to sustain this insurance mechanism for the poor and nonpoor informal. The merger of several CBHI schemes to create larger CBHI risk pools could make this scheme financially more sustainable. SHI remains a project facing a complex political path and its future remains in question.

### (c) Rwanda: A pioneering, lone, and coveted UHC success story

Rwanda is the country with the highest enrolment in health insurance in Sub-Saharan Africa. At the core of Rwanda's path to UHC is its community-based health insurance (CBHI) system, which covers more than three-quarters of the population (Chemouni 2018). While 96% of people in Rwanda were covered by health insurance in 2011, CBHI had the highest coverage rate at 91 per cent (International Labour Office 2016).

Rwanda's CBHI program started in 1999 and was fully implemented in 2006-2008. Its goal was to provide affordable basic services to the uninsured which accounted for the vast majority of the country's population. Funding for Rwanda's CBHI comes from annual member premiums (50%), other insurance funds, external funds, and the central government. The average annual premium per person in 2007 was US$ 1.81. There are premium exemption for the poorest. Rwanda's CBHI

system has had multiple achievements: it has reached more than 90% coverage, increased health care utilization, and decreased household catastrophic expenditure (Makaka, Breen, and Binagwaho 2012; Woldemichael, Gurara, and Shimeles 2019). It has also increased life expectancy at birth and reduced child and maternal mortality (International Labour Office 2016). Remaining challenges are low utilization rates and catastrophic expenditure rates that are higher for poor enrollees.

Parallel to its CBHI policy, Rwanda carried out another important reform of its health system. It introduced performance-based financing (PBF) and decentralization (Rusa et al. 2009). PBF was implemented in 2002-2008. Government makes payments to public health facilities conditioned upon taking measurable action or achieving predetermined performance targets. The transfer from the central government to health facilities equals US$1.80 per capita conditional on a performance-based formula that includes 22 key indicators. The PBF policy has resulted in an increase in health care utilization and a reduction in catastrophic expenditures, a goal shared with the CBHI policy.

Rwanda's CBHI system, with its broad population coverage, cannot easily be exported to other countries because a set of special circumstances led to its successful development. An analysis of the political economy of Rwanda's CBHI reform by Chemouni (2018) concluded that "the commitment to expanding health insurance coverage was made possible by a dominant political settlement. CBHI is part of the broader efforts of the regime to foster its legitimacy based on rapid socio-economic development. Yet, CBHI was chosen over other potential solutions to expand access to health care because it was also the option the most compatible with the ruling coalition core ideology.". This author also concluded that pursuing UHC is an eminently political process where ideology plays a central role. He claims that a UHC strategy that is compatible with the political economy of a country but incompatible with the ideas of the ruling coalition is likely to run into political obstructions. Finally, Chemouni also questioned the relevance of Rwanda's experience for other developing countries, as the main mechanism to reach UHC, by relying only on voluntary enrolment and community management of CBHI.

The World Health Organization (WHO 2020) concludes that CBHI schemes usually rely on voluntary enrolment and collect member's financial contributions to set up pooling funds through which to offset the cost of health care. Low-income countries seeking UHC often view CBHI as a promise to cover the poor and the nonpoor informal populations. Yet, evidence suggests the impact of CBHI on financial protection and access to needed health care is moderate for those enrolled. Further, most CBHI schemes have low participation levels and the poorest people usually remain excluded. Theory and practice show that CBHIs play only a limited role in helping countries move towards universal health care (UHC). However, they can have other positive impacts such as community development and local accountability of health care providers.

### (d) Sri Lanka: the well-performing all public conventional health system

Sri Lanka has for decades been a role model for health and development. Yet the country is currently in an economic crisis resulting from several political mishaps as well as the COVID-19 pandemic. Heavy borrowing in international financial markets at high interest rates, banning the import of chemical pesticides to curb outflow of foreign currency, tax cuts, the effects of the COVID-19 pandemic and, more recently the depressed tourism sector caused by the Russia-Ukraine war have thrown Sri Lanka into an economic downfall. The situation has forced millions of people into poverty and has put national health care in jeopardy (The Lancet Regional Health (Southeast Asia) 2022).

But before the current crisis, Sri Lanka had done remarkably well over time in achieving good health outcomes while spending a relatively small share of its GDP on health. The country's health system, like that of Bangladesh, is considered a model for good health at a low cost and features in an important international publication among a few selected developing countries with such quality (Balabanova, McKee, and Mills 2011). In Sri Lanka, most health indicators have continued to improve over the years while communicable diseases show a low prevalence and the MCH indicators are on a par with some of the developed countries. The likely explanation for these health gains despite low health spending may be the continuing investments in social and human development policies of successive governments such as free education and poverty alleviation programs, which have resulted in improved health care. According to (Rajapaksa et al. 2021) Sri Lanka's health gains "may be attributed to the socio-political milieu of the country from early on and the widespread health services which have been free at the point of delivery, which acted as drivers of demand."

According to Smith (2018), "Sri Lanka has provided universal, free access to government-provided health care services to its population since the 1930s. Preventive health care services are provided through a well-planned network of facilities across the country, each of which is led by a Medical Officer of Health. Their responsibilities include maternal and child health and infectious disease control. The separate curative care network offers comprehensive services but is less well-organized, as there is no referral system and many patients bypass lower-level facilities in favor of secondary and tertiary care. The private sector also plays an important role in Sri Lanka's health system equilibrium, especially in the context of outpatient curative care, where government doctors can supplement their salaries during off-duty hours and patients willing to pay out-of-pocket can receive more convenient, personalized care."

What is remarkable about Sri Lanka, in the context of several prevailing health reform paradigms in the developing country context, is that up until recently Sri Lanka had made all these achievements without making any significant health system reforms. Thus, all health financing comes from the treasury, financing and provision remain in public hands without the so-called purchaser-provider split, government health care providers are financed through supply-side

budgets while performance-based financing plays no role in paying for health care, and no national health insurance system has been created (Smith 2018).

Out-of-pocket (OOP) spending accounts for about 40% of total health expenditures. Evidence on utilization patterns suggests that access to care in the government sector is pro-poor. The bottom 40% is more likely to use public outpatient care than the top 40%, while inpatient use is quite equal across all groups. While there is no explicit targeting, utilization patterns suggest that there is implicit targeting of the poor, largely because the better-off opt out due to the "consumer experience" of accessing health care in the public sector. In particular, government operating hours are less convenient, waiting times are much longer, and provider

Government health services started with the creation a civil medical department in 1858. In 1926, the preventive services were reorganized with the establishment of the health unit system. The legal framework for the country's health services the Sri Lanka Health Services Act 12 of 1952, with revisions in 1956 and 1962. The Medical Service Minute of Sri Lanka No. 662/11, published in 1991 and amended in 2001 and 2014, is applicable to medical personnel employed in the health services of the country (Rajapaksa et al. 2021).

Curative services are provided by a government-run network of tertiary- and secondary-care, divisional hospitals (outpatient and inward care), and primary medical care units offering outpatient care. Around the country's territory the medical officer of health (MOH) and his team provide preventive services through health units. All publicly provided curative and preventive health services are free of charge at the point of delivery; they account for 95% of inpatient care and around 50% of outpatient care. The armed forces, police and prisons have their own, separate health providers. A small but growing private health care sector exists but its prices limit its market to only a small share of the population. Health care is a partially devolved public service. The Ministry of Health (MoH) is responsible for stewardship functions while the primary and secondary levels of curative care and preventive services function under nine provincial ministries. The first comprehensive national health policy based on PHC was prepared in 1992 and later revised with a focus on universal health coverage (UHC) (2014–This2016). The current policy (2016–2025) addresses emerging health issues, quality and safety, and the expectations of the people (Rajapaksa et al. 2021).

### (e) Thailand: A successful and incremental UHC strategy emphasizing PHC

Thailand, like many other developing countries, chose an incremental approach to health coverage expansion (Reich et al. 2016). It gradually increased coverage for nearly 30 years by extending health protections to different groups of the population such as the poor, public and private sector employees and the informal sector (Tangcharoensathien et al. 2012). In 2001 Thailand passed the National Health Security Act, a reform expanding coverage to 18.5 million uncovered people and achieved UHC. The reform also shifted government financing away from major urban hospitals toward PHC. The government made a bold decision to use general taxation

to finance the Universal Health Coverage Scheme without relying on contributions from members, at the time when per capita income in Thailand was a mere US$ 2,091 in current dollars.

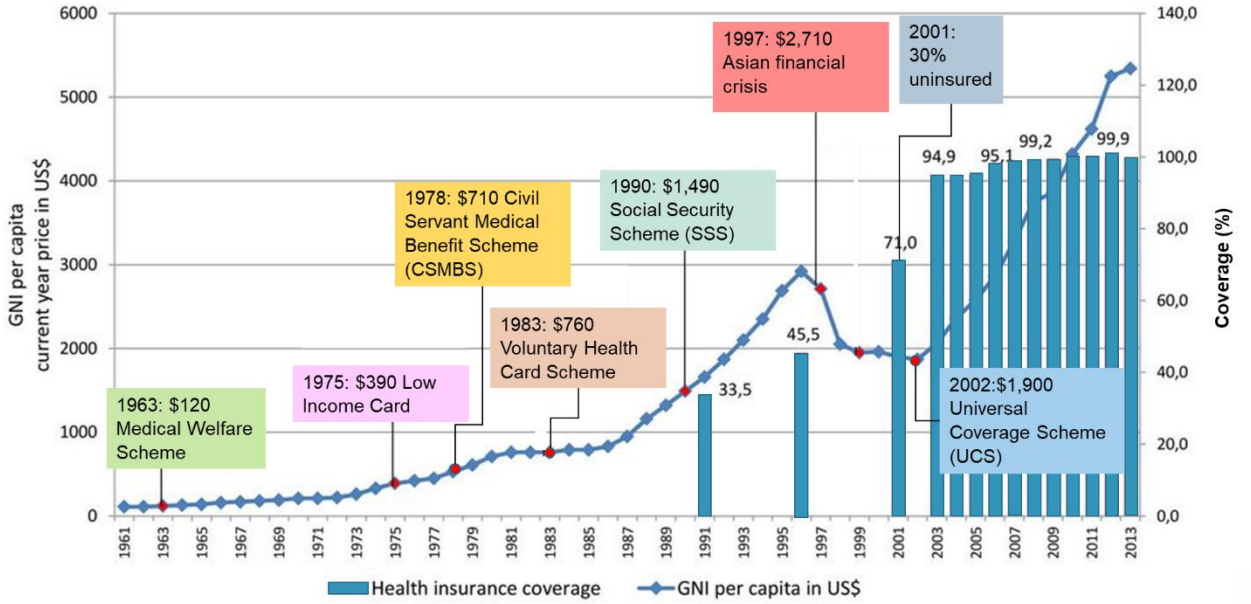
The country has achieved full population coverage through three public health insurance schemes. They are described in Table 8 while the evolution of coverage and per capita income is shown in Figure 31. The available evidence shows a high level of service coverage and financial risk protection and low level of unmet health care need (Tangcharoensathien et al. 2019). It also shows "substantial reduction in levels of out-of-pocket payments, the incidence of catastrophic health spending, and in medical impoverishment. The scheme has also "greatly reduced provincial gaps in child mortality. Certain interventions such as antiretroviral therapy and renal replacement therapy have saved the lives of adults. Well-designed strategic purchasing contributed to efficiency, cost containment, and equity. Remaining challenges include preparing for an ageing society, primary prevention of non-communicable diseases, law enforcement to prevent road traffic mortality, and effective coverage of diabetes and tuberculosis control" (Tangcharoensathien et al. 2018).

**Table 8 Key characteristics of the three main public health insurance schemes in Thailand as of 2020**

| Characteristics | Government Employees (CSMBS) | Social Security Scheme (SSS) | Universal Health Coverage (UC) |
|---|---|---|---|
| Population Coverage | Civil Servant, pensioners and their dependents (parents, spouse, children) | Formal sector private employee | The rest of Thai population who are not eligible for CSMBS and SSS. |
| **Benefits** | | | |
| Ambulatory services | Public Only | Public & Private | Public & Private |
| Inpatient services | Public & Private (emergency only for private) | Public & Private | Public & Private |
| Choice of provider | Free choice | Contracted hospital or its network with referral line, registration required | Contracted hospital or its network with referral line, registration required |
| Cash benefit | No | Yes | No |
| Maternity benefits | Yes | Yes | Yes |
| Annual Physical checkup | Yes | No | Yes |
| Prevention Health Promotion | No | Yes | Yes |
| Services not covered | Special nurse | Private bed, special nurse | Private bed, special nurse, eyeglasses |
| Copayment | Yes (inpatient at private hospital only) | Maternity, emergency services | 30-baht/visit* |
| **Financing** | | | |
| Source of funds | General tax | Employee & Employer | General tax |
| Financing body | Comptroller General Department, Ministry of Finance | Social Security Office | National Health Security Office |
| Expenditure per capita (in 2006) | 8,785 | 1,738 | 1,659 |
| Per capita tax subsidy (in 2006) | 8,785 (plus administrative cost) | 579 (plus administrative cost) | 1,659 (plus administrative cost) |

Source: Reported by Wagstaff and Manachotphong (2012a).
* The 30-baht copayment was eliminated in 2006.

**Figure 31 Thailand's path to universal health coverage against GNI per capita, 1963-2013**




Source: Prakongsai (2015) and Health Insurance System Research Office (2012).

Wagstaff and Manachotphong (2012a) conducted an empirical study to explore the possibility that Thailand's UHC policy may inadvertently result in distorted labor market choices, with workers preferring informal employment over formal employment. This would lead to negative effects on investment and growth, as well as reduced protection against non-health risks and the income risks associated with ill health. According to these authors, the Thai reform was an especially interesting one from a labor market perspective for three reasons: First, there were minimal copayments and no joining fee in Thailand's UC scheme –everyone was covered automatically with a 100% subsidy. Second, the relative generosity of the two schemes differed. Both were less generous than the social security scheme: on a per-beneficiary basis Thailand's UC scheme spent 85% of the amount spent by the social security scheme. Third, the social security scheme treated dependents differently: Thailand's social security scheme did not cover dependents. Thus, at least prior to the UC reform, the health coverage rules gave each household member an incentive to seek a formal-sector job. Health coverage rules prior to the reform thus created an incentive for Thai households to keep adding formal-sector workers. The reform may have had an informalizing effect– a larger fraction of workers were encouraged to formalize prior to the reform but discouraged from formalizing after the reform. The authors found that universal coverage in Thailand appeared "to have encouraged employment especially among married women, to have reduced formal-sector employment among married men but not among other groups, and to have increased informal-sector employment especially among married women. The largest positive informal-sector employment effects are found in the agricultural sector." (Wagstaff and Manachotphong 2012b).

# ANNEX D. THE SPECIAL CASE OF HEALTH INSURANCE FOR CIVIL SERVANTS[7]

## (a) Introduction

Countries with national health service-like health system offer the same coverage to civil servants (CSs) that they offer all other citizens or residents. Instead, countries with a hybrid health system that relies on SHI often prioritize the coverage of CS because of political economy considerations: typically, CSs are a powerful political stakeholder and they often demand that government cover them with health insurance. This is the case in Bangladesh, a country that has set out to pursue UHC with a hybrid system that combines SHI for the formal sector (including civil servants) with government subsidized coverage for the poor and the nonpoor informal.

Owing to CSs' political strength, setting up health coverage programs for them is the very first step that many countries take when implementing SHI. For example, India launched its Central Government Health Scheme (CGHS) in 1954 (Welfare 2022). China also launched its Government Insurance Scheme for Civil Servants in the early 1950s(Liang and Langenbrunner 2013). Turkey initiated health insurance for CSs in 1949 (Turkey 1950). Mexico introduced the Institute of Security and Social Services of State Workers (ISSSTE) for CSs in 1959 (López, Nieto, and Others 2015). Indonesia started its Askes program for CSs in 1968 (Humas 2020). Thailand launched its Civil Servants Medical Benefits Scheme in 1960 (Towse, Mills, and Tangcharoensathien 2004). Korea started mandatory insurance for CSs in 1979 (Bazyar et al. 2021).[8]

In most cases, health insurance schemes for CSs were introduced prior to the launch of social insurance for the private formal sector, although in some countries (e.g., Vietnam) a single program for both groups was established at the same time. In Korea CSs' health insurance was offered only after large firms (500+ employees) had adopted it. In Africa, there are more countries with CSHI than for the private formal sector. Political considerations, including the relatively strong political clout of CSs, are important factors behind the common pattern whereby countries choose to launch coverage programs for CSs first.

## (b) Health insurance for civil servants in Bangladesh

The feasibility of setting up health insurance for CSs has already been the subject of study in Bangladesh.

A Concept Paper by Hamid (2014) carried out an actuarial study to assess the financial feasibility of the CSHI scheme in Bangladesh. In accordance with the international experience described in the preceding section, he stated that *"Introducing a contributory as well as compulsory health*

[7] This annex reproduces a Policy Brief with the same name written by study co-author Ricardo Bitrán under a previous assignment financed by WHO's Office in Bangladesh.

[8] This and the following paragraphs are taken from Smith, O. (2020). A Note on Insurance Schemes for Civil Servants Around the World. New Delhi, The World Bank.

*insurance scheme for public servants may be a starting point of introducing SHI in Bangladesh.(…) This scheme either may be gradually extended to cover the employees of the autonomous institutions, private institutions in the formal and semi-formal sectors or may lead to develop separate scheme for them via gaining knowledge and experience, and developing insurance infrastructure".*

A subsequent report on the same subject by Hamid et al. (2015) provided further detail on the institutional design of the CSHI scheme, conducted further simulations about the expected utilization of inpatient services by the insured, and proposed that the premium be cofinanced by the CSs and the government as the employer.

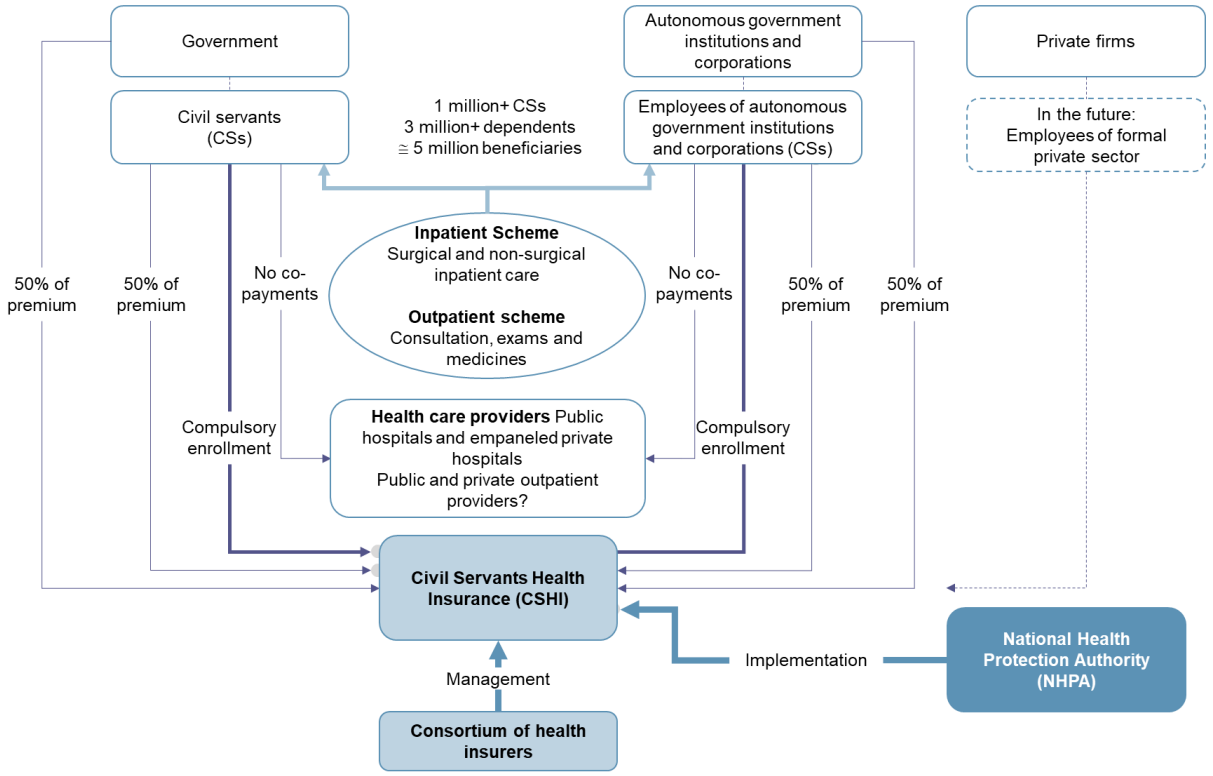
The design elements of the proposed CSHI scheme described in these two reports were as follows:

- It would be a contributory health insurance scheme covering hospital care, initially for public servants and the employees of autonomous government institutions and corporations and their eligible family members. Approximately 1 million CSs/government employees would join along with another 3 million family members, for a total of 4 million beneficiaries.
- The insurance scheme could subsequently be extended to the employees of the formal private sector.
- Enrolment in the scheme would be compulsory for all CSs and employees of government companies.
- Enrolment would require the payment of an "actuarially fair" premium, that is, a premium that would allow the scheme to balance revenue from premiums with expenditures from hospital care and administration.
- Financing of the premium would be split between the CSs (worker) and the government (employer). The contributing shares of CSs and government remain to be determined but could be in percentage terms 50:50, or a smaller share for the CS and a larger share for government.
- Government's subsidization of the premium of lower grade employees (e.g., third- and fourth-class employees) could be higher than for regular CSs.
- The premium could be deducted from the worker's salary.
- If the spouse is also a government employee, then the premium could be deducted from only one of them (e.g., the younger of the two).
- The recommendation to require that CSs pay a premium is to draw needed revenue for this social program but also to familiarize them with the real cost of health insurance. Not charging a premium to the insured could, in the future, result in continuous pressure on the government to increase the scheme's benefits.
- The insured would not have to make any copayments (in would be a so-called "cashless" health insurance) to health care providers when receiving health care.

- The CSHI scheme would be implemented for a block period of 5 years.
- The benefit would cover all family members (that it, it would be on a "floater basis" during the 5-year block period with no restriction on the volume of care received.

The following figure depicts the CSHI scheme proposed by Hamid and colleagues.

**Figure 32 Proposed design of CSs' Health Insurance Scheme for Bangladesh**




Source: Prepared by the author from (Hamid et al. 2015).

The most recent actuarial study that Hamid and his colleagues examined the financial feasibility of a health insurance scheme which considered three inpatient and three outpatient health benefits packages (I, II, or III), where the difference between the packages in each category of care was the maximum annual coverage ceiling per insured family (Hamid et al. 2015). Beneficiaries would not be required to make any copayments as long as they did not meet the annual ceiling, but they would pay providers' bills in full after reaching the ceiling. As is shown in Table 9, the annual financial coverage ceiling for the inpatient package would vary between 3.5 and 7.0 times the average monthly salary of a CS depending on the package chosen, while the employee's monthly premium would vary accordingly, from 1.4% to 2.6% of the average salary.[9] Similar information is presented in Table 10 for the outpatient component of the proposed coverage scheme. Maximum annual benefit amounts would one-tenth those proposed for the inpatient

[9] Average monthly salary of civil servant in 2022: 28.400 BDT (http://www.salaryexplorer.com/salary-survey.php?loc=18&loctype=1&job=30&jobtype=1).

coverage, although the monthly premium would be similar –a rather surprising proposal considering the tenfold difference in coverage ceilings for these two types of care. In any case, a total employee monthly contribution of, say, 2.8% of the employer's salary for Package I, and an equivalent matching contribution by government as the employer, seems in line in magnitude with the international practice. It must be noted, however, that these estimates were made assuming relatively low frequencies of annual hospitalization for children and adults (from 3.2% to 4.0% respectively, compared with 8% to 12% for private sector employees) and of ambulatory care (from 25% for children to 78.8% for the worker's parent, equivalent to less than one annual visit per capita to the doctor or health care provider per year).

**Table 9 Inpatient protection scheme**

| Package | Parents' age up to 65 years | | Parents up to age 70 years | |
|---|---|---|---|---|
| | Maximum benefit per family per year | Premium per employee per month | Maximum benefit per family per year | Premium per employee per month |
| In BDT* | | | | |
| Package I | 100,000 | 400 | 100,000 | 500 |
| Package II | 150,000 | 600 | 150,000 | 650 |
| Package III | 200,000 | 750 | 200,000 | 800 |
| In relation to average monthly salary | Number of times | Percent | Number of times | Percent |
| Package I | 3.5 | 1.4% | 3.5 | 1.8% |
| Package II | 5.3 | 2.1% | 5.3 | 2.3% |
| Package III | 7.0 | 2.6% | 7.0 | 2.8% |

Source: Top half of the table from (Hamid et al. 2015). Bottom half calculated by the author.
* As of March 2022 1 US$ = 86 BDT

**Table 10 General outpatient protection scheme**

| Package | Parents' age up to 65 years | | Parents up to age 70 years | |
|---|---|---|---|---|
| | Maximum benefit per family per year | Premium per employee per month | Maximum benefit per family per year | Premium per employee per month |
| **In BDT** | | | | |
| Package I | 10,000 | 400 | 10,000 | 500 |
| Package II | 15,000 | 550 | 15,000 | 650 |
| Package III | 20,000 | 650 | 20,000 | 800 |
| **In relation to average monthly salary** | **Number of times** | **Percent** | **Number of times** | **Percent** |
| Package I | 0.4 | 1.4% | 0.4 | 1.8% |
| Package II | 0.5 | 1.9% | 0.5 | 2.3% |
| Package III | 0.7 | 2.3% | 0.7 | 2.8% |

Source: Top half of the table from (Hamid et al. 2015). Bottom half calculated by the author.
* As of March 2022 1 US$ = 86 BDT

Hamid and his colleagues also estimated the total government spending required to cofinance coverage, under different scenarios regarding both the package implemented and the share of the premium financed by government.

**Table 11 Inpatient Scheme: Annual budgetary allocation required by the government[10]**

| Package | Scenario I: 50:50 | | Scenario II: 60:40 | | Scenario III: 75:25 | |
|---|---|---|---|---|---|---|
| | Parents' age up to 65 years | Parents' age up to 70 years | Parents' age up to 65 years | Parents' age up to 70 years | Parents' age up to 65 years | Parents' age up to 70 years |
| In Crore Taka | | | | | | |
| Package I | 240 | 300 | 288 | 360 | 360 | 450 |
| Package II | 360 | 390 | 432 | 468 | 540 | 585 |
| Package III | 450 | 480 | 540 | 576 | 675 | 720 |
| In relation to public spending and expenditure on CSs' salaries (%) | % of public spending | % of CSs' salaries | % of public spending | % of CSs' salaries | % of public spending | % of CSs' salaries |
| Package I | 0.04% | 0.44% | 0.05% | 0.52% | 0.06% | 0.66% |
| Package II | 0.06% | 0.57% | 0.08% | 0.68% | 0.10% | 0.85% |
| Package III | 0.08% | 0.70% | 0.10% | 0.84% | 0.12% | 1.05% |

Source: Top half of the table from (Hamid et al. 2015). Bottom half calculated by the author.
1 Crore Taka = 10 million BDT.
1 US$ = 86 BDT.

## (c) Health insurance for civil servants in other countries

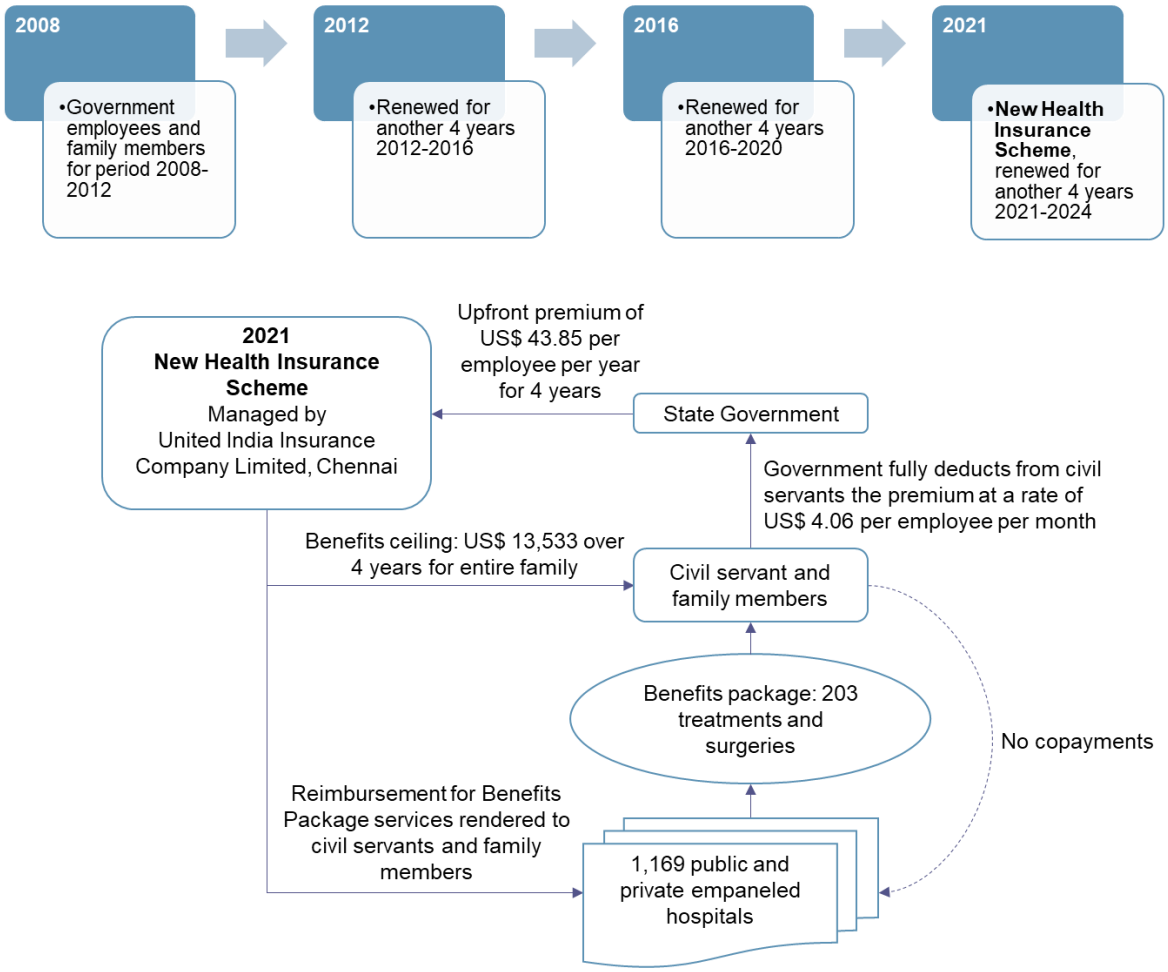
As already stated, many countries around the world have set up health insurance schemes for CSs and have adopted diverse designs in terms of the sources of financing, the health benefits covered, the institutional design, and the provider payment methods. Smith offers a useful comparison of key design features of CSs insurance schemes in selected countries (Smith 2020). To illustrate the variation in design, this section offers a description of two such schemes, the scheme set up in Tamil Nadu State India, and Thailand's CSMBS.

### *Tamil Nadu State, India*

The CS health insurance scheme implemented in Tamil Nadu shares many similarities with that proposed by Hamid and colleagues for Bangladesh. As is shown in Figure 33, it is a mandatory insurance for all CSs; it covers CSs and their family members, including the spouse, children, and the employee's parents; the state government directly deducts the premium from the employee's payroll; funding for the scheme comes entirely from the employees' premium, with no additional funding from government; there is an annual benefits ceiling spanning a period of four years; the beneficiaries (CSs and their covered family members) are not required to make any copayments, and therefore it is a so-called "cashless" insurance; the scheme offers a broad health benefits package; and a commercial health insurer manages the scheme.

[10] GDP in 2022: 400 US$ billion (https://tradingeconomics.com/bangladesh). Government spending as a share of GDP in 2022: 16,3% (https://www.statista.com/statistics/438401/ratio-of-government-expenditure-to-gross-domestic-product-gdp-in-bangladesh). Government spending in 2022: 65 US$ billion (Calculated by the author). Salaries of civil servants as a share of the public budget in 2022: 12,2% (https://unb.com.bd/category/Special/spending-on-public-servants-remuneration-to-witness-uptick-from-next-fiscal/67193). Salaries of civil servants in 2022: 8.0 US$ billion (calculated by the author).

**Figure 33 New Health Insurance Scheme in Tamil Nadu State, India**




Source: Constructed by the author from The Hindu, T.N. implements new health insurance scheme for its staff, in The Hindu. 2021 (July 2): Tamil Nadu and (Nadu 2021).

An apparent difference with the CSHI that Hamid et al. proposed for Bangladesh is that Tamil Nadu's health benefits package seems to cover only hospital services, whereas Bangladesh's proposed CSHI would cover both hospital and ambulatory services. In addition, Tamil Nadu's scheme allows the participation of private hospitals but reimburses them only 75% of the tariff set in the insurer's schedule if the hospital does not belong to the insurer's network. Also, in Tamil Nadu civil servants are required to make an additional premium payment to set up a fund that is intended to cover infrequent, high-cost treatments.

### *Thailand's Civil Servant Medical Benefit Scheme (CSMBS)*

Created in 1963, the CSMBS was Thailand's first health insurance scheme and the precursor of other insurance arrangements which would subsequently help this country achieve UHC around 2002 (

Figure 29).

**Table 5 Key characteristics of the three main public health insurance schemes in Thailand as of 2020**

| Characteristics | Government Employees (CSMBS) | Social Security Scheme (SSS) | Universal Health Coverage (UC) |
|---|---|---|---|
| Population Coverage | Civil Servant, pensioners and their dependents (parents, spouse, children) Figure 29 | Formal sector private employee | The rest of Thai population who are not eligible for CSMBS and SSS. |
| **Benefits** | | | |
| Ambulatory services | Public Only | Public & Private | Public & Private |
| Inpatient services | Public & Private (emergency only for private) | Public & Private | Public & Private |
| Choice of provider | Free choice | Contracted hospital or its network with referral line, registration required | Contracted hospital or its network with referral line, registration required |
| Cash benefit | No | Yes | No |
| Maternity benefits | Yes | Yes | Yes |
| Annual Physical checkup | Yes | No | Yes |
| Prevention Health Promotion | No | Yes | Yes |
| Services not covered | Special nurse | Private bed, special nurse | Private bed, special nurse, eyeglasses |
| Copayment | Yes (inpatient at private hospital only) | Maternity, emergency services | 30-baht/visit* |
| **Financing** | | | |
| Source of funds | General tax | Employee & Employer | General tax |
| Financing body | Comptroller General Department, Ministry of Finance | Social Security Office | National Health Security Office |
| Expenditure per capita (in 2006) | 8,785 | 1,738 | 1,659 |
| Per capita tax subsidy (in 2006) | 8,785 (plus administrative cost) | 579 (plus administrative cost) | 1,659 (plus administrative cost) |

Source: Reported by Wagstaff and Manachotphong (2012a).
* The 30-baht copayment was eliminated in 2006.

The CSMBS covered government employees and their dependents as well as retirees from civil services. When created, it covered 7% of the country's population. Unlike the medical schemes of Tamil Nadu and that proposed for Bangladesh, Thailand's CSMBS was entirely subsidized by government and constituted one of serval fringe benefits of CVs (Bennett, Viroj, and Tangharoensathien 1993). Payment for health care providers was initially designed to be fee-for-service for outpatient care and diagnosis related groups (DRGs) for hospital care.

The provider payment methods devised for the CSMBS resulted in considerable cost escalation (Bennett, Viroj, and Tangharoensathien 1993; Jindapol and Others 2014) and led to various reform proposals. Efforts to harmonize Thailand's three health insurance coverage schemes progressed slowly as it met resistance from the CSMBS members and mainly public hospitals who benefit from excessive SMBS outpatient claims.

[1]The World Bank, 2018; Diagnostic study of public financial management of strengthening health financing and services delivery in Bangladesh