SHASTHYO SUROKSHA KARMASUCHI (SSK)

Step towards the Universal Health Coverage

The fast increasing health care cost and the growing burden of non-communicable diseases especially for demographic & epidemiological transition progressively add to the demand for complex and expensive health care. At the same time, the high out of pocket spending (almost 64% of the total health expenditure) and the catastrophic impact of the health care cost, especially on the poor and vulnerable, must be decreased and financial protection for health must be increased. The impressive performance of preventive and primary care has to be maintained and made available for the population

To cope with the challenges and to increase financial protection for the entire population anddecrease out-of-pocket payments at point of service, the Health Care Financing Strategy has been developed with the aim to achieve the following **three strategic objectives:**

- Generate more resources for effective health services
- Improve equity and increase health care access especially for the poor and vulnerable
- Enhance efficiency in resource allocation and utilization

As an initiative towards implementing the Health Care Financing Strategy, SSK (Shasthyo Surokhsha Karmasuchi) is the social health protection scheme has beendeveloped by the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MoHFW).

The long-term vision is a scheme combining risk pooling, purchaser-provider split, and autonomous providers with a stewardship function for MoHFW that will be reached through a step-wise implementation. SSK pilot scheme has the following objectives:

- Improve access of the poor to hospital inpatient care by reducing financial barriers;
- Increase the authority at hospital level for functional improvement in the health sector in phases as a part of Local Level Planning (LLP) and development.
- Introduce performance based financing models.

It is expected that the following effects will be achieved:

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

In the first phase, only the poor will be covered and government will pay the premium for their protection. In the long run Above Poverty Level population (APL) will be included as paying members make the scheme sustainable. The combination with compulsory health insurance appears much more promising in terms of risk pooling, cross-subsidizing and also in revenue generation for future scale up and sustainability.

Important feature of SSK

- Initially the SSK scheme will only enrol the Below-Poverty-Line (BPL) population. In the course of the project it will be decided if the scheme can be opened to compulsory membership for the Above-Poverty-Line (APL) population for sustainability & risk pooling.
- The head of the household (BPL) would be the smart card holder and entitled members of the household would be identified through the card.
- The members will receive onehealth card per household, which will enable them to request services from Upazila Health Complexes and on a referral basis from District Hospitals based on quality standards and a list of services. In the long run also accredited NGO and private providers may get contracts to treat SSK patients.
- Upazila Health Complex (UHC) will act as a focal point for service delivery and will enjoy certain degree of autonomy (contractual, financial and administrative) which may require waiver from the existing provisions. District Hospital will act as secondary referral point with the UHC as gatekeeper.
- Membership in SSK will have several advantages for members: 1. No co-payments at Upazila level or in District Hospitals, 2. Access to a grievance authority, where they can complain about the quality of service, 3. guaranteed free access to essential drugs at UHC and DH. These advantages are not guaranteed for non-members.
- SSK members will receive necessary inpatient health carethrough Upazila Health Complexes (UHC), and on a referral basis from District Hospitals (DH). At a later stage it is possible also to include private and NGO facilities.
- Hospitalized SSK members will be treated according to defined medical treatment guidelines. The treatment guidelines will support to calculate and standardize the reimbursement to the hospital.Reimbursement will follow a case- and diagnosis based payment system (CDBP = limited DRG based on 50 diseases), which will be gradually refined.
- SSKcell will fixflat rate premiums per household. For poor families fulfilling the poverty criteria, premiums will be paid by the government under funding from DP.
- The benefit package is limited to BDT 50 000 per health card per year.
- The benefit package will include the treatment of 50 diseases along with free drugs and diagnostic facilities for inpatient care in UHCs and in DH upon referral.
- A grievance procedure will be established based on which members will have the right to complain if they do not obtain the guaranteed services free of charge, which will be made known to all members. The grievance management body will have the mandate to inspect and recommend sanctions to the competent authority.
- Under the supervision of MoHFW, SSK will be managed by SSK cell and operatedby a Scheme

Operator.The Scheme Operator will be selected through competitive bidding. The Scheme Operator will have the main task to register members, to issue health cards, and to handle the claims of the hospitals. SSK cell will have its office in Dhaka. Scheme Operator will be located at Upazila level in UHC. Each UHC will have a SSK-booth staffed with at least one officer.

- SSK cell will maintain the register of members, conduct tenders in order to select Scheme Operator, and will allocate the premiums collected for the poor to the contracted Scheme Operator, which then will pay the to the hospitals based on the claims processed.
- Hospitals (UHC, DH) will be partly funded from governmentbudget and partly from SSK premiums. The funding responsibilities will be split according to cost categories:(i) Basic investment and salaries by the government, and(ii) the rest, especially drugs and diagnostics by SSK premium).
- Hospitals (UHC and DH) need an accreditation and have to be included in a hospital plan in order to receive public subsidies and in order to be allowed to treat SSK patients. For the pilot phase (July 2014- June 2016)the selected UHCs in Kalihati, Ghatail, and Modhupur as well as the DH in Tangail will be contracted even without accreditation.
- SSK will pay contracted hospitals for inpatient services on a per case basis following a DRG (Diagnosis Related Groups) system with about 50 positions. The payments will be negotiated between hospitals and Scheme Operatorand adjusted based on the claim history and the available budget. The Scheme Operator will obtain a fixed administration fee.
- Contracted health care providers will receive the regular public budget plus the extra payment from the SSK. With the extra funds they have to finance drug supply, maintenance and other running costs (all except salaries and investment) and will have room to improve and expand services so they can meet the quality criteria and avoid complaints. Main control mechanism is the grievance procedure and quality monitoring through SSK.

SSK cell

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