33RD CMAAO GENERAL ASSEMBLY

PENANG, MALAYSIA

SYMPOSIUM

Path to Universal Health Coverage

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Definition Of Universal Health Coverage (UHC)

UHC may be defined as a situation where the whole population of a country has access to a good quality services (core health services in minimum) according to the needs and preference, regardless of income level, social status or residency.

Health is one of the basic human rights. Most of the countries recognize this constitutional fact but are reluctant to implement this constitutional obligation with an argument that there are other more important obligations like food, shelter, education etc.

Overview

Lancet commission on investing in health looked at broader measures of growth and found that from 2000 to 2011, health investments were responsible for nearly a quarter of growth in developing countries.

Since the early 1990s, health gains and economic progress have been extraordinary. The number of people living in low-income countries has fallen from 3.1 billion(57.8% of the world's population) in 1990 to 820 million(11.7% of the world's population) in 2011 and much of the world's poor population now lives in middle income countries.

Overview Contd.

UHC strengthens country's competitiveness while lifting people out of poverty and protecting a growing middle class from falling back into it.

World Bank and WHO research shows that half the world's population cannot access needed health services, while 100m people are pushed into extreme poverty each year beause of health expenses. 800m people spend at least 10 percent or more of their household budget on healthcare expenses.

Overview Contd.

The emergence of deadly communicable diseases has become an obstacle for the development of sectors like the tourism industry on which so many countries rely. So in order to boost up the capability of prevention and treatment of such diseases the country has to keep sufficient measures in the national budget.

20 million deaths each year, more than a third of all deaths are avoidable and caused by socio-economic injustice – a number and a proportion that have not changed for the past 40 years.

Sustainable Development Goals (SDG)

Goal 1. End poverty in all its forms everywhere
Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture
Goal 3. Ensure healthy lives and promote wellbeing for all at all ages
Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
Goal 5. Achieve gender equality and empower all women and girls
Goal 6. Ensure availability and sustainable management of water and sanitation for all
Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all
Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

Sustainable Development Goals (SDG) Contd.

Goal 10. Reduce inequality within and among countries
Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable
Goal 12. Ensure sustainable consumption and production patterns
Goal 13. Take urgent action to combat climate change and its impacts Goal
Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development
Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

Health related SDG

Target	Indicator
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 livebirths	3.1.1 Maternal mortality ratio
	3.1.2 Proportion of births attended by skilled health personnel
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 livebirths and under-5 mortality to at least as low as 25 per 1,000 livebirths	3.2.1 Under-five mortality rate 3.2.2 Neonatal mortality rate
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age, and key populations
	3.3.2 Tuberculosis incidence per 100,000 population
	3.3.3 Malaria incidence per 1,000 population
	3.3.4 Hepatitis B incidence per 100,000 population
	3.3.5 Number of people requiring interventions against neglected tropical diseases
3.4 By 2030, reduce by one-third the premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and wellbeing	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease
	3.4.2 Suicide mortality rate

Health related SDG Contd.

Target	Indicator
3.5 Strengthen the prevention and treatment of substance-abuse, including narcotic drug-abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance-abuse disorders
	3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol
3.6 By 2020, halve the number of global deaths and injuries from road-traffic accidents	3.6.1 Death rate due to road-traffic injuries
3.7 By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs	3.7.1 Proportion of women of reproductive age (1549 years) who have their need for family planning satisfied with modern methods
	3.7.2 Adolescents' childbirth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age-group

Health related SDG Contd.

Target	Indicator
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all	3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)
	3.8.2 Proportion of population with large household expenditure on health as a share of total household expenditure or income
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1 Mortality rate attributed to household and ambient air pollution
	3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)
	3.9.3 Mortality rate attributed to unintentional poisoning

Health related SDG Contd.

Target	Indicator
3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1 Age-standardized prevalence of current tobacco-use among persons aged 15 years and older
3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all	3.b.1 Proportion of the target population covered by all vaccines included in their national program
	3.b.2 Total net official development assistance to medical research and basic health sectors
	3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis

How far Bangladesh is ready to implement UHC

SDG target	Name of the indicator	Target to be achieved by 2030	Baseline value for Bangladesh	National target (HNPSIP 2016-2021 and other strategic documents)
3.1: Maternal health	3.1.1: Maternal mortality ratio (MMR)	Less than 70 per 100,000 livebirths	176 (WHO estimate 2016)	105 per 100,000 livebirths by 2021 (HNPSIP 20162021)
	3.1.2: Births attended by skilled health personnel		42.1 (BDHS 2014)	65% by 2021 (HNPSIP 2016-2021)
3.2: Newborn and child health	3.2.1: Under-five mortality rate	Less than 25 per 1,000 livebirths	46 (BDHS 2014)	37 per 1000 livebirths by 2021 (HNPSIP 2016-2021)
	3.2.2: Neonatal mortality	Less than 12 per 1,000 livebirths	28 (BDHS 2014)	21 per 1000 livebirths by 2021 (HNPSIP 2016-2021)

SDG target	Name of the indicator	Target to be achieved by 2030	Baseline value for Bangladesh	National target (HNPSIP 2016-2021 and other strategic documents)
3.3: Communicable diseases	3.3.1: Estimated HIV incidence rate	By 2030 end the endemic of AIDs	<1 (WHO 2014) Keep the AIDS epidemic from expanding beyond the current level (<1%)	Avoid a gradual spread of HIV infection from highrisk groups to the general population
	3.3.2: TB case detection rate/ TB incidence rate per 100,000 population	End epidemics of TB by 2030	53% (GTBR 2014 estimates	75% (HNPSIP 2016-2021)
	3.3.3: Malaria incidence rate per 1000 population	End epidemics by 2030	High endemic (three districts): 1.0-10/1000 population Low endemic (ten districts): .1-1.0/1000 population World Malaria Report 2015	Reduce malaria morbidity and mortality until the disease is no longer a public-health problem in the country
	3.3.4: Hepatitis incidence per 100,000 population	Combat hepatitis		
	3.3.5: Neglected Tropical Diseases (NTDs): people requiring intervention (preventive + new cases) against NTDs	End epidemic by 2030		- Kala-azar: Annual incidence rate to <1/10,000 population in all endemic upazilas (subdistricts) by 2015 Elimination of filariasis Prevention and control of dengue

SDG target	Name of the indicator	Target to be achieved by 2030	Baseline value for Bangladesh	National target (HNPSIP 2016-2021 and other strategic documents)
3.4: Non-communicable diseases	3.4.1: Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease	Reduce by one-third the premature mortality by 2030	18% (World Health Organization Noncommunicable Diseases (NCD) Country Profiles, 2014)	Reduce by one-third the premature mortality due to NCDs from current rate
	3.4.2: Suicide mortality rate (per 100,000)	Reduce one-third of premature mortality by 2030	8 per 100,000 according to WHO 2014 report	Reduce by one-third the premature suicidal death from current level
3.5: Substance abuse	3.5.1: Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance abuse disorders	Strengthen the prevention and treatment of substanceabuse, including narcotic drugabuse and harmful use of alcohol		
	3.5.2: Alcohol per-capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol	Strengthen the prevention and treatment of substance-abuse, including narcotic drug-abuse and harmful use of alcohol	Almost zero alcohol consumption (0.2 in 2010 WHO report 2014	Committed to global

No. of Hospitals & Beds in Bangladesh

A. Hospitals		
Type	No. of facilites	No. of functional beds
100-bed hospital	1	100
Chest diseases hospitals	13	816
Dental college hospital	1	200
District and general hospitals	64	10,450
Hospital of alternative medicine	2	200
Hospital of alternative medicine 2		200
Infectious disease hospitals	5	180
Leprosy hospitals	3	130
Medical college hospitals	17	13,713
Specialized hospital	5	1,050
Specialty postgraduate institute and hospital	11	3,034
Trauma center	5	100
Upazilla Health Complex & Union level Hospital		19,441
Private Hospitals		48,725
Total		98,339

No. of sanctioned, filled-up and vacant posts (Rev. & Dev.) under the DGHS (August 2017)

Category of post		Sanctioned post		Filled-up post			Vacant	
		No.	% of all sanctioned posts	No.	% of all filledup posts	% of sanctioned posts in respective categories	No.	% of sanctioned posts in respective categories
Class I	Doctors	24,989	19.05	20,602	21.49	82.44	4,387	17.56
	Non-doctors	466	0.36	201	0.21	43.13	265	56.87
Class II		28,122	21.44	19,960	20.82	70.98	8,162	29.02
Class III		52,304	39.88	38,029	39.66	72.71	14,275	27.29
Class IV		25,277	19.27	17,085	17.82	67.59	8,192	32.41
Total		131,158	100.00	95,877	100.00	73.1	35,281	26.9

- No. of doctors in both public and private sector : 75,000 (Doctor:population – 1:2133)
- No. of beds in the private sector : 48,725
- No. of community clinics : 13,800 (each for 6000 population)
- No. of drugs declared as essential : 285 (N.B. The government has the mandate to fix the price of essential drugs.
- Digital technology has been adopted and gradually getting strengthened.
- 4th Health, Population and Nutrition Sector Programme has been adopted for 2017-2022 with a budgetary allocation amounting to USD 14.71 billion.
- Quality improvement secretariat has been established.
- Health workforce strategy has been formulated.

Total Health Expenditure, GDP, and Annual Growth Rates, 1997-2015

Year	Total health expenditure		GDP		Per Capita				
	Amount (Taka in million)	Nominal Growth rate (%)	Amount (Taka in million)	Nominal Growth Rate(%)	GDP	THE			Ratio of THE to GDP (%)
					Taka		US$	PPP$	
1997	46,755		2,060,032		16,835	382	9	26	2.3
1998	50,904	9	2,269,299	10	18,183	408	9	27	2.2
1999	56,985	12	2,465,089	9	19,377	448	9	29	2.3
2000	63,608	11	2,685,033	9	20,974	492	10	31	2.3
2001	72,030	14	2,913,371	9	22,351	533	10	35	2.5
2002	81,559	13	3,142,804	8	23,695	615	11	38	2.6
2003	87,882	8	3,483,201	11	25,828	652	11	39	2.5
2004	100,456	14	3,832,939	10	27,988	734	12	43	2.6
2005	115,399	15	4,270,741	11	30,751	831	14	48	2.7
2006	137,114	19	4,823,370	13	34,299	975	15	55	2.8
2007	156,977	14	5,497,997	14	38,661	1,104	16	60	2.9
2008	181,775	16	6,286,822	14	43,746	1,265	18	65	2.9

THE, GDP & Annual Growth rate contd.

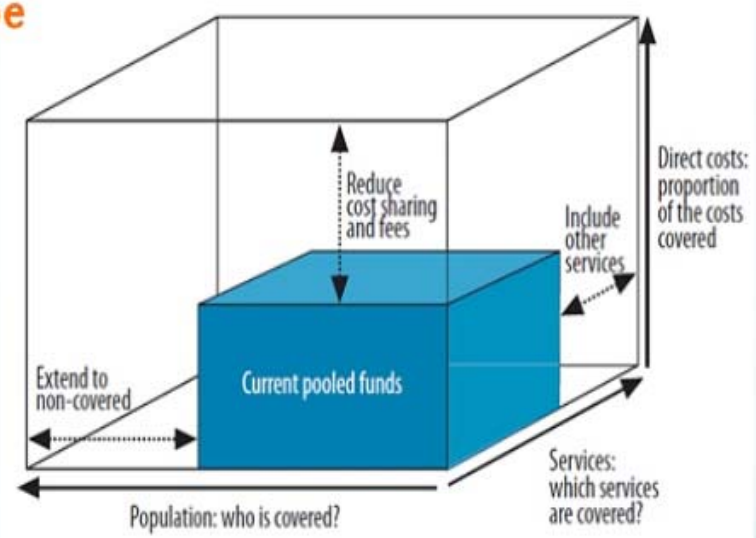
Year	Total Health Expenditure		GDP		Per Capita				
	Amount(Taka in million)	Nominal Growth Rate (%)	Amount(Taka in million)	Nominal Growth Rate (%)	GDP	THE			Ratio of the GDP(%)
					Taka		US$	PPP $	
2013	353,960	9	11,989,232	14	78,515	2,318	29	89	3.0
2014	398,420	13	13,436,744	12	86,857	2,575	33	96	3.0
2015	451,889	13	15,158,022	13	96,671	2,882	37	102	3.0
Average annual growth rate									
1998-2002		12		9					2.4
2003-2007		14		12					2.7
2008-2012		16		14					3.0
2013-2015		12		13					3.0
1998-2015		13		12					2.8

Path Towards Universal Health Coverage : Bangladesh Perspective

The UHC Cube

Three dimensions of UHC:

1.Population coverage (and equity)
2.Service coverage
3. Financial risk protection



Three dimensions to consider when moving towards universal coverage

Expected Outcome from UHC

Journey to UHC

2012: Developed the HCFS(Health Care Financing Strategy)

2013: Concept paper of SSK finalized (Target Below Poverty Line Population) & benefit package developed.

2014: Developed Social Health Protection Act

2015: Developed concept paper for RMG and formal sector

2016: Launched SSK for piloting in Tangail

2020:Scale up plan after conduction of endline for SSK

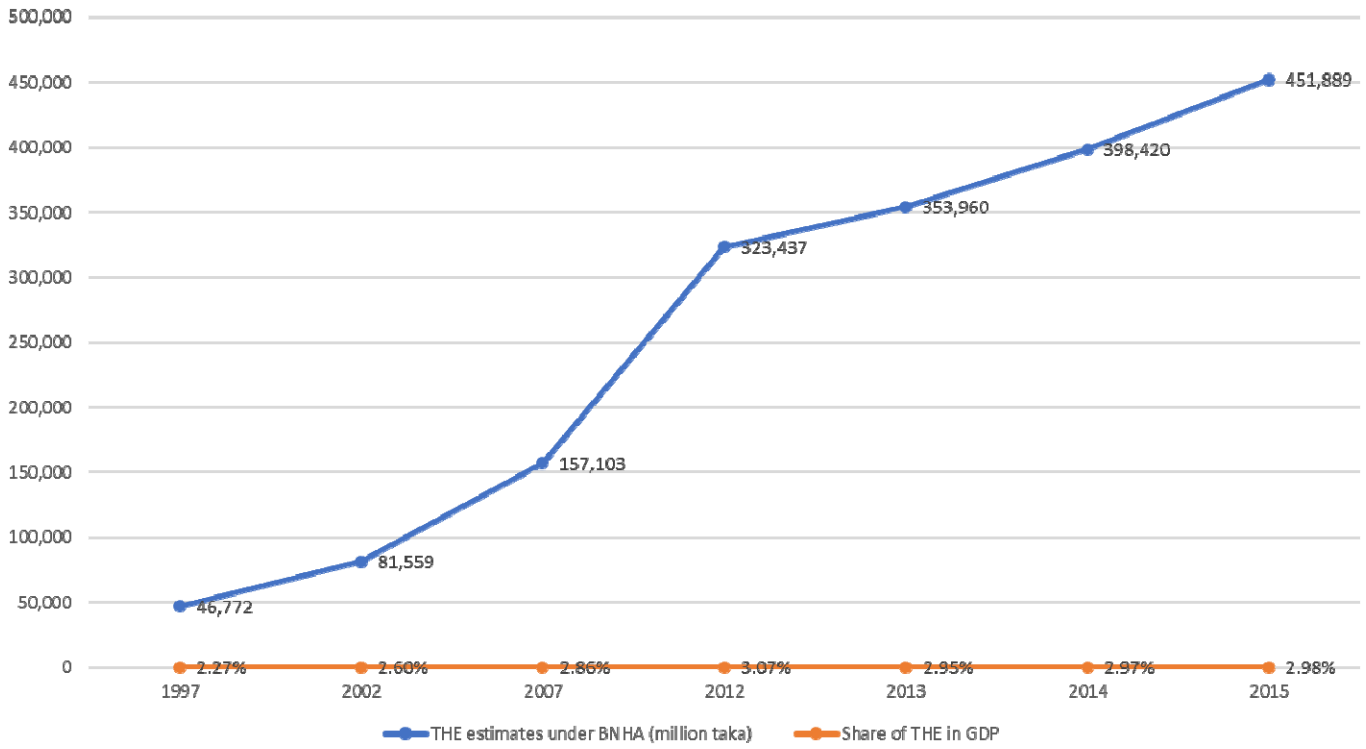
Health Care Financing Features

We have a HCF system as part of the national financial management system.

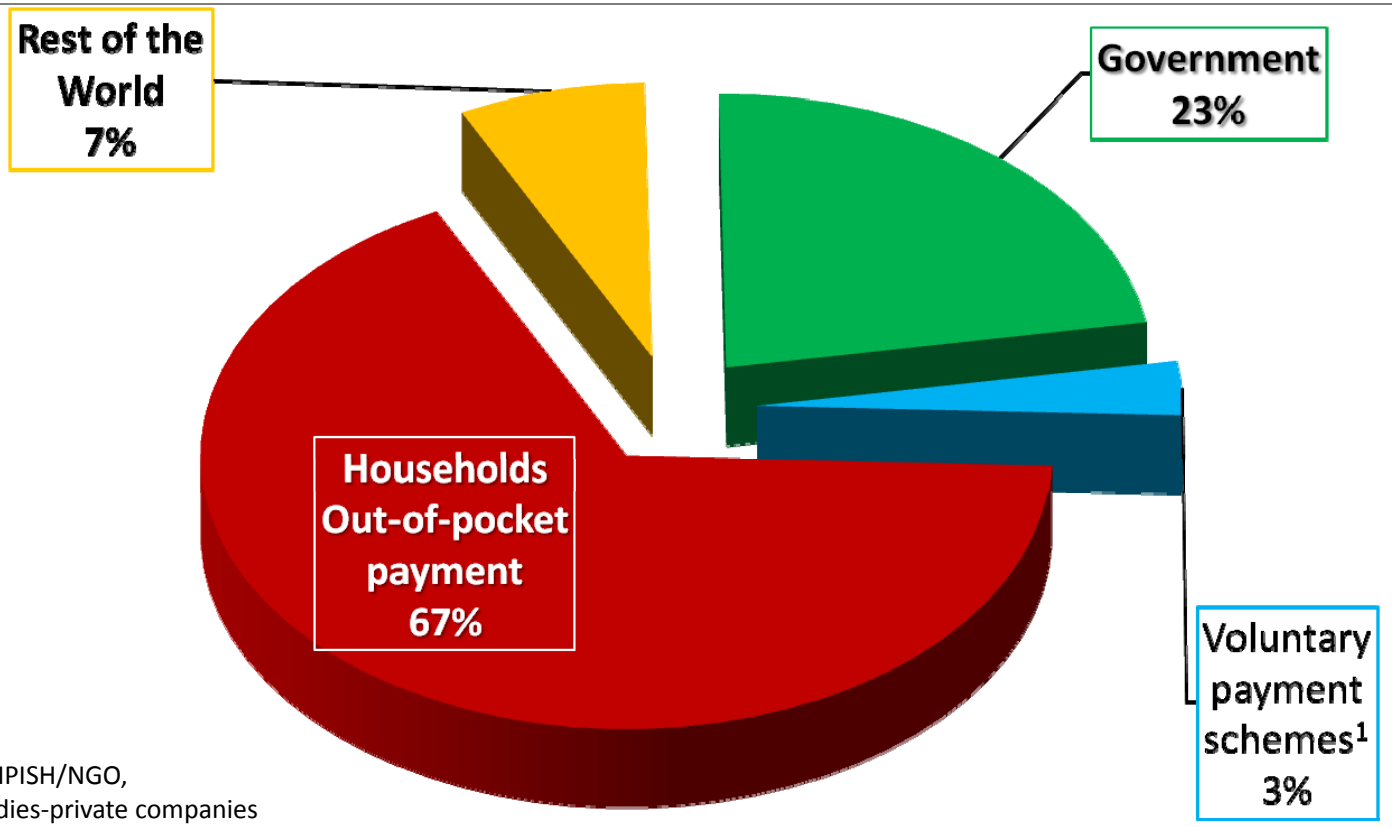
Main Features

1. Share in the national budget --- **5.2%** (2017-2018) > 4.7 %
1. Allocation for the health sector has increased by 39.18% over that of RBFY17
2. 6.2% of Total ADP which is higher than 4.4% (previous year)
3. Per capita Health expenditure---**US$ 37** (2015)[1]
4. Out-of-pocket---**67%** of Total health expenditure (THE) (2015)[2]
5. Coverage of insurance --- **<1%** of THE (2015)[2]
6. Government is financer and provider of services
7. Budget norms follow civil service and budgetary regulations and codes.

THE Estimates in BNHA 1997-2015

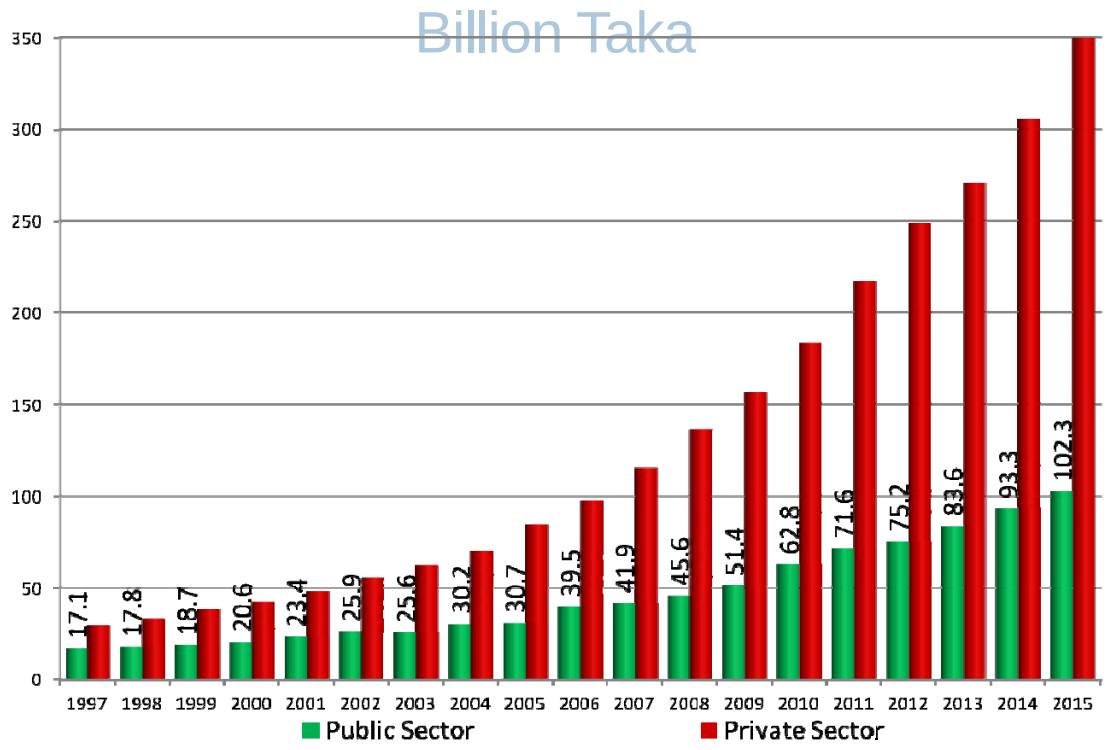


OOPE as a share of THE increased to 67% in 2015 while public share remained the same



[1] Voluntary health insurance, NIPISH/NGO, Corporations-autonomous bodies-private companies

Public spending on health grew but at a slower pace than private spending during 1997-2015



- **Public expenditure in nominal terms have increased every year**

Regional comparison: 2014
Expenditure and selected Indicators

Indicator	Bangladesh	Bhutan	India	Myanmar	Nepal	Pakistan	Sri Lanka
Per capita THE	$ 31	$ 89	$ 75	$ 20	$ 40	$ 36	$ 127
THE as % of GDP	3%	4%	5%	2%	6%	3%	4%
Pub. Exp. as % of THE	28%	73%	30%	46%	40%	35%	56%
Life Expectancy at birth (yrs)	72	69	68	66	68	66	75
Infant Mortality Rate	32	28	39	41	31	67	09
Under 5 Mortality Rate	40	34	50	52	31	83	10
Maternal Mortality Rate	188	156	181	184	275	184	31

Source: World Bank

Bangladesh Steps toward UHC…

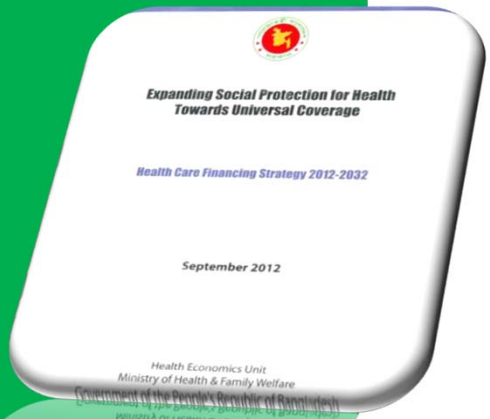
1. Renewed Commitment through Health Policy 2011
2. Revitalized and established nearly 13000 community clinics and improved hospital services
3. Increased health manpower for hospitals and health centers to provide health care services
4. Increased efficiencies in procurement, distribution and utilization of essential medicines and equipment
5. Expanded demand side financing for ante-natal care and deliveries attended by skilled birth attendants
6. **Adoption of the HEALTH CARE FINANCING STRATEGY**

Strategic document!

Expanding Social Protection for Health:

Towards Universal Health Care Coverage

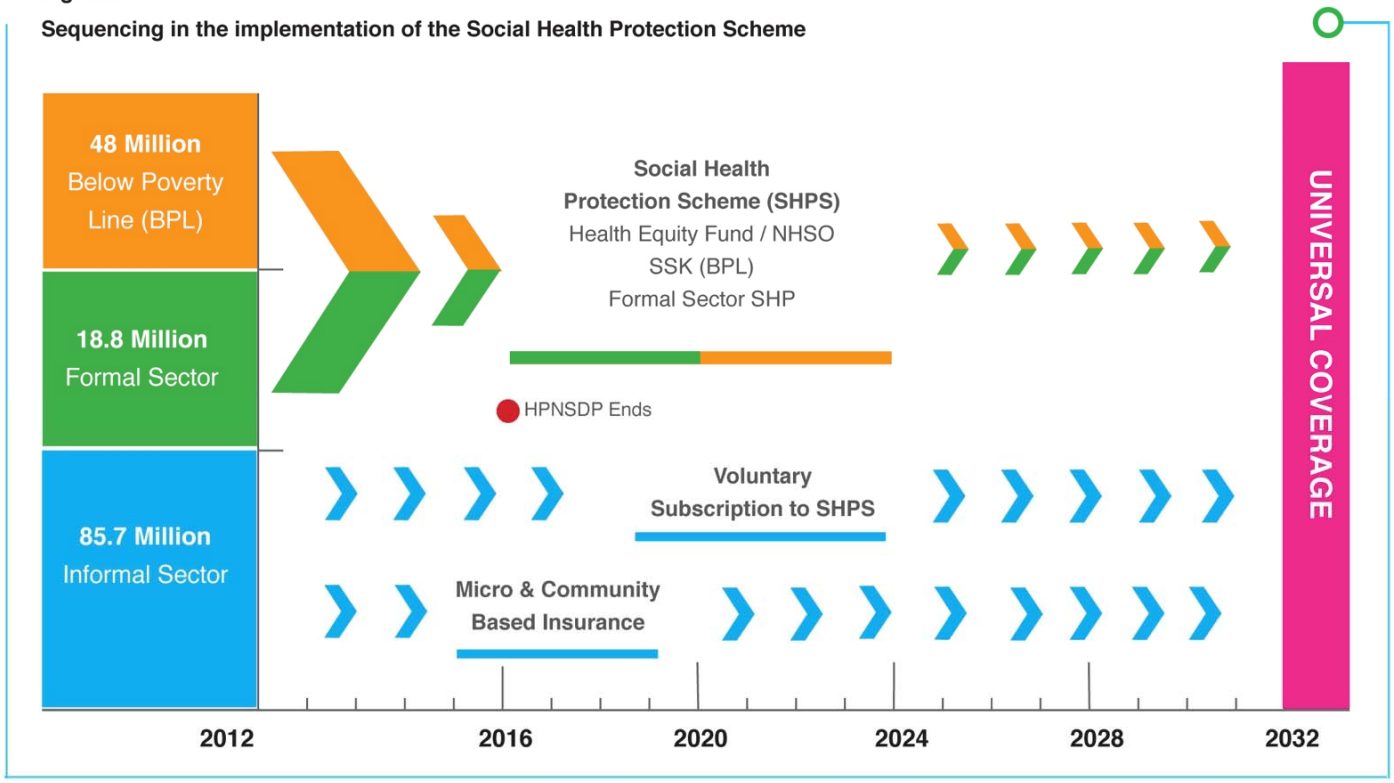
Health Care Financing Strategy 2012-2032



What is planned to attain “UHC”?

Figure 5

Sequencing in the implementation of the Social Health Protection Scheme



Source: Bangaldesh Health Financing Strategy 2012 - 2032

Strategic objectives

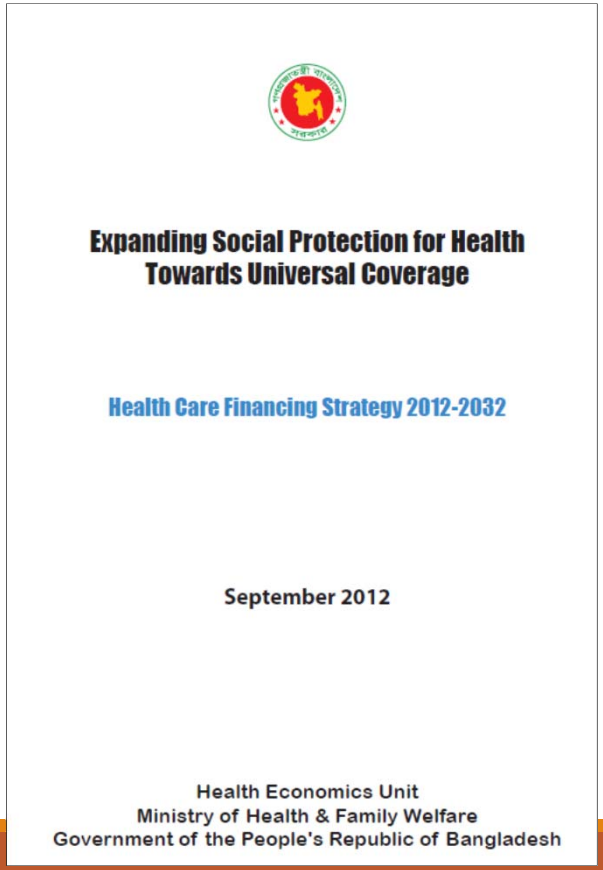
Health Care Financing Strategy 2012 – 2032 (HCFS 12-32)

Three strategic objectives:

i) Generate more resources for effective health services

ii) Improve equity and increase access especially for the poor and vulnerable; and

iii) Enhance efficiency in resource allocation and utilization



Core Activities

(i) **Design & implement Social Health Protection Scheme**

Determine institutional arrangements for Social Health Protection Scheme

Design and implement National Health Security Office

Implement SSK for BPL

Design social health protection scheme for above poverty line .

Activities

(ii) **Strengthen financing and provision of public health care services**

Implement needs and performance based allocation

Scale up/Reinforce Results Based Financing

Retain User fees at point of collection

Activities

(iii) Strengthen national capacity

Support information exchange platform/knowledge hub/resources pool

Develop the capacity to design and manage the social health protection scheme

Strengthen Financial Management and Accountability

Improve monitoring and evaluation

Introduce mechanisms to support the production of additional key staff (nurses, paramedics and medical technicians)

Who will benefit from UHC?

Poor
48 million

Formal Sector
18.8 million

Informal Sector
85.7 million

HCFS: Implementation status

Implementation status of interventions included in the Health Care Financing Strategy

- MOHFW finalized design of **SSK (GOB funded insurance for the poor)** and initiated implementation of SSK in three upazilas
- Package/Modality has been finalized **for the Ready Made Garment Worker's scheme**
  (a proposed social health protection scheme for population above poverty line)
- **Civil servants scheme:** Feasibility study completed
  (a proposed social health protection scheme for above poverty line)
- **Need based resource allocation formula** has been approved by the MOHFW. Next step is approval of delegation of power to expense money at the facility level
- **The National Health Protection Act has been drafted** and is in the process of passing by national parliament.

SSK

SSK: Introduction

SSK (Shasthyo Surokhsha Karmasuchi i.e. Health Protection Programme) is a Social Health protection/ health financing scheme which is the step towards of Universal Health Coverage and first initiative of implementing the health care financing strategy developed by Health economics unit of MOHFW.

SSK (Shasthyo Surokhsa Karmasuchi): Background

2012: National Health Care Financing Strategy approved
2012: SSK Concept Paper developed
2013: SSK concept paper finalized and decided to pilot in three Upazillas(Sub districts) of Tangail district
2014: Benefit Package finalized (50 cases)
2014: Household survey completed in piloting facilities and finalized the data base for BPL(according to selection criteria)
2015: Green Delta Inc selected as Scheme Operator
2015: Contact with HHI for IT software
2015: SSK protocols has finalized for 50 cases (DRG)
2016: 24th March: SSK Launched at Kalihati
2017: 12th September: SSK Launced in Ghatail & Modhupur

Guiding Principle for SSK

Universality

Equity

Non discrimination

Comprehensive care

Financial protection

Protection of Patient rights

Patient choice

Continuity of care

Consolidated and strengthening public health provisioning

Accountability and Transparency

Community Participation

Putting hands in peoples hand.

Guiding Principle for SSK contd.

1. The poor and vulnerable should be covered from the start – do not start with insurance for the formal sector and civil servants with the intention of bringing in the poor and informal sector later
2. Start by covering interventions against infectious diseases, targeting RNMCH, expanding to NCDs rapidly – the most highly cost-effective interventions
3. Limited if any payments at the point of service – poor and vulnerable exempted if fees are charged
4. Expand health services over time as rapidly as possible – prevention, promotion, treatment, rehabilitation, palliation

Guiding concept for SSK contd.

1. Voluntary insurance cannot get to UHC – at best, a supplement to compulsory pooling
2. Catastrophic insurance – e.g. insurance for unpredictable high cost items such as inpatient care - cannot get to UHC

SSK :

Prepayment and pooling of resources - compulsory

Minimizing user fees and charges – zero for the poor and vulnerable (possibly "negative fees")

Good quality services are available

The combination of financial risk protection with the availability of good quality services – instrumental to increasing health and economic wellbeing, but also valued for its own sake

Dimension of SSK

Component	Area	Remarks
Quality	Timely Integrated service Appropriate- Best clinical practice	Quality Dimension
Package	Need based	78 case benefit package (DRG)
Financial Protection	Free care Affordable care Payment at risk	
Coverage for all	BPL household	

To Achieve UHC: SSK will focus

Access to the poor

Financial risk protection

Quality of Care

Increase the authority at hospital level for functional improvement

Reduce OOP

SSK : Objectives

To Improve access of the poor to hospital inpatient care by reducing financial barriers;

To decentralize autonomous hospital activities for functional improvement in the health sector in phases

To develop of Local Level Planning (LLP).

To develop Partial financial autonomy

To Introduce performance based financing models
Introduce modern Information and Communication Technologies for increased efficiency and transparency in the health sector (e. g. claims processing, accounting, controlling, and electronic patient records).

SSK : Indicators

Number of BPL families enrolled

Number of SSK Patients admissions per UHC

Number of claims processed per UHC

Frequency of diagnosis as per DRG per UHC

Average life expectancy among members

OOP

SSK: Output

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 insurance fund;

Defined quality standards;

Improved efficiency and transparency in hospital management.

SSK: Elements

Administration (SSK cell & Scheme operator)

SSK membership

SSK Management Committee

Benefit Package

Health Card

SSK IT

Quality Improvement

SSK: Supporting structure

SSK Cell

Scheme Operator

SSK Management Committee

3 SSK kiosk in 3 Upazillas and 1 kiosk in DH

SSK Medicine store(3 piloting facilities)

Outsourced Staff (3 UHC): Cleaner & Security staff

SSK : Challenges

HRH (Shortage Leadership/Motivation)

Inclusion of OPD in benefit package !

Empanelment of Private health facilities!

Introduction of P4P!

SSK: Status

SSK Information at Kalihati, Ghatail and Madhupur Upazila									
Sl. No	Particulars	Reporting date 22.7.2018				Cumulative (From opening to till date)			
		Kalihati	Ghatail	Madhupur	Tangail District hospital	Kalihati (From 27.3.2016)	Ghatail (From 14.9.2017)	Madhupur (From 18.9.2017)	Remarks/ Cumulative
1	No. of SSK OPDs treated	40	35	56		11,009	3850	7065	
2	No. of SSK IPDs admitted	9	9	8	1	1636	635	783	
3	No. of SSK IPDs release	6	4	3	1	1614	616	764	
4	No. of SSK IPDs refereed	1	2	5	0	195	133	249	
5	No. of SSK IPDs absconded	0	0	0	0	3	1	0	
6	No. of SSK IPDs in hospital	22	19	**19**	8(K:0, G:3, M:5)				
7	**Enrollment**		0	0		27533	27,151	25,985	53, 136
	Card Distribution		0	0			23,968	22,329	46,297

Next Steps!!

Inclusion of OPD in benefit package for SSK

Empanelment of Private sector

Revision of benefit package

End line Evaluation of SSK

Extension of 10 UHC from 2020

Health Insurance Scheme of RMG

Piloting for Resource Allocation Formula(RAF)

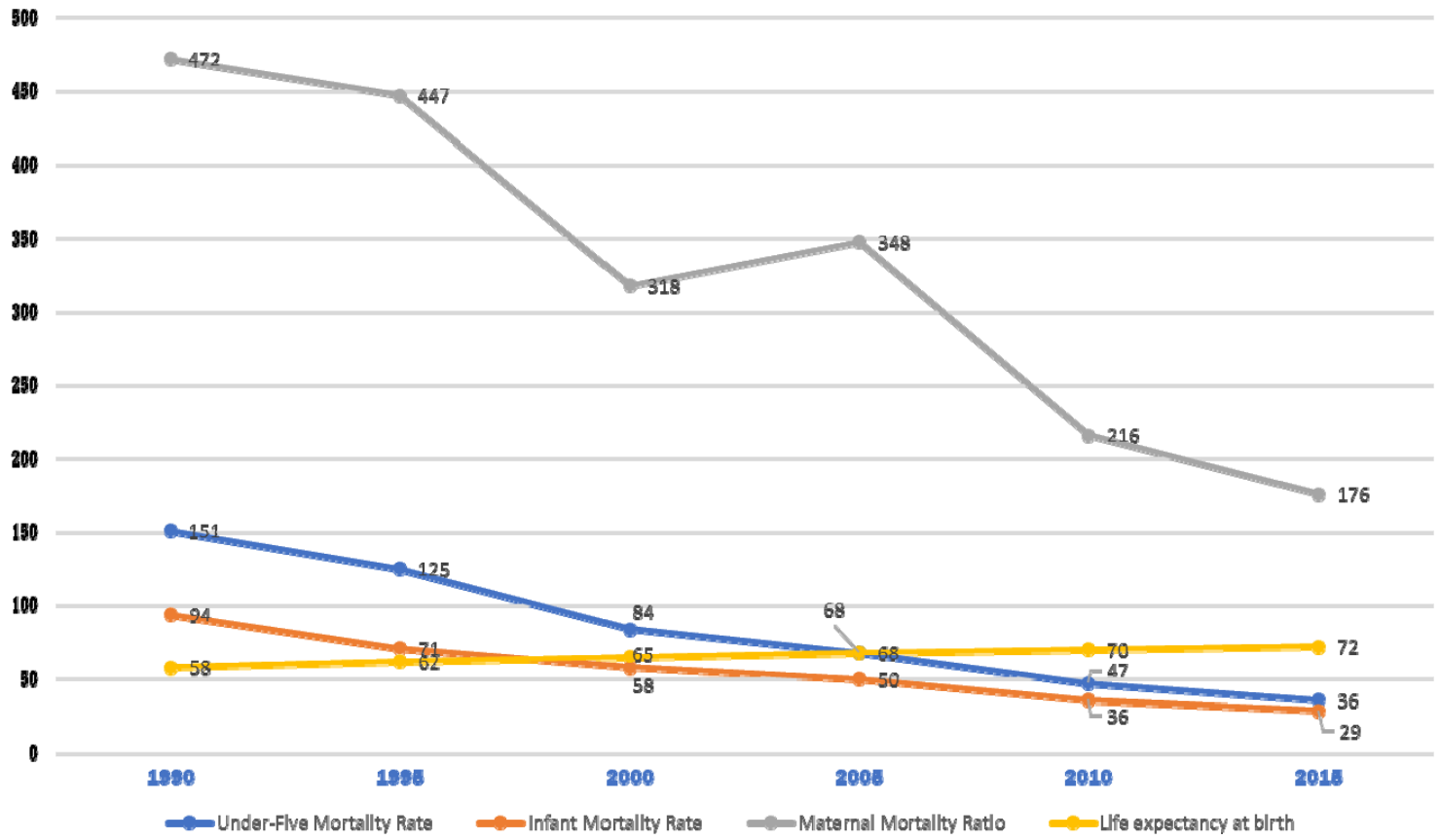
Social Health Protection Act

Formation of NHSO

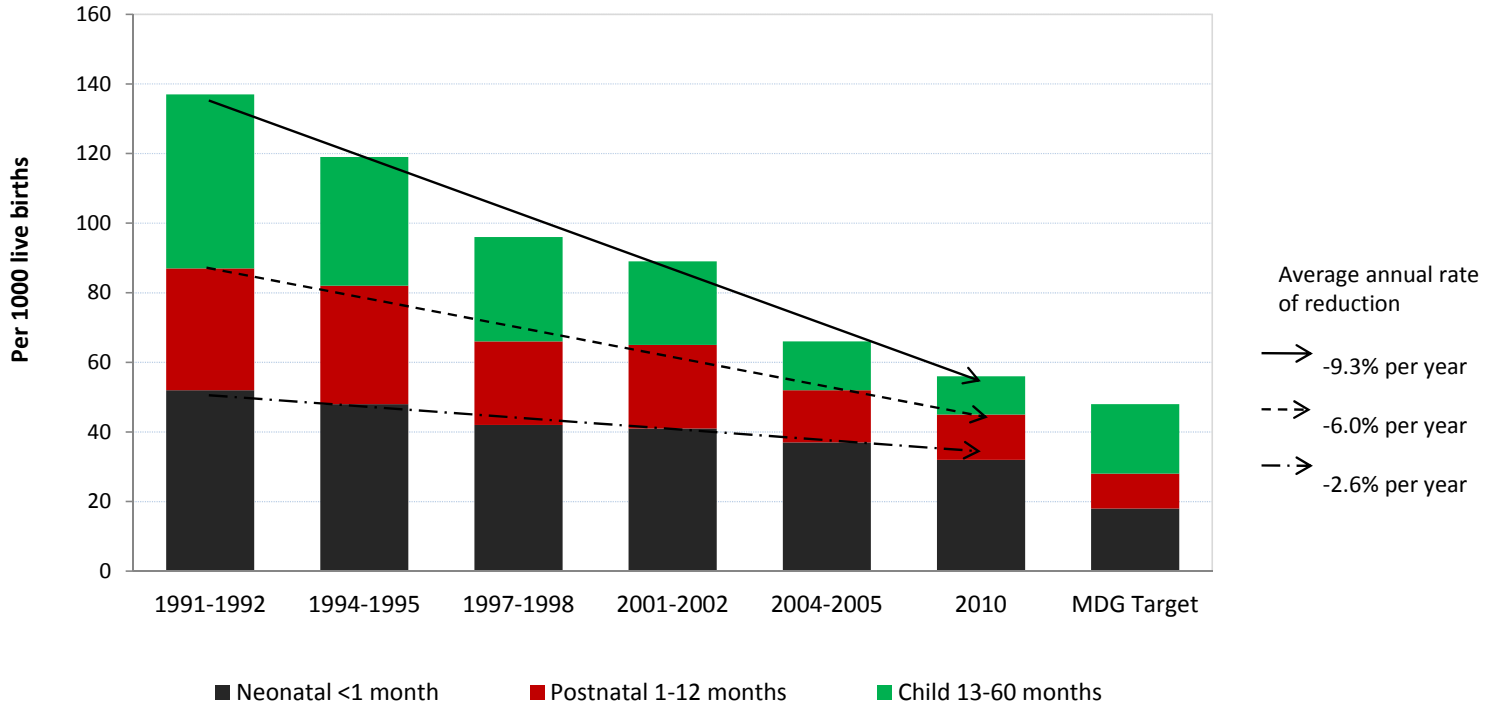
Civil Servant Scheme!

Reduced Mortality and Increased Life Expectancy

(Source: BDHS; BBS; H Bulletin; WB; MDG: End-Period Stocktaking and Final Evaluation (2000-2015) by GED, Planning Commission, GoB)



Progressive improvement in child health over the years



Sources: Measure DHS- Demographic and Health **Survey** URL: http://www.statcompiler.com/

Health Sector of Bangladesh

A Story of Achievements

1. *Bangladesh over the years have achieved remarkable progress*
2. *Through the government agenda the country had been on track with the MDGs*
3. *The country has the highest EPI coverage (82%) amongst neighboring countries*

Thank you