Note to Task Teams: The following sections are system generated and can only be edited online in the Portal. ***Please delete this note when finalizing the document.***

Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 10-Aug-2021 | Report No: PIDC29865

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Bangladesh	P174439		Bangladesh - Improving Services Quality of Hospital Network and Financial Protection for the Poor (P174439)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
SOUTH ASIA	Oct 18, 2021	Dec 21, 2021	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance	Ministry of Health and Family Welfare	

Proposed Development Objective(s)

To support the Government of Bangladesh to improve quality and utilization of clinical services for priority conditions, and expand coverage of health protection schemes.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	250.00
Total Financing	250.00
of which IBRD/IDA	250.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	250.00
IDA Credit	250.00

Environmental and Social Risk Classification	Concept Review Decision

Substantial	Track II-The review did authorize the preparation to continue

Note to Task Teams: End of system generated content, document is editable from here. ***Please delete this note when finalizing the document.***

Other Decision (as needed)

B. Introduction and Context

Country Context

1. Bangladesh has made rapid social and economic progress in recent decades and reached lower middle-income status in 2015. Officially reported gross domestic product (GDP) growth averaged close to 6 percent annually since 2000 and accelerated to over 8 percent in FY19. Strong labor market gains contributed to a sharp decline in poverty, with the national poverty rate falling from 48.9 to 24.5 percent between 2000 and 2016, while extreme poverty declined from 34.3 to 13.0 percent.[1] However, the pace of poverty reduction slowed in recent years particularly in urban areas and in the west of the country. Similarly, the progress on shared prosperity slowed between 2010 and 2016 after a decade of improvements, with annual consumption growth of the bottom 40 percent trailing that of the overall population (1.2 versus 1.6 percent).

2. The COVID-19 pandemic caused major disruptions to economic activity in FY20 and FY21. The government implemented a number of national shutdowns since March 2020 to control the domestic outbreaks. Control measures resulted in a sudden stop of economic activity in many sectors. Consequently, real GDP growth is estimated to have decelerated to 2.4 percent in FY20. Early signs of recovery emerged in the first half of FY21, after movement restrictions were progressively lifted. However, a new wave of COVID-19 infections during March and April resulted in renewed movement restrictions that have dampened economic activity.

3. Bangladesh's economy is expected to recover gradually, while remaining vulnerable to shocks, particularly those related to climate change. Given the significant uncertainty pertaining to both epidemiological and policy developments, real GDP growth for FY21 could range from 2.6 to 5.6 percent depending on the pace of the ongoing vaccination campaign, whether additional restrictions to mobility are required and how quickly the world economy recovers. The unprecedented uncertainties related to COVID-19 are likely to dampen private investment. The recovery in subsequent years is expected to be gradual, with the waning of pandemic-related economic disruptions partly offset by increasing fragilities in the banking system. Meanwhile, Bangladesh is extremely vulnerable to the effects of climate change.[2] Additional rural-urban climate-related migration would have significant consequences for air and water pollution and unsustainable consumption of natural resources, while putting additional pressure on urban labor markets. Addressing climate risks is increasingly urgent to ensure sustainable economic development of the country.

[1] Household Income and Expenditure Survey, 2000/01 through 2016/17.
[2] Germanwatch (2020) Global Climate Risk Index 2020.

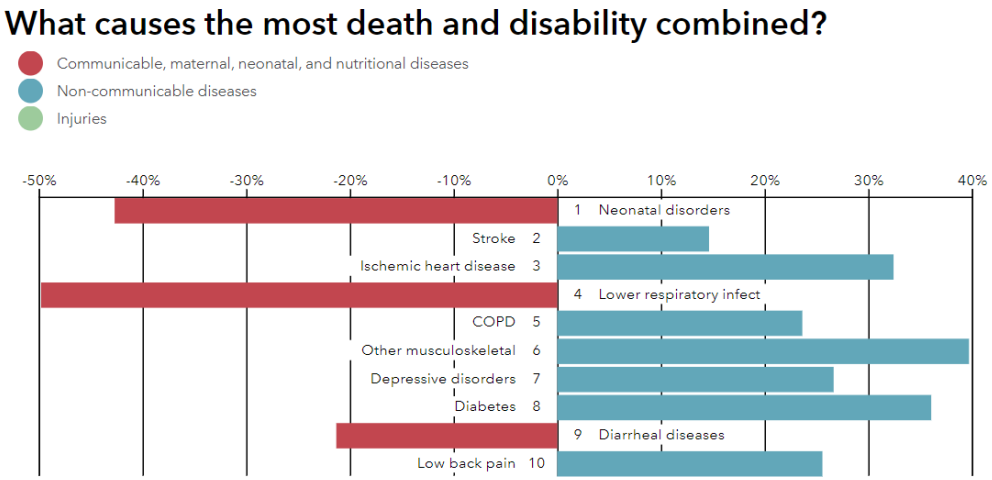
Sectoral and Institutional Context

Health outcomes

4. Bangladesh has been one of the world's top performers on the Millennium Development Goals. Life expectancy for females in Bangladesh increased from 59.5 years in 1990 to 74.6 years in 2017, and from 57.3 to 71.8 for males. Similarly, under-5 mortality impressively declined from 132.9 to 29.3 per 1,000 live births between 1990 and 2019.[3] Maternal mortality fell by 69 percent between 1990 and 2015. The prevalence of stunting in Bangladesh also decreased significantly over the past two decades. However, the under-five mortality rate, and in particular, the neonatal mortality rate that accounts for nearly half of deaths among children under 5 years, have not showed any sign of further decline since 2014.[4] It will be very challenging for Bangladesh to achieve the final targets set under the current Health Nutrition and Population Sector Program (HNPSP) unless novel approaches are adopted.

5. The disease pattern in Bangladesh has changed over the years. Notably, Non-Communicable Diseases (NCDs) have become the leading cause of disease burden in the country (Figure 1). In terms of disease burden measured by death and disability combined, the percentage caused by NCDs increased from 52 percent to 65 percent between 2000 and 2019. Addressing this emerging challenge will require significantly different health system approaches.

Figure 1: Leading causes of death and disability in Bangladesh, and percent change between 2009 and 2019



Top 10 causes of death and disability (DALYs) in 2019 and percent change 2009-2019, all ages combined

Health service coverage and quality

6. Although several indicators of health service delivery for maternal and child health care are relatively strong, there are concerning gaps in provision of care for NCDs. While 94 percent of public facilities provide basic maternal and child services (sick child, vaccinations, antenatal care and family planning), only 42 percent provide services for basic infectious disease care (tuberculosis, HIV, sexually-transmitted infections) and 52 percent provide services for common NCDs (diabetes, hypertension, and COPD). Bangladesh performs particularly poorly in providing care for some NCDs such as

[3] Institute for Health Metrics and Evaluation. Bangladesh. Institute for Health Metrics and Evaluation. Published September 9, 2015. Accessed February 16, 2021. http://www.healthdata.org/bangladesh
[4] Bangladesh Demography and H Survey in 2014 and 2018 and Multiple Indicator Cluster Surveys (MICS) in 2019.

cancers and stroke, as well as neonatal conditions.[5] For example, among all men and women living with hypertension, less than half of women and one in three men receive a diagnosis for their condition. Even when diagnosed, not all patients initiate treatment and among those who are initially treated approximately one third are controlled hypertensives (15 percent of hypertensive women and 9 percent of hypertensive men receive treatment adequate for the control of their illness). Similarly, for persons living with diabetes mellitus, approximately 40 percent receive a diagnosis, 38 percent of women and 35 percent of men are initiated on treatment but only 12 percent of diabetic women and 13 percent of diabetic men have controlled blood glucose levels[6]. Although household survey data indicate that the utilization of both outpatient and inpatient care is higher among women, this is largely a reflection of differences during child-bearing years. For example, inpatient admissions are significantly higher among males among both under-5 and over-60 populations, pointing to an important gender equity agenda with regard to service utilization.

7. Bangladesh's health access and quality score ranked 133 of all of 195 countries assessed in 2016. The Health Access and Quality (HAQ) index score increased from 17.8 in 1990 to 47.6 in 2016 (on a scale from 0 to 100). However, further improvement in health access and quality has slowed after a period of rapid improvement between 1990 and 2000. Major access and quality gaps have been observed for cancers, neonatal disorders, stroke, epilepsy and adverse medical practices.

8. The COVID-19 pandemic has created additional barriers for the delivery of essential health and nutrition services in Bangladesh. Bangladesh experienced the sharpest reductions in service delivery from March to May of 2020, with a decline in the number of expected outpatient consultations by 74 percent, of antenatal care consultations by 23 percent, institutional deliveries by 26 percent, childhood vaccinations by 56 percent and injectable family planning visits by 22 percent. Disruptions in essential health service delivery were observed to be significantly greater for hospitals and Upazila Health Complexes. It is estimated that as of December 2020, these service disruptions led to approximately 11,337 additional child deaths and 387 additional maternal deaths, in addition to excessive deaths caused by NCDs[7]. Although there has been some recovery from the disruptions to essential health service delivery, as of March 2021, the provision of outpatient consultations continued to be nearly 25 percent lower than expected based on previous years.

Health system governance

9. The Constitution[8] of the People's Republic of Bangladesh asserts that the State will secure basic health services to all citizens of the country. This has been reaffirmed by the three specific objectives of the Government of Bangladesh's (GoB's) National Health Policy (2011) which includes ensuring primary and emergency health care for all, enhancing equitable quality health care and accessibility, and promoting preventive health care services. Bangladesh is also committed to achieving target 3.8 of Sustainable Development Goal (SDG) 3 emphasizing achieving Universal Health Coverage (UHC), including financial risk protection, access to *quality* essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all by the year 2030.

10. Health policy formulation is a joint product of the Government and development partners. The Planning Commission prepares the national Five-Year Plans (FYP) (currently the Eighth Five Year Plan, 2020–2025). Health sector planning is the

[5] GBD 2015 Healthcare Access and Quality Collaborators. *Healthcare Access and Quality Index based on mortality from causes amenable to personal healthcare in 195 countries and territories, 1990–2015: a novel analysis from the Global Burden of Disease 2015 study*. The Lancet. 2017 May 18.
[6] National Institute of Population Research and Training (NIPORT), and ICF.. *Bangladesh Demographic and Health Survey 2017-18*. 2020. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF.
[7] Roberton, T and Villar Uribe. *The impact of service disruptions in Bangladesh due to the COVID-19 pandemic*. World Bank Internal Report. 2021
[8] Article 15.1 of the Constitution stipulates that it shall be a fundamental responsibility of the State to secure for its citizens the provision of the basic necessities of life, including food, clothing, shelter, education and medical care. In addition, Article 18 of the Constitution asserts that the State shall raise the level of nutrition of its population and improve public health as some of its primary duties. *(ref: Bangladesh health system review. Health Systems in Transition, Vol. 5 No. 3 2015. Asia Pacific Observatory on Public Health Systems and Policies)*

main responsibility of the central government and has been led by the Ministry of Health and Family Welfare (MoHFW) in collaboration with key domestic stakeholders and development partners. National health plans provide guidelines describing the overall sectoral goals, targets, and strategies for a five-year period, while also providing a strategic framework to guide investments and budget allocation in the health sector. Under each HNPSP, operational plans are developed. They are also monitored, evaluated, and updated regularly. In addition, the MoHFW also develops various specific strategies for health care financing, Maternal and Child Health, and NCDs, among others.

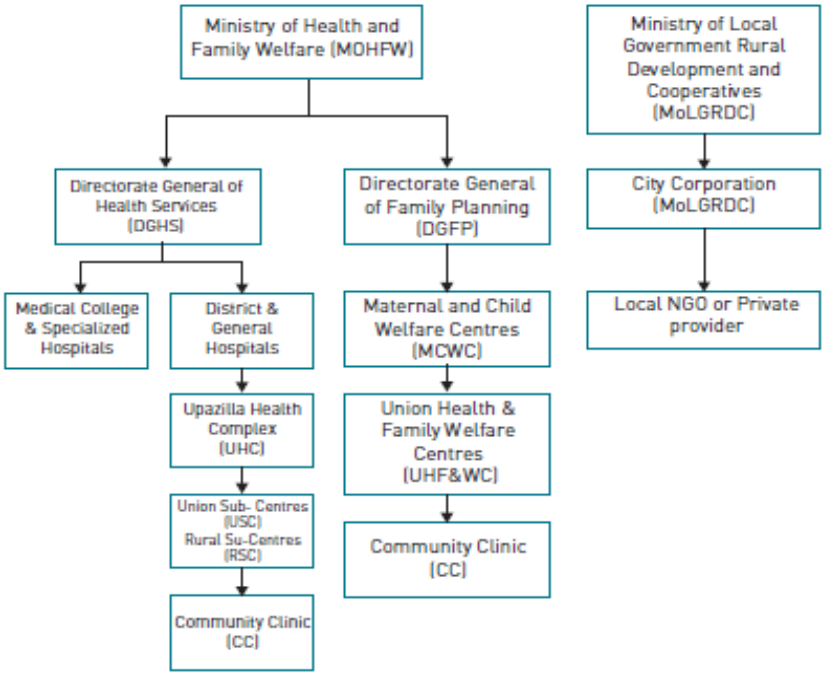
11. A number of challenges were highlighted by the independent review team during the mid-term review of the current 4th HNPSP (2017-2022). The objective of the HNPSP is to achieve UHC by fostering improvements in equitable access to high quality health care, through efficient service delivery. The key health system challenges identified during the mid-term review included (a) limited progress has been made in taking forward the Health Financing Strategy aimed to increase government spending and reduction of out-of-pocket payments; (b) limited access to 24/7 emergency obstetric and neonatal care; (c) lack of a functioning referral system across the various tiers of the health systems; and (d) gaps in provision of care for NCDs including mental illnesses and injuries. Because of the delays, including those caused by the COVID-19 pandemic, the MoHFW plans to extend the 4th HNPSP for one year until June 2023.

Health service delivery systems

12. Bangladesh is at the very early stages of undertaking health system and service delivery reforms that are common among middle-income countries. These include a shift in the focus from reproductive and child health towards NCD care; from access to quality of care; from paper-based to digital information systems; from "accounting" (counting inputs) to "accountability"; from an exclusive focus on the public sector to an inclusive view of the health system including the private sector; from top-down MoH management to greater autonomy to health providers; from out-of-pocket (OOP) financing to budget financing; and from (supply-side) input-based financing to (demand-side) strategic purchasing of services. Together these reforms will require years or even decades to fully materialize, but they represent essential ingredients to a modernized Bangladeshi health system that is prepared to address new challenges and the growing expectations of the population.

13. Bangladesh has a pluralistic health system, involving government, non-governmental and private health services. There are many actors, including public (MoHFW, Ministry of Local Government, Rural Development and Cooperatives, Ministry of Women and Children's Affairs, Ministry of Social Welfare etc.), private, NGOs, CSOs, etc. working for the betterment of the health of the population. While holding exclusive regulatory control over the functions of public, private and NGO providers, and including the responsibility for financing, functionaries, supplies, maintenance and infrastructure development for service delivery, the MoHFW delivers services through both the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) operating structure at different levels (Figure 2) mainly for rural populations. Other sectors also finance and operate their own health care services. In urban settings, provision of health services is the direct responsibility of the local governments. To add to the complexity, sectors such as railways, etc. run their own health service provision.

Figure 2: Simplified health service delivery organizational structure in Bangladesh



Source: Bangladesh Health System Review (2015)

Primary care service delivery networks

14. Strong primary health care (PHC) networks that link clients to higher-level services are critical for achieving UHC. PHC service delivery in Bangladesh occurs at community clinics, union sub-centers as well as upazila health complexes. Ideally, these facilities should mainly focus on disease prevention and ambulatory health care and referring patients with complications to hospitals and specialists at higher levels. The PHC network has been instrumental in advancing health outcomes in the past; however, service readiness and structured referral mechanisms need to be strengthened, among other actions, to improve overall service quality, prevention of overcrowding of hospitals, and efficiency in an era where the disease profile has changed significantly.[9]

Secondary health care

15. Improving hospital care quality is important both for the effective response to COVID-19 and the further reduction of neonatal and infant mortality, and NCDs. A number of recent studies have revealed that COVID-19 mortality is negatively associated with the number of hospital beds, in particularly intensive care unit beds, in both low-income and high-income countries[10,11]. Facility-based services has contributed to the significant reduction of neonatal mortality in low- and middle-income countries[12,13,14]. Decreasing the chronic NCD burden requires a two-pronged approach:

[9] The *4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR) 2020.*; 2020.

[10] Liang, LL., Tseng, CH., Ho, H.J. *et al. Covid-19 mortality is negatively associated with test number and government effectiveness*. Sci Rep. 2020; **10:**12567.

[11] Janke A., et al. *Analysis of hospital resource availability and COVID-19 mortality across the United States*. Journal of Hospital Medicine. 2021; 16:E1-E4.

[12] Darmstadt, GL, et al. *Evidence-based, cost-effective interventions: how many newborn babies can we save?* The Lancet. 2005; Volume 365, Issue 9463, 12–18.

[13] Moyer, CA. et al. *Facility-based delivery and maternal and early neonatal mortality in sub-Saharan Africa: A regional review of the literature*. African Journal of Reproductive Health. 2013; 17(3): 31-43.

[14] Feng, XL., et al. *China's facility-based birth strategy and neonatal mortality: a population-based epidemiological study*. The Lancet. 2011; Volume 378, Issue 9801, 22–28.

implementation of the multisectoral policies aimed at decreasing population-level risks for NCDs, and effective and affordable delivery of primary care interventions for patients with chronic NCDs (NCD best buys). However, hospitals play important role in making sure of technical assistance, quality of NCD care, and reduction of fatality rate of stroke, myocardial infarction, kidney failure, etc. These evidences underscore the importance of improving hospital capacity in order to reduce mortality and improve population health.

16. Availability and utilization of hospital care appears to be low in Bangladesh, underscoring the importance of hospital system capacity development. Bangladesh has a low number of hospital beds per 1000 at 0.8 (similar to India at 0.7, but far lower than the minimum requirement of 3 recommended by the WHO). Hospital bed occupancy rates (BOR) are quite high (perhaps driven by limited supply), at an average of 92 percent across a large sample of several levels of hospitals, with district hospitals at 125 percent occupancy. However, the BOR at upazila health complexes is much lower. Forty-eight percent of upazila health complexes had a BOR less than 80 percent.[15] Bangladesh also has some of the lowest hospital discharge rates, at 24 per 1000 population per year (far lower than the low- and lower-middle income country average in Asia Pacific of 96),[16] which suggests low population-level utilization of hospitals for inpatient care, perhaps driven by perceived low quality and high cost. Hospital system capacity development will only become more imperative as needs for complex medical intervention for NCDs rise. In brief, although excess hospital use is a major concern in many countries, inpatient utilization rates are so low in Bangladesh that foregone care, rather than unnecessary care, is the more important concern at present.

17. A number of reasons may be responsible for the low availability and utilization of hospital care in Bangladesh:

- **High out-of-pocket spending is a common feature among patients admitted to hospitals.** The average OOP incurred per admission is over BDT 11,000, or almost US$150, at government hospitals, almost two-thirds of which is spent on medicines and diagnostics. This qualifies as “catastrophic” (exceeding 10 percent of a household budget) for the majority of households in Bangladesh.
- **The public hospital system is constrained by an ill-distributed service mix and workforce vacancies.** The service mix is poorly distributed in that the specialty hospitals are primarily in Dhaka, and therefore more difficult to reach for remote or under-resourced populations. In addition, the low ratio of 5 doctors and 2 nurses per 10,000 population[17] and high rates of provider vacancies (33 percent of physician positions, 11 percent of nurse/midwife positions, and 38 percent of medical specialist positions are vacant[18]), in addition to limitations in clinical competency, must be addressed to improve quality of care and user focus.
- **Public hospitals also experience shortages of equipment, supplies, and medicines, particularly for high-priority conditions.** Only 66 percent of District Hospitals have a full set of six basic pieces of equipment (adult scale, infant/child scale, blood pressure cuff, stethoscope, thermometer, light source for examination). This is in contrast to private hospitals, where over 82 percent have all six items. The availability of infection control measures is highly variable in DHs. For example, less than 60 percent have medical masks and only 47 percent have alcohol-based hand disinfectant. The availability of any one of the 14 WHO-recommended set of essential medicines is highly variable, and medicines to manage NCDs such as mental health conditions, hypertension,

[15] Smith OK, Vargas V, Ahmed S, Begum T. *Fiscal Space for Health in Bangladesh: Towards Universal Health Coverage*. World Bank; 2016. http://documents1.worldbank.org/curated/en/268141537541184327/pdf/AUS17126-WP-OUO-9-Assessing-Fiscal-Space-for-Health-in-Bangladesh-has-been-approved-P158730.pdf

[16] *Health at a Glance: Asia/Pacific 2018: Measuring Progress towards Universal Health Coverage*. Accessed July 14, 2020. https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-asia-pacific-2018_health_glance_ap-2018-en;jsessionid=t7GAnCCUZh3snti3kbTg_Zr4.ip-10-240-5-71

[17] Ahmed SM, Hossain MA, Raja Chowdhury AM, Bhuiya AU. *The health workforce crisis in Bangladesh: shortage, inappropriate skill-mix and inequitable distribution.* Hum Resour Health. 2011;9(1):3. doi:10.1186/1478-4491-9-3

[18] Niport NI of PR and T-, Welfare M of H and F, ICF. *Bangladesh Health Facility Survey 2017*. Published online February 1, 2020. Accessed July 14, 2020. https://dhsprogram.com/publications/publication-SPA28-SPA-Final-Reports.cfm

hypercholesterolemia, and diabetes mellitus are the lowest of all 14 examined (available at less than 75 percent of DHs). Laboratory diagnostic capacity is particularly low in DHs for NCD-related tests. Specifically, only 29 percent of DHs can conduct a blood glucose test (particularly important for diabetes diagnosis), and only 40 percent can conduct a liver or renal function test.[19]

Digital health

18. Advancing the appropriate use of at-scale patient-to-provider, provider-to-provider digital health tools is growing in importance to support expansion, efficiency, and quality in patient-centered care. Digital health systems in Bangladesh play a critical information management role across multitudinous systems: they support patient clinical care, disease surveillance, population-level vaccination campaigns, and have been integral to the COVID-19 pandemic response. The national reference OpenMRS+ platform and corresponding shared health record (SHR) database are utilized at a few public hospital facilities, and private provider networks are delivering more robust PHC referral chains such as the Digital GP model in select Upazilas of the Jamalpur district. Tele-health call centers like Shastho Batayon (16263), Telenor's Toniq, the COVID-19 Surokkha vaccine registration platform, and mobile-applications like the DGFP eMIS have made strides in leveraging digital health platforms for patient-centric care. While many mature digital systems are utilized in Bangladesh and deployed well-beyond the pilot phase, there is much work to be done from the perspectives of interoperability of systems and client and information utilization. Additional gaps in specific care priorities such as technology addressing the NCD burden and general pharmacy services must be supported and integrated with patient information systems.

Health financing

19. Inadequate and inequitable financing to the health sector are critical impediments toward achieving the goals set out in Bangladesh's national policy documents, including the commitment to UHC. Total health expenditure per capita was US$42 in 2018, while government health expenditure was less than 1 percent of GDP, among the lowest in the world. As a result, over two-thirds of total health spending is sourced from OOP spending, the most inefficient and inequitable mode of financing health. Household survey data reveal that the incidence of catastrophic health expenditures has been rising steeply since 2000. A World Bank (WB) report found that over the short to medium term, reprioritization of the MoHFW budget by increasing its share of the total national budget represents a significantly larger potential source of fiscal space than economic growth or other sources of fiscal space.

20. In addition to the level of health spending, there is a need to undertake health financing reforms. Many key aspects of the middle-income country health financing agenda have yet to gain traction in Bangladesh. These include a shift away from input-based line-item budgets towards demand-side financing with a focus on the poor. This agenda was initiated by the GoB in the form of the Health Care Financing Strategy (2012-2032), the key strategic document guiding the UHC financing agenda, but implementation progress has been very limited almost 10 years since its launch. The link between the strategy and MoHFW's annual budget is very weak. A key pillar of the strategy was the creation of *Shasthyo Surokhsha Karmasuchi* (SSK), a health protection scheme targeted to the poor with an explicit benefit package of health services and output-based provider payment model. The scheme was launched in 2016 in three upazilas in Tangail, but coverage remains very low (less than 100,000). Also, the establishment of a National Health Security Office (NHSO) to administer demand-side financing schemes has yet to be accomplished. As a result, the potential for SSK to become an important vehicle for health financing reform in Bangladesh remains largely untapped.

[19] Niport NI of PR and T-, Welfare M of H and F, ICF. Bangladesh Health Facility Survey 2017. Published online February 1, 2020. Accessed July 14, 2020. https://dhsprogram.com/publications/publication-SPA28-SPA-Final-Reports.cfm

Health care seeking behavior

21. Only 15 percent of outpatient care is delivered by public facilities, with over 80 percent by private providers or pharmacies; however, 55 percent of inpatient care is delivered at government hospitals. Urban Bangladeshis tend to switch between public and private providers until they receive a satisfactory health outcome (Figure 3). The first point of contact for a poor client – most often a slum dweller – is a home remedy by either self-treatment or through a traditional (informal) provider.[20] In rural Bangladesh, self-treatment and delay of care seeking are common. Again, homeopaths and village doctors are among the first line of contacts. Seeking outpatient care at public facilities is rare and seems to be the last choice. Access, cost, severity of illness, gender, age, and illness type are among the important determinants of treatment choice for both urban and rural poor. Public facilities tend to be preferred by individuals from the low-income quintiles. There is increasing utilization of private hospitals, although they still account for less than half the total, as patients seek alternatives to public facilities, even if at significantly higher expense. Despite perceived better quality as measured by cleanliness and responsiveness in private hospitals among the patients interviewed[21], there is no significant difference in staffing, skills and professionalism between public and private hospital service providers[22].

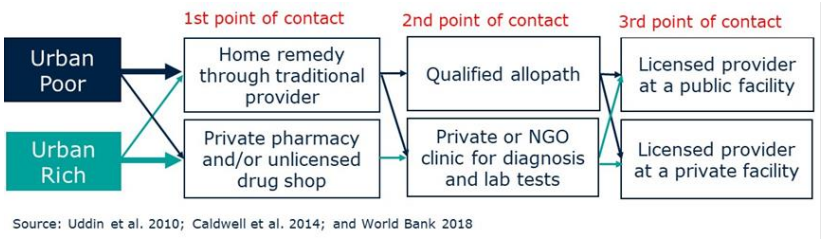


Figure 3: Health Seeking Pathway for Urban Consumers.

Relationship to CPF

22. **This project is fully consistent with the current country partnership framework (FY2016-2020).** Human development is one of the foundational priorities specified in the CPF. Key interventions proposed under the CPF include improving the quality of public service delivery (including workforce skills); increasing public funding for health and moving towards universal health coverage; and extending coverage of innovative social protection to both the rural and urban poor.

C. Proposed Development Objective(s)

Note to Task Teams: The PDO has been pre-populated from the datasheet for the first time for your convenience. Please keep it up to date whenever it is changed in the datasheet. ***Please delete this note when finalizing the document.***

22. The project development objectvies are to (a) support the Government of Bangladesh to improve the quality and appropriate utilization of clinical services for priority conditions, and (b) expand coverage of health protection schemes.

[20] Caldwell, B.K., Rashid, S.F., & Murthy, S. *The informal health sector and health care-seeking behavior of mothers in urban Dhaka slums*. 2014. J Pop Research, 31, 111–129.
[21] Siddiqui N., et al. *Comparison of Services of Public, Private and Foreign Hospitals from the Perspective of Bangladeshi Patients.* J HEALTH POPUL NUTR 2007; 25(2):221-2302007.
[22] Andaleeb, S.S. *Service quality in public and private hospitals in urban Bangladesh: a comparative study.* Health Policy 2000; 50:25-37.

Key Results (From PCN)

23. The project development objectives will be measured by four key results in the project division, including: (a) improved availability of NCD services, intensive care, comprehensive emergency obstetric and neonatal care (CEmONC), emergency medical services, safe blood services in hospitals and selected Upazila Health complexes; (b) increased coverage of appropriate treatment for people currently living with, or at high risk for, diabetes and cardiovascular diseases; (c) increased proportion of women between 30 and 49 years old screened for cervical cancer at least once; and (d) increased number of poor households protected by health protection schemes.

D. Concept Description

24. The project is intended to support the ongoing 4th HNPSP and to generate information on good practices to inform the transition to the upcoming 5th HNPSP. It will mainly support the government-proposed priority activities in the following operational plans (OPs) under the 4th HNPSP: community basic health care, Upazila Health Complex, hospital, health information system (including e-Health), NCD, human resource development, health financing, and maternal and child health.

25. By focusing on one division, Barisal, the project will function as a demonstration of the impacts of multi-pronged interventions. The Division of Barisal has been proposed by the Government because of needs (based on high NCD burden and gaps in service delivery quality, and poverty level. The MoHFW has committed to fill the gaps in terms of infrastructure (such as IT, civil works, etc.), human resources and commitment to reform/innovation proposed under the project. While Barisal is the district selected to receive the bulk of the resource support, the specifics of project design will draw on lessons learned from other districts, and the project will also involve creation of various mechanisms, guidelines, protocols, templates, and systems that will be applicable across the entire country. Successful interventions can be scaled up nationwide as part of the 5th HNPSP.

26. The project will encompass three components as follows.

Component 1: Health System Strengthening

27. This component relates to strengthening the foundations of the health system to improve the quality and appropriate utilization of clinical services. This means ensuring policy development or revision, capacity building and technical assistance for implementing service delivery reform/innovations (e.g., redesign of service provision models including introduction of hub and spokes model, patient-centered care, digital health, etc.) and quality enhancement (e.g., service provider accreditation, development and updating of standards, protocols, and implementation of accountability and incentive mechanisms that encourage increase in output, improved service quality, technical performance and care coordination as described in Table 1).

Table 1: Characteristics of effective facility collaboration to be supported by this project

Network functions	Service delivery components	*Digital components*
Expanded access	• Service package definition by level of care • Systems to promote shared laboratory diagnosis results among service providers • Transport links for routine, urgent and emergency cases • SOPs for transfer and referral	• Telemedicine (provider-patient)
Continuity of care	• Systems to support consistent clinical documentation • Facilitation of consistent communication between facilities/providers and communities	• Unique patient IDs • Medical record sharing systems
Right-based care	• Patient-centered approach (in terms of where, when and what services are provided) • Expert patient and peer learning systems	• Apps for facilitating compliance • Telemedicine • E-prescription
Communication	• Health care provider training on respectful communication with clients • Clear definition of cadre roles and responsibilities • SOPs on communication flows	• Teleconsultation (provider-provider)
Shared learning	• Learning meetings • Participatory facilitation • Network clinical audits	• Conferencing
Resource rationalization	• Rational distribution of resources • (Service package definition by level of care) • Claims submission systems	• E-claims • PFM systems • Telemedicine

Component 2: Improved health services for priority conditions

28. This component will support the delivery of high-quality client-centric health services for pregnant women, newborns, children, adolescents and people living with non-communicable diseases and injuries. Health service providers at different tiers, like community clinics, union sub-centers/rural dispensaries/union health and family welfare centers, Upazila health complexes and district/general hospitals, under the defined "hub and spokes" service network will be supported with improved infrastructure and other key inputs (in terms of human resources, funding, equipment, medicines and other supplies). Quality enhancement programs will be implemented to strengthen facility management and health care providers' clinical competencies in diagnosing and treating high-burden conditions like NCDs and neonatal/infant conditions/illnesses. Key facility-level functions/services to be supported include emergency medical service, safe blood service, intensive (including cardiac) care, Comprehensive Emergency Obstetric and Newborn Care services (CEmONC), etc. Digital health and telemedicine, managed equipment service, and logistical service will be promoted through service contracts.

Component 3: Improved financial protection for the poor

29. This component aims to support the emergence of new and improved health protection schemes that can effectively provide financial protection to the poor and vulnerable while strengthening hospital accountability. The project will support the redesign of health protection schemes (including improvements to beneficiary identification, benefit package definition, management structures (purchaser-provider split, claims processing, management information system, etc.) through capacity building for the Health Economics Unit (HEU) and project districts, support of

premiums, scheme operator management costs, and other areas. Due to the potential complementarities between the health protection scheme and supply-side investments, the project is expected to initiate financial protection scheme coverage in the same division (Barisal) prioritized by other components, while also supporting HEU's current operations indirectly through scheme-wide structural improvements. In addition, autonomy with regard to the utilization of claim revenues retained by hospitals will be piloted in the project districts.

Note to Task Teams: The following sections are system generated and can only be edited online in the Portal. ***Please delete this note when finalizing the document.***

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

Note to Task Teams: This summary section is downloaded from the PCN data sheet and is editable. It should match the text provided by E&S specialist. If it is revised after the initial download the task team must manually update the summary in this section. ***Please delete this note when finalizing the document.***

Environmental risks include generation of medical wastes, wastewater discharges from the health facilities, and air emissions from incinerators and the major social risks of the project relate to inclusion of all stakeholders who come from diverse social backgrounds. Social impacts may also include management of labor and potential risk related to SEA/SH. There will also be risks and impacts related to infrastructure repair and renovation; and rehabilitation of health facilities. However, they are localized and short-term. With enhanced capacity of the staff to manage E&S impacts, these risks and impacts are expected to be mitigated adequately. The project is expected to take place within the footprint of existing facilities and is not expected to involve any land acquisition or involuntary resettlement. No large-scale labor influx is expected as the magnitude of construction limited to repair, renovation and small extension of the existing facilities.

Note: To view the Environmental and Social Risks and Impacts, please refer to the Concept Stage ESRS Document**.** ***Please delete this note when finalizing the document.***

CONTACT POINT

World Bank

Shiyong Wang, Bushra Binte Alam, Owen K. Smith
Senior Health Specialist

Borrower/Client/Recipient

Ministry of Finance
Fatima Yasmin
Secretary
secretary@erd.gov.bd

Implementing Agencies

Ministry of Health and Family Welfare
Md. Helal Uddin
Additional Secretary
helalu06@yahoo.com

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Shiyong Wang, Bushra Binte Alam, Owen K. Smith

Approved By

Country Director:	Dandan Chen	22-Aug-2021

Note to Task Teams: End of system generated content, document is editable from here. ***Please delete this note when finalizing the document.***