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BANGLADESH

POLICY REVIEW OF PREPAID HEALTH SCHEMES

Landscape Review of Prepaid Health Schemes in Bangladesh

This policy brief describes the landscape of prepaid health schemes in Bangladesh and discusses some of the major challenges these schemes have faced. The Health Finance and Governance (HFG) project prepared this policy brief based on a United States Agency for International Development-funded study entitled 'Landscape of Prepaid Health Schemes in Bangladesh'. The HFG team also analyzed data obtained from both secondary and primary sources including key informant interviews and site visits and incorporated past experience of innovative schemes.

1. Background

According to a 2014 ILO report in 44 countries across the world, more than 80 per cent of inhabitants remain without coverage as they are not affiliated to any health system or scheme. These countries include Azerbaijan, Bangladesh, Burkina Faso, Cameroon, Haiti, Honduras, India and Nepal. Health protection coverage is crucial for every human being and to the economy as a whole since labor productivity requires a healthy workforce and employment effects of the health sector significantly contribute to overall employment in most countries.[1] In the absence of formal insurance mechanisms, Bangladeshis are often forced to resort to informal coping mechanisms while facing health shocks. In 2010, the World Health Organization estimated that approximately 100 million people are pushed below the poverty line each year by payments for healthcare. Micro health insurance (MHI), a prepaid health scheme, is a financial risk protection mechanism for improving health care utilization of low-income households in developing countries. MHI has emerged as an innovative health financing tool targeting the informal sector.[2] Globally there are four types of delivery channels offering MHI: 1) the provider-driven model; 2) the partner-agent model; 3) microfinance institutions (MFIs)-initiated model; and 4) the community-based model. In Bangladesh, two channels have historically driven the introduction of MHI and microfinance institutions (MFIs) including the Grameen Bank, BRAC, Society for

1 Addressing the global health crisis: universal health protection policies / International Labour Office, Social Protection Department. Geneva: ILO, 2014. (Social protection policy papers ; Paper 13)

2 For the purpose of this paper, prepaid health scheme for the poor refers to micro health insurance; we have used these terms interchangeably throughout the text.

Social Services, and Sajida Foundation (SAJIDA). These organizations have successfully initiated MHI schemes aimed at protecting borrowers from financial loss resulting from illness or injuries and thus their ability to repay the loans. Further, some health care providers such as Gonoshasthaya Kendra and Dhaka Community Hospital (DCS) have initiated prepaid health schemes aimed at providing health care for low income underprivileged populations at an affordable cost in urban and rural areas of Bangladesh. Currently, the available MHI schemes can be grouped into the following categories:

- Health care provider- driven initiatives
- MFI- driven initiatives
- Innovative schemes

2. Prepaid Health Schemes

Provider- Driven Model

Under the provider-driven model, health care providers (i.e., hospitals, clinics, or groups of doctors) are responsible for designing, marketing, providing health services, and carrying the insurance risk. Gonoshasthaya Kendra is a prominent example of a provider-driven model in Bangladesh; it offers a voluntary social class-based health insurance where premium and benefits vary across the six social classes of the catchment population (i.e., destitute and ultra-poor, poor, lower middle class, middle class, upper middle class, and rich) as depicted in Table 1. The six social classes cover the whole population with progressive, premium, and high copayment (70%) for upper tiers and an overall 35 percent cost recovery rate. The major challenges of this model include low enrollment of the rich, overall low renewal rates, limited scalability and non-replicability.

Table 1: Gonoshasthaya Kendra

Coverage	Delivery model	Name of insurance product	Target population	Enrolment criteria	Annual premium (BDT)*		Benefit package (BDT)*	Costs recovery (%)	Major challenges and criticisms
					Individual (BDT)*	Family (BDT)*			
Target population: 1.2 Million population in 10 districts No. of card holders: about 50,000 Coverage rate: about 4%	Provider driven	Social Class Based Health Insurance	Destitute & Ultra poor	Voluntary	70	140	(i) No charges for paramedic and GP services (ii) No charges for consultation of expert physicians	35%	Low enrolment of the rich and overall low renewal rate
			Poor	Voluntary	100	240	(i) No charges for paramedic and GP services (ii) Considerable discount on consultation of expert physicians		
			Lower Middle Class	Voluntary	200	550	(i) No charges for paramedic and GP services (ii) Fair discount consultation of expert physicians		
			Middle Class	Voluntary	500	1100	(i) No charges for paramedic and GP services (ii) Some discount on consultation of expert physicians		
			Upper Middle Class	Voluntary	900	2700	i) No charges for paramedic and GP services (ii) Some discount on consultation of expert physicians		
			Rich	Voluntary	1200	3500			

DCH operates a scheme to serve the ready-made garment workers. Under this scheme, DCH provides primary health care (both preventive and curative) through an MBBS doctor and an assistant offering weekly on-site visits as needed. The employer manages the patient's prescribed medicines and pays DCH an agreed monthly amount for services. Currently, the DCH scheme serves about 8,000 workers in 24 factories with 100 percent cost recovery. There is 10 percent discount (i.e., 90% copayment) for the referral services to DCH. This model provides convenient primary care services and is replicable. Its major challenges include limited geographic reach, service availability (once a week), and weak protection at secondary level.

MFI- Driven Model

A number of MFIs including Grameen Bank (through Grameen Kalyan (GrK)), BRAC, and Society for Social Services initiated voluntary MHI in the late 1990s and early 2000 to protect their borrowers from financial loss due to income/ productivity loss and treatment costs. However, these organizations did not achieve cost recovery and discontinued the schemes. The Bangladesh wing of International Network of Alternative Financial Institutions (INAFI) also piloted an MHI scheme. However, INAFI also discontinued the scheme after the pilot phase for the same reason.

GrK and SAJIDA are more prominent among the schemes currently offering MHI in Bangladesh (Table 2). GrK, with copayments of more than 50 percent of cost of care mainly provides basic primary health care to the beneficiaries voluntarily enrolled by its own health centers. In recent years the cost recovery rate has been 65-70 percent. The major challenges of this model include low enrolment, low renewal rate, lack of continuum of care, and services offered only at primary health centres.

SAJIDA's Nirapotta is the only example of mandatory MHI in Bangladesh. This scheme is mandatory for its microfinance and Small and Medium Enterprise (SME)members, and the premiums are paid by the borrowers as it is part of the loan payment. The premium ranges from BDT 250 to BDT 1,050, depending on the amount and tenure of the loan. There is an additional premium of BDT 100 for each supplementary loan. SAJIDA reimburses up to BDT 4,000 of health expenses and runs two hospitals. The insured in-hospital catchment areas have the opportunity to seek health care from these hospitals up to BDT 4,000. However, given the price of health care in the market, the coverage is not adequate and the insured pays a large amount of the medical expenses. [3] It is well recognised that the 'reimbursement system' is not a form of prepayment as the insured must pay first. To provide financial protection cashless or low co-payments are preferred to reimbursement scheme. SAJIDA has achieved the breakeven in recent years (with part of operation subsidized by microfinance surplus).

Table 2: Microfinance Institution - Driven Model

Name of the scheme and/ organization	Delivery model	Name of insurance product	Target population	Enrolment criteria	Annual premium (BDT)*	Benefit package (BDT)*	Costs recovery (%)	Health care providers	Major challenges and criticisms
SAJIDA 130,000 in 10 districts	MFI initiated	Nirapotta	SAJIDA's microfinance borrowers and SME borrowers	Compulsory	250 - 1050 based on amount of loan	Reimbursement : 500-4000	Break even	SAJIDA Hospital and any other hospitals	Errors in claim settlement and delay in claim settlement for operating both microfinance and microinsurance with the same set of staff
Grameen Kalyan Card holders: 15,868	MFI initiated	Basic primary care	Rural people	Voluntary	(i) 200 for Grameen microcredit member (ii) 300 for other	10-70% discount on various services Referral benefit: 2000		Grameen Kalyan's own health centres	Low renewal and lack of continuum of care

Innovative schemes

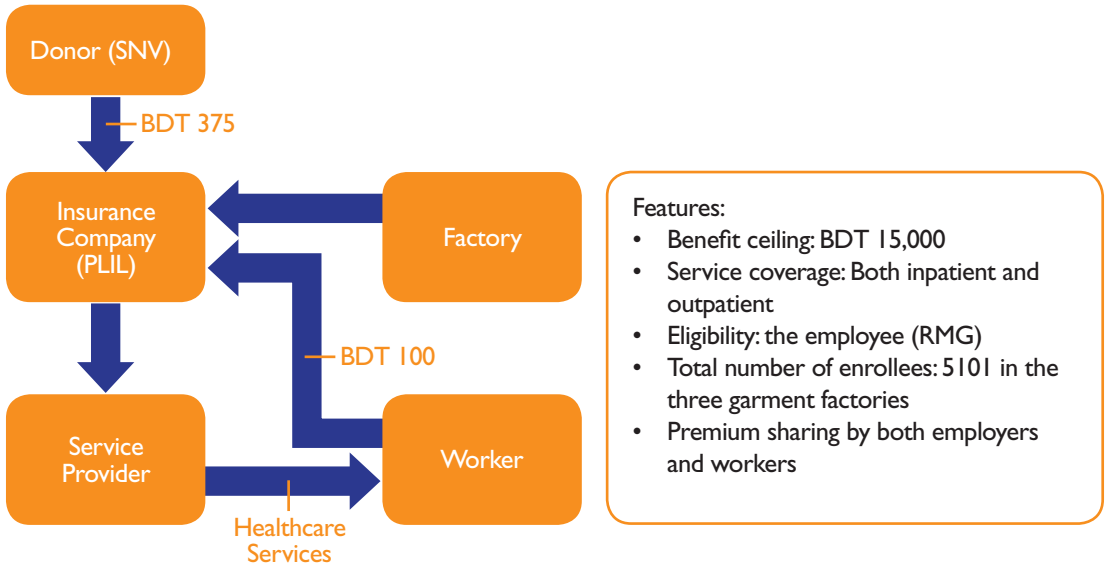
In addition to the provider-driven and MFI-driven models, some research organizations and development agency have initiated a variety of innovative health insurance schemes. Among them, the Niramoy scheme, piloted by Institute of Microfinance (InM), had a wide benefit package including outpatient care and surgical and non-surgical inpatient care offering a 20 percent copayment on drugs. The scheme also contracted with an Apex insurance company, a medical college hospital, and reputed pharmaceutical companies. The Niramoy scheme had anticipated the inclusion of 3,000 households for its breakeven. However, the scheme folded when it was only able to enroll 190 households.

Another innovative scheme, *Amader Shastho* targeted a remote population of Cox's Bazar. Icddr,b carried out this scheme which achieved a reduction in some out-of-pocket expenses for outpatient and inpatients from 66 percent to 50 percent respectively. Like some MHI schemes, it also established partnerships and referrals with local partner hospitals. Other MHI pilots with different target groups included BRAC Health Security Program; Developing Inclusive Insurance Sector Project by Palli Karma-Sahayak Foundation (PKSF) partners; Ayesha Abed Foundation Health Security Scheme (AAF-HSS). Currently, only AAF-HSS is on-going with others collapsing after the piloting phase due to low enrolment, low renewal due to lack of awareness, and negative perception about insurance.

3 The average costs of an inpatient episode is about BDT 8000 (USD 103) (Source: InM-GDIC pilot scheme 2013-2014)

The Diabetic Association of Bangladesh (BADAS) also piloted a health insurance scheme for the garment workers funded by Swiss Agency for Development and Cooperation. The scheme was operated by National Health Network (NHN), New Asia Group (NAG), and United Insurance Company (UIC). The hospitals under NHN were the health care providers, NAG was the employer of the garments workers insured under the scheme, and UIC was the risk carrier.

Figure 1: SNV's Insurance Model for Readymade Garment workers



The *Shasthyo Suroksha Karmasuchi* (SSK). Health Economics Unit (HEU), Ministry of Health and Family Welfare (MOHFW) launched this model at Kalihati upazilas in Tangail District in March 2016 to extending health care services to households below the poverty line in alignment with the Bangladesh Health Care Financing Strategy 2012-32. The scheme was recently expanded to two other upazilas (Modhupur and Ghatail) in the district. The Government of Bangladesh fully subsidizes the premium per household per year (BDT 1,000). This premium entitles each household to offer healthcare services worth BDT 50,000 per year for 50 different disease categories of in-patient services. SSK pays for drugs, diagnostics, supplies, and referral transport costs. Upazilas Health Complex is the health service provider and the district hospital is the referral hospital.

3. Challenges in Prepaid Health Schemes in Bangladesh

The challenges faced by prepaid health schemes in Bangladesh are illustrated below:

Demand side:

- Lack of knowledge and negative perception of insurance in the country as a whole. Bangladesh is lacking an insurance culture and the lack of knowledge makes the population warry of insurance. Previous poor experience with insurance, poor coverage, difficulty in getting insurance to pay, slow payments, has added to the negative perception of insurance
- Unattractive benefit packages: the packages cover little or require a high copayment providing little financial protection.
- Low demand for MHI (i.e., low enrolment and low renewal) resulting from the two above elements.

Supply side:

- The lack of reliable quality providers has led some micro insurance providers to set up their own health facilities which restricts the scalability and replicability.

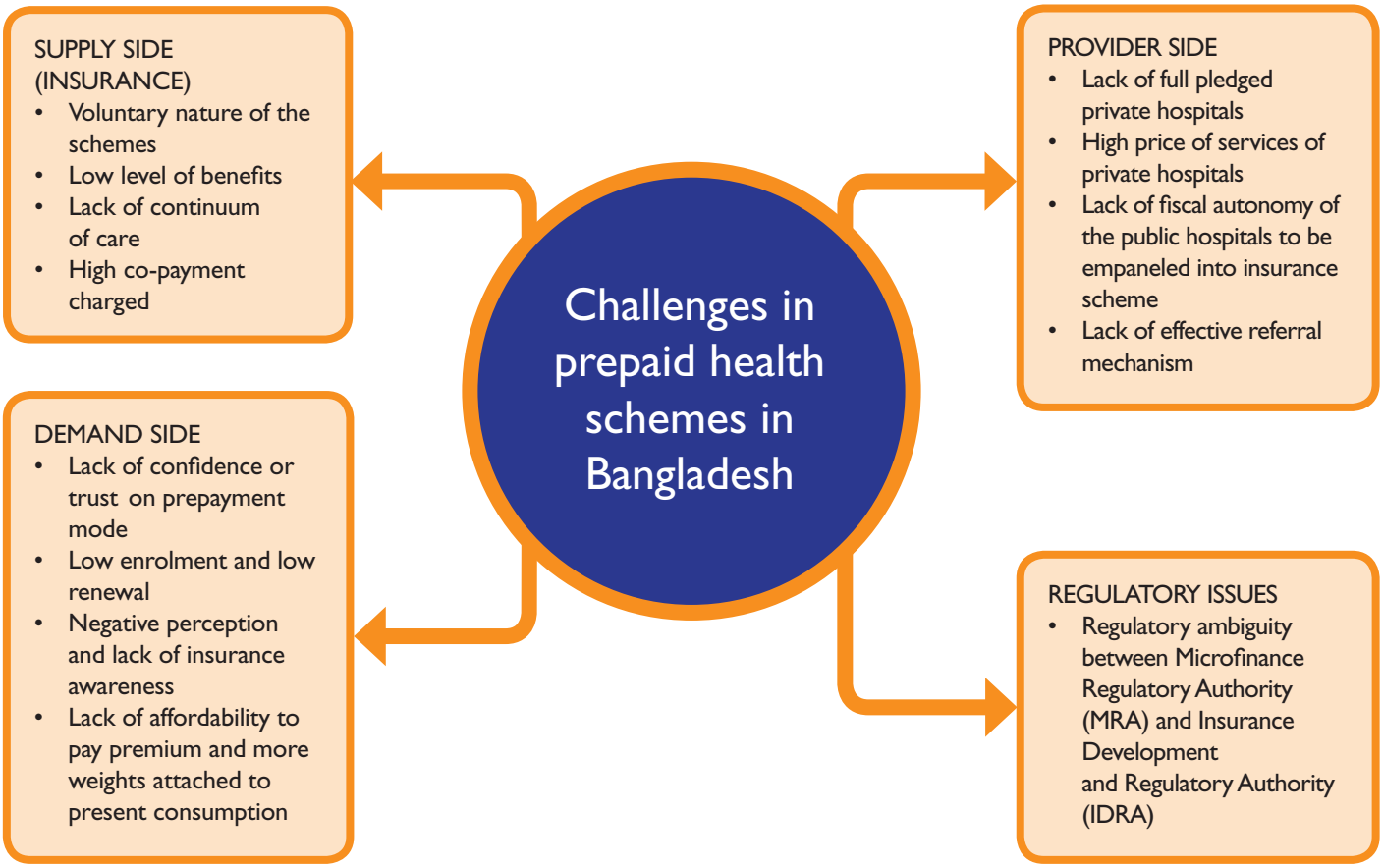
Provider side:

- Lack of extensive provider networks: there are no provider network that offer services nationwide.
- Lack of qualified medical staff for providing services for 24/7 in most of the private hospitals. The lack of 24/7 service makes the providers, and the insurance scheme affiliated with them, less attractive.
- MIS and accounting system are not compatible with the regular submission of claims in proper format. Insurance requires data in a format that is not routinely kept by the providers

Regulatory:

- The government's MRA Rules 2010, Clause 16 (2) mentions that microcredit activities also include insurance services. However, Clause 8(1) of Insurance Act 2010 National Insurance Policy 2014, says that if any MFI or non-governmental organization wants to protect its clients by any insurance, it needs to have a contract with a registered insurance company under IDRA.

Figure 2: Challenges in prepaid health schemes in Bangladesh



4. Conclusion

MFI institutions have not yet been able to leverage their size and skills to offer MHI in Bangladesh, as they have in India. Currently, Bangladesh does not have an insurance culture and the population's lack of trust in insurance institutions is high. Additionally, there is a lack of insurance knowledge and skills micro lending institution. Existing schemes offer unattractive benefit packages, high co-payments, and poor claim settlement; refusal or slow payments, partial reimbursements. Fraud. Finally, the lack of network of health providers means coverage is local and with weak referral linkages (no continuum of care).

Large scale voluntary schemes in the informal sector have not been successful in other developing countries. Where informal economy workers have been covered at scale, the schemes have been subsidized as part of a larger national insurance program. It is impractical to initiate a compulsory scheme without having a large group. Although there are about 40 million microfinance members in Bangladesh, the government, through an appropriate regulatory authority, is needed to exploit this potential.

Table 3: Summary of the prepaid health schemes in Bangladesh

Name of the scheme and/ Organization	Delivery model	Name of insurance product	Target population	Enrolment criteria	Annual premium (BDT)*		Benefit package (BDT)*	Costs recovery (%)	Health care providers	Population and geographical coverage	Major challenges and criticisms
Dhaka Community Hospital (DCH)	Provider driven	Industrial Health Program	Garment workers	Compulsory, but free, for all workers in the selected garment factories	Lump sum payment by employers based on capitation method		(i) Preventive care (ii) Free consultation services (iii) Free medical checkup once a year (iv) 10% discount referral and/or inpatient care	100%	DHC	About 8000 employees in 24 factories	Very high copayments for inpatient and referral services
Gonoshasthaya Kendra	Provider driven	Social Class Based Health Insurance	Destitute & Ultra poor	Voluntary	Individual (BDT)* 70	Family (BDT)* 140	(i) No charges for paramedic and GP services (ii) No charges for consultation of expert physicians	35%	GK health centers and hospitals	Target population: 1.2 Million population in 10 districts No. of card holders: about 50,000	Low enrolment of the rich and overall low renewal rate
			Poor	Voluntary	100	240	(i) No charges for paramedic and GP services (ii) No charges for consultation of expert physicians				
			Lower Middle class	Voluntary	200	550	(i) No charges for paramedic and GP services (ii) No charges for consultation of expert physicians				
			Middle class	Voluntary	500	1100	(i) No charges for paramedic and GP services (ii) considerable discount on consultation of expert physicians				
			Upper middle class	Voluntary	900	2700	(i) No charges for paramedic and GP services (ii) Some discount on consultation of expert physicians				
			Rich	Voluntary	1200	3200	(i) No charges for paramedic and GP services (ii) Some discount on consultation of expert physicians				
BADAS	Provider driven	Outpatient and Inpatient	The lowest salary groups of some selected garment factories	Compulsory	487 per worker which is paid by the employer		Maximum annual 15000 per worker	Below breakeven	National Health Network	8000 workers of seven garment factories of New Asia Group	High claim rate and potential loss
Sajida Foundation	MFI initiated	Nirapotta	Sajida's microfinance borrowers and SME borrowers	Compulsory	250 - 1050 based on amount of loan		Reimbursement : 500-4000 per episode	Break even	Hospital of Sajida Foundation	130,000 in 10 districts	Errors in claim settlement and delay in claim settlement for operating both microfinance and microinsurance with the same set of staff
Grameen Kalyan	MFI initiated	Basic primary care	Rural people	Voluntary	(i) 200 for Grameen microcredit member (ii) 300 for other		10-70% discount on various services Referral benefit: 2000 annually		Grameen Kalyan's own health centres	Card holders: 15,868	Low renewal and lack of continuum of care

Name of the scheme and/ Organization	Delivery model	Name of insurance product	Target population	Enrolment criteria	Annual premium (BDT)*	Benefit package (BDT)*	Costs recovery (%)	Health care providers	Population and geographical coverage	Major challenges and criticisms
Amader Shasthya (ICDDR,B)	Community based	Outpatient	Rural people	Voluntary	500 per household	Maximum annual 30,000 per household		Outpatient care by community run health centre with assistance of icddr,b; referral and inpatient by empanelled local hospitals	10,000	Low renewal rate
		Inpatient			1200 per household	Maximum annual 54000 per household				
DIISP	MFI initiated	Inpatient	Rural people	Voluntary	250	200 to 400 per day is given as cash benefit for a maximum of 30 days, excluding the first day	Generated surplus	Paramedic services by MFIs and inpatient care by empanelled hospitals	33,771 members of 40 MFIs	Low enrolment
Niramoy (Institute of Microfinance and Green Delta Insurance Company Ltd)	Joint initiative of MFIs and Insurance company with the assistance of some researchers	Outpatient, inpatient and maternity	Microfinance members	Voluntary	380 per individual	No charges excluding medicine and injectable. There is 20% copayment on medicine and injectable.	Loss incurred	Community Based Medical College Hospital, Mymensing	Target: 3000 households or 15000 people Card holders: 200 household or 1000 people	Low enrolment

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The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, Training Resources Group, Inc.
For more information visit www.hfgproject.org/
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Recommended citation: Hamid, Syed Abdul. May 2016. *Bangladesh Prepaid Health Schemes Landscape*, Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

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