Final Draft

Study on

Operational Mechanism for Social Health Insurance in Poverty Prone Sub-district of Bangladesh: Development of Tools & Guidelines

(Along with Summary Report of Field Survey)

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Sponsored & Financed by WHO (Dhaka)

December-2005
## Contents

<table>
<thead>
<tr>
<th>Topics</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Providing Sustainable Health Care and Social Health Insurance in Bangladesh: Constraints &amp; Remedies</td>
<td>3-10</td>
</tr>
<tr>
<td>2. Basic Principles &amp; Practices of Commercial Insurance</td>
<td>11-16</td>
</tr>
<tr>
<td>3. Private Health Insurance Market and Practices</td>
<td>17-23</td>
</tr>
<tr>
<td>4. An Overview of Social &amp; Community Health Insurance</td>
<td>24-28</td>
</tr>
<tr>
<td>5. Problems involved in providing CHI (Community Health Insurance)</td>
<td>29-34</td>
</tr>
<tr>
<td>6. Mandatory &amp; Voluntary Health Insurance: Experience of Other countries</td>
<td>35-41</td>
</tr>
<tr>
<td>7. Community Based Micro Health Insurance Schemes of Bangladesh</td>
<td>42-47</td>
</tr>
<tr>
<td>8. Role of Government in Implementing SHI scheme</td>
<td>48-54</td>
</tr>
<tr>
<td>9. Designing an Appropriate Pilot Scheme</td>
<td>55-62</td>
</tr>
<tr>
<td>10. Modus Operandi of Ideal Pilot Scheme</td>
<td>63-71</td>
</tr>
<tr>
<td>11. Funding of SHI Scheme and Fund Management Issues.</td>
<td>72-80</td>
</tr>
<tr>
<td>12. Suitability &amp; Modality of Solidarity SHI Model</td>
<td>81-88</td>
</tr>
<tr>
<td>13. Concluding Remarks and Recommendations</td>
<td>89-94</td>
</tr>
</tbody>
</table>

### Annexes

<table>
<thead>
<tr>
<th>Annexes</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary Findings of Field Survey</td>
<td></td>
</tr>
<tr>
<td>15. Annex-B</td>
<td>IV-IX</td>
</tr>
<tr>
<td>Findings of Survey : House hold owners</td>
<td></td>
</tr>
<tr>
<td>16. Annex-C</td>
<td>X-XIII</td>
</tr>
<tr>
<td>Findings of Survey : Civil Society members</td>
<td></td>
</tr>
<tr>
<td>17. Annex-D</td>
<td>XIV-XVII</td>
</tr>
<tr>
<td>The role of Zakat in risk management for the poor*</td>
<td></td>
</tr>
<tr>
<td>The experience of Selangor Zakat Centre (Malaysia)</td>
<td></td>
</tr>
<tr>
<td>18. Annex-E</td>
<td>XVIII</td>
</tr>
<tr>
<td>Voucher</td>
<td></td>
</tr>
<tr>
<td>Role of Private Medical Practitioners in the CINI ASHA’s (India) Urban Health Program</td>
<td></td>
</tr>
<tr>
<td>19. Annex-F</td>
<td>XIX-XXI</td>
</tr>
<tr>
<td>List of abbreviation and acronyms</td>
<td></td>
</tr>
<tr>
<td>20. Annex-G</td>
<td>XXII</td>
</tr>
<tr>
<td>Bibliography</td>
<td></td>
</tr>
</tbody>
</table>
Providing Sustainable Health Care and Social Health Insurance in Bangladesh: Constraints & Remedies

Good health has direct positive impact on the quality of life. Good health is not simply the absence of disease or infirmity, it is a state of complete physical, mental and social well being. It contributes to a persons capabilities and raises earning capacity. Developmental goals can not be achieved without a healthy population. This means people must be healthy in order to contribute to social and economic development.

The health level of a country’s population is directly related to the economic development and prosperity of the nation. This means it is the level of the economic development of a nation which determines the level of health care its people enjoys. However, it is common world wide that the medical expenses grow more rapidly than income.

Bangladesh has achieved some progress in health and family planning. Fertility has decreased and child immunization schemes have reached to approximately 73% of the population. Life expectancy has risen to 59 from 45 in 1970. But even today less than 40% of the population has access to basic health services. Therefore, the reform of health care system has become the main concern of Bangladesh.

Health Insurance As Security
As a matter of policy and due to accelerating privatization programme of the government of Bangladesh, it was expected that more and more schemes regarding health insurance will be introduced by private insurers and the Ministry of Health will be performing its conventional responsibility for the planning and supervision of the overall health services of the nation. This includes the following:

a) Development of manpower facilities and equipment.
b) Licensing and monitoring of performance of the resources developed.
c) Controlling environment.
d) Provision of personal preventive care for the entire population.

Over and above these tasks, Ministry of Health is responsible for the development of national health plans which cover the financing of health care and regulation of the supply of facilities in the public and private sectors. While the Ministry of Health is generally charged with providing and enhancing the health of the population, health insurance protects all or part of the population from the inability to acquire health care because of financial constraints.

Health insurance serve as a response to financing the access of individuals to health care. It is, therefore, logical to expect that health insurance scheme of a country like Bangladesh be treated as a social security programme and should be planned within the framework of an overall national health plan. Health Insurance need to be developed as a stable mechanism for financing personal health care.

Rahman Maswoodur, The Independent Bangladesh Year Book 1999-, P-73
Social security emerged as a goal of societies where “freedom from want” was proclaimed as a basic human right. An example of social security approach was the enactment of a National Health Service (N.H.S) in the U.K. in 1948. With the adoption of this the British Government undertook the full responsibility for the provision of health services to the entire population. The Government also undertook the commitment to pay for N.H.S. mainly through general revenue financing.

The national health service approach was adopted by other east and west European countries. However, in the Nordic countries, the N.H.S approach was applied only in part, in combination with compulsory health insurance. The only large industrialized country that followed a different path has been the United States. They retained a preference for private insurance. Canada on the other hand took a more radical step and introduced a comprehensive health insurance system in 1966.

The historic International Conference on Primary Health Care was held in Alma-Ata(USSR) in 1978 which called for a new approach to health and health care to attain the goal for “Health for All” (H.F.A) by the year 2000. In order to achieve the goal of H.F.A, the governments of the developing countries felt the need to mobilize additional resources in health care financing.

Many of these countries realized that one of the most promising options was compulsory health insurance in the form of social security programme. That is why in many of the developing countries in Asia, Africa and Latin America, compulsory health insurance is one of the options for the government to finance health care programmes for the mass population.

The prime objective of social insurance is to provide basic economic security to people against the long-range risks of premature death, old age, sickness, disability and unemployment. Social insurance is provided in a situation where the consumer is faced with the problem of not getting adequate insurance coverage because of either or both affordability and availability. Social insurance is generally introduced when it is impossible or impractical for private insurers to solve a social problem. The basic distinctions between social and private insurance are that social insurance, in contrast to private: (a) is compulsory, (b) individual choice of selecting the amount of benefit is not allowed (c) provides a minimum level of benefit.

**Problems of Health Insurance**

Health insurance risks poses complex problems for providers of health insurance. Insurers need to apply the principles of insurance to fund the provision of a tangible service i.e. health care. A variety of different health care services can be covered by an insurance plan depending upon the needs and capacity to pay premiums by the prospective policyholders. Health care services can be provided under different schemes such as:

a) Preventive and Primary Care  
b) Medical Care  
c) Tests and Examinations  
d) Medications.
Insurers are required to decide which of these services to be covered and the level of coverage to be provided. Decision in this regard is dependant to three main factors i.e.

i) Demand

ii) Affordability and

iii) Availability of services.

The high costs of health care services means that health insurance can only be made sustainable through high premiums that may surpass the insured's ability to pay. At the same time majority of the population can not manage to meet the high cost of health care without insurance.

How often policy holders use the services is a key factor of health insurance expenses. Insurers, therefore, must calculate the expected likelihood that policyholders would require treatment and the type of treatment they would require. Methodology for estimating the cost of treatment varies according to the type of coverage they provide.

Health insurance plans are highly susceptible to abuse through adverse selection and moral hazard. The requirement that policy holders enroll as a family reduces adverse selection to some extent. By enrolling entire families a mix of high and low risk users within the insurance pool is created. However, policyholders can also abuse health insurance plans by attempting to obtain treatment for non-family members. This can be protected by providing photo-1D (identity) cards. Before receiving the insurance benefits, policyholders should present their valid photo-1D card.

One way to avoid adverse selection is to make the insurance compulsory. It is then possible to relate the premium not to risk but income. The rich then should pay more than the poor. Such systems has worked well in countries which can fully finance the entire population to access a wide range of health care related benefits. It is very difficult to extend work based social insurance in a developing country like Bangladesh. This is simply because of large rural and informal workforce.

Moral hazard of the insured can hardly be controlled and there is no simple solution to this problem. One way of handling this issue is the requirement of pre-authorization or pre-notification. As a result, the insured need to advise the insurer in advance of any proposed treatment. This affords a number of benefits such as:

a) The insured is rest assured that the treatment is covered and the cost will be reimbursed.

b) The insurer is given an opportunity to advise on cover, for alternative treatment or preferred providers

c) The insurer can prefer to settle claims direct with providers, which will give the insurer the opportunity to check charges for accuracy and or appropriateness.

Problems of Private health insurance
Private health insurance systems differ from public financing systems in several ways. A private insurance plan typically competes for customers. The customers also may choose among several plan that have different features. These plans also have different prices and consumers have to decide if a more desirable insurance plan is worth its higher price. But different prices are often associated with a range of plans that provide different benefits and difficult to compare. Moreover, people with low income are unlikely to be able to afford any insurance at all from the private insurers.

Recently, managed health care plans have emerged in a number of countries. Managed care plans combine the financing and delivery of health care in the same contract. Managed health care system offers both insurance protection and a prescribed net work of health care providers. In the developed counties managed health care plans are offered as a lower cost alternative to financing insurance plans.

Private health insurance include both financial insurance plans (which pay for covered services from any qualified provider) and managed care plans which pay only for covered services that are delivered by providers who are under contract to the plan.

As with most product, buyers will tend to choose an insurance plan that has a lower price. Insurers try to cut cost by insuring only low-risk people and restricting the range of risk, i.e. by denying coverage to many prospective customers. People may also find that claims are being denied by one reason or other and the service is very poor. Managed care plans are, therefore, desirable. But this requires active management of a large network of health care providers.

Furthermore, adverse selection, moral hazard, lack of awareness, lack of transparency and high administrative costs are very relevant to private health insurance system in developing countries like Bangladesh.

Regulation of Private Insurance
Government is supposed to regulate private insurance effectively. An effective regulatory system need to have an effective enforcement strategy. Regulations without enforcement is like a tiger without teeth. Unfortunately in Bangladesh insurance regulatory authority is very weak and have little impact on quality or other desirable outcomes.

Regulation of private insurance is an extension of insurance law. We have in Bangladesh the Insurance Act 1938, with little amendments during last few decades. The Act contains a “definition” of health insurance business only. ①

① Section 2 subsection 7A defines health insurance business as the business of effecting contract of insurance upon human sickness or accidental human body injury necessitating medical treatment by a medical practitioner.
There are lack of qualified people in the regulatory body and, therefore, constitutes weak institutional capacity. Insurance regulation in Bangladesh is ineffective to a great extent. Policy makers are not very much aware of the extent or nature of private financing through private insurance system in health care.

According to insurance experts, if there is an arm of the financial sector where regulation is highly essential, it is in the insurance sector. This is because the very essence of transaction of insurance contract is based on trust. The vast sum of money that accrues from insurance transactions makes State control and regulation inevitable. Government regulation of insurance typically should have three goals:

a) facilitating and maintaining stable and sound market.
b) protecting the insureds interest
c) maximizing consumer participation.

Regulation to stabilize insurance market include the following:

i) Setting financial standard for entry (capital requirements) and operations (solvency regulation).

ii) Regulation governing the ethical practice and codes of conduct

iii) Regulation regarding submission of financial reports and statements.

Regulation regarding consumer protection and ensuring maximum participation of consumers are interrelated. In order to protect consumers, the regulatory authority should publish on a regular basis all relevant information about the product and practices of the insurance operators. They should also make available to public statistics and data about the financial performance of insurance companies. Without, being familiar and up to date; the regulators can not expect to prevent abuses.

The regulators must realize that the insurance system, whether private or public, must strike a balance between economic efficiency and equity. This will help gaining social acceptability of private health insurance. Furthermore, the regulators must ensure financial stability of the insures and the integrity of insurance contracts.

There is a general belief that in the coming years, there will be more and more internationalization of the insurance business and foreign insures will have access to local insurance market. This means, our regulations ought to provide the needed structure for a competitive liberalized market. It is no denying of the fact that our regulatory personnel are of insufficient quantity and or quality.

Even if we have appropriate laws and regulations, we perhaps can not provide the needed oversight. The new order to global competition will bring problems with existing regulatory framework, unless we prepare ourselves to cope with the ensuing situation. This is very important, because pro-competitive regulation requires a greater emphasis on solvency oversight, transparency and market monitoring. In this respect we may need technical assistance for capacity building.
Task Ahead
There is general acceptance that universal health insurance is not feasible at this time in Bangladesh. Yet, it is also accepted that ways and means must be found to finance the potentially large and unexpected consequences of ill health. These two conclusions suggest that an appropriate strategy is required that develop risk pooling schemes tailored to the needs of particular population groups. Further, in order to popularize health insurance schemes, effective mechanism should be evolved in order to create public awareness. The NGOs may play a significant role in this respect. Proper motivation and publicity is necessary to make common people aware of the benefit of health insurance schemes.

Compulsory health insurance is mostly suitable only for those who work in formal employment. In Bangladesh, formal sector employment accounts for less than six percent of the population although this figure will rise to perhaps 10-12 percent if dependents, at least spouses, are included as beneficiaries of insurance. It includes both public sector workers and formal private sector working in registered premises. According to the labour force survey, a total of 35 percent of the population currently work in the private informal sector. However, many of these are currently un-waged workers. Many would find insurance either unaffordable or unattractive.

In Bangladesh, there are already a number of notable and innovative community insurance schemes largely run by civil society organizations and non-government organizations such as Grameen, Gonashaya Kendra, Shakhti, Dhaka Community Hospital etc. In the case of community health insurance it would be better for government to issue guidelines for local groups on the concept of health insurance and the main issues to be considered when designing and implementing a scheme.

For introducing health insurance, the pertinent question is who are the target group. If it is elite class only, it would not have of much significance. But if it is for middle/lower income group, State’s obligation is to provide such service at the minimum cost as the common mass can not afford to bear high cost. For introducing health insurance schemes, precautionary measures will have to be taken to minimize moral hazard. Health insurance schemes has to be based on health statistics, morbidity study etc. Efforts must be taken in these areas in order to design appropriate product and fix premium on a scientific basis.

There is evidence that many people in Bangladesh make large and often unaffordable payments for serious illness. Often this leads to debt and impoverishment. It is also evident that people are willing to pay for health care services when they are ill. Therefore, it is very important to consider the requirements for establishing feasible schemes of health care and health insurance.

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† Tim Enson - Covering the population: extending health insurance in Bangladesh. Research note 18 May 2000, P-5, Health Economics Unit (MOHFW).
First of all we need to have an enabling framework for development of health insurance. In this respect the government has a key role to play in different areas. For example, legislation is required for the introduction of compulsory insurance. Successful introduction of health insurance requires the development of a range of management and administrative skill so that the health insurance system can function effectively. It is also necessary to establish a framework for monitoring the different health insurance schemes. A strong and effective regulatory structure is required for ensuring a quality and transparent system.

Need for Social Insurance
Social insurance aims primarily at providing society with some protection against one or more major hazards which are sufficiently widespread and far reaching in effect. Usually these risk are not many in number, yet if not guarded against through some organized means, they produce large dependency problems. Social insurance is generally compulsory giving the individual no choice as to membership. Nor it can be as a rule the incumbent select the kind and amount of protection or the price to be paid for it. Indeed, social insurance views society as a whole and deals with the individual only so far as he constitutes one small element of the whole.

The great advantage of the social insurance approach is that it is not viewed as a social welfare benefit, but as a benefit earned through an insurance plan. Affluent nations have found that social insurance plans have wider public support and are more stable than social welfare programs.

We are talking about social insurance in Bangladesh simply because security and protection of life, health etc is the essence and function of the State. The role of a welfare government is not complete without a social insurance system. It is true that all insurance is essentially a social function. But social insurance is the policy of organized society to furnish the required protection of insurance to some sections of the population who can not afford to pay for that.

Basic principle of insurance is the creation of a pool of resources from which help can be given to contributors when an insured contingency occurs. When we are talking about social insurance as a national security program, it is felt that it should belong to the people as a whole. It is also felt that the State should take positive role in promoting social health insurance schemes.

The concept of a new social insurance scheme for Bangladesh need to be developed, because the government can not embark upon this responsibility alone by itself. The scheme should be State sponsored, community based and to be operated by independent quasi-government organizations or friendly societies or micro credit operators. Co-operation between the government and non-government organizations will be required to provide social health insurance schemes through non profit institution.
Several basic questions need to be answered before designing and implementing any social health insurance scheme. These are:

i) Whom to protect and at what levels?

ii) What risks to be protected and under what conditions?

iii) Who will provide the services of social insurance?

iv) What role the Govt. will play under a new social health insurance system?

In Bangladesh, we should have a basic minimum program of social security. There must be a basic level of state support to the poor so that the essentials of life can be guaranteed. The government must endeavor to do so in a way which discourage dependency. This suggests that there should be three tiers to the system:

a) minimum public assistance to relieve poverty (such as old age pension)

b) compulsory insurance or universal coverage for poor people

c) voluntary top-up insurance (offered by private insurers)

A comprehensive system of social health insurance would include provisions to compensate part of the involuntary loss of earning for any common reason beyond the control of an individual poor. Such reasons may be grouped into those which cause prolonged and permanent loss of earning and those which cause more or less temporary loss of earnings.

It is felt that establishment of a single comprehensive system of social health insurance due to sickness, disability, premature death, etc. would prove to be economic and attractive. S.H insurance should cover all the family members within the defined age limit. The proposed comprehensive group social health insurance system would bring simplicity and economy in operation. The cost of group comprehensive cover is less in relation to the return to be anticipated in protection.

Generally, social insurance scheme is a government run plan with a standardized benefit structure and contribution rates. As an alternative, government may mandate that everyone in the specified groups must be covered by social health insurance but the groups may choose from among several schemes offered. However, there may be a need for the government to retain an interest as insurer of last resort because there is a risk that disproportionate number of poor risks will aggregate to one provider thereby undermining solvency.
Basic Principles & Practices of Commercial Insurance

We know that insurance is a social device whereby the uncertain risks of individuals may be combined in a group and when the individuals pay small periodic contributions to create a common fund, out of which those who suffer loss may be reimbursed. The basic concept of insurance is risk pooling or group sharing of losses. This means, when a person is exposed to loss from a particular source, a large group combine their risks and agree to share losses on some equitable basis. The risks may be combined under an arrangement whereby the participants mutually insure each other, or they may be transferred to an organization that, for a consideration (premium) is willing to assume the risks and pay the resulting losses.

The basic theorems of probability are of great importance in insurance, specially in rate making, financial management and contractual provision formulation. They are of crucial importance in protecting the solvency of the insurer by enabling more accurate predictions of losses, specially when empirical data are scanty or not available, and guesses must be made as to the course of future events. They give guidance to the insurer in determining what constitutes an adequate number of exposure units in order to achieve financial stability.

The chief risks of the insurer are:

a) the uncertainties involved in estimating the probability of an event,
b) the uncertainties involved in determining that the events to be insured are independent and random or they conform to some mathematical assumptions,
c) the fact that the insurer may not have a sufficient number of exposures to predict losses with a required degree of certainty.

On the other hand the chief risk of the insured is the uncertainty attached as to whether or not a given loss will occur to him individually. It is not the probability of loss which causes difficulty, but rather the uncertainty as to whether an individual will be among those who are expected to suffer loss. Therefore, the insureds try to reduce risk through insurance cover and other means. Insurance reduces risk both to society and to individuals by combining under one management a large group of people, so that the aggregate losses to which society is subject become predictable within narrow limits. From the standpoints of the insurer, the requisites of insurable risks are:

a) there must be a sufficient number of homogenous objects to allow a reasonably close calculation of probable future losses,
b) the loss must be accidental and unintentional in nature,
c) the loss must be capable of being determined and measured.

Green M.R. Risk & Insurance - South-Western Publishing Co. Ohio, P-46
Ibid, P-47.
The major functions of insurance are selling, underwriting, rate making, claims management, investing, financing, accounting, market research, providing services, personnel management etc. It is the underwriting, claims handling and rate making tasks which are most nearly exclusive functions of insurance. The other functions are necessary to carry out those basic tasks, are not exclusively insurance functions. Re-insurance is another important function of insurers, which is accomplished by an external organization. Reinsurance is required for distribution of insurers risk and thus to maintain financially stable and sound organization.

It is also important to note that insurance is basically a legal contract and must meet the general requirements of contract. The insurance contract must be made by parties with legal capacity to contract and must be supported by consideration. Furthermore, because insurance is a contract of utmost good-faith, breach of warranty, concealment of material facts and or material misrepresentation on the part of the insured, can void the insurance coverage. Similarly, no insurance contract is valid, if insurable interest of the insured can not be proved.

**Insurable health risk.**

Theoretically, only pure risk (chance of loss and no possibility of gain) could be the subject of insurance, but practically, there are other requirements. The most important requirements are:

a) The risk must be common to a large number of people otherwise accurate prediction and, consequently adequate rates would be impossible.

b) The loss must be definite. This means a loss if sufficiently definite has to be clearly identifiable and measurable. However, in disability insurance, it is often difficult to know whether a loss insured against has actually been suffered or an injury is disabling to the extent claimed. This type of losses insured under health insurance contracts are defined in terms of loss of income or of actual expenses incurred.

c) The loss must be unexpected. In other words the loss must be fortuitous. Losses deliberately brought about by the insured are excluded.

d) The risk should not be one which presents exposure to catastrophic loss. Insurers are careful to guard against such a possibility. For example, epidemics may be excluded in health insurance.

e) The loss should not be trivial. The expense of completing the insurance contract and administering the plan will not be justified for very small losses. In this respect health insurance poses problems. If health insurance plans are designed to cover full cost of minor hospitalization or medical expenses, the costs of administering and processing relatively small claims may consume an unreasonably large percentage of the insurance premium. For this reason, provisions are often included in health insurance policies to exclude reimbursement of expenses below some minimum amount.
f) The chance of loss must be calculable. The risk must be of such a nature that it is possible to calculate the chance of loss with reasonable accuracy. Non availability of morbidity and disability statistics causes problem to health insurance.

g) The cost should be feasible. The risk must be of such a nature that the losses actually experienced can be met at a reasonable cost. This makes it easier to obtain the large numbers necessary for reliable predictions and at the same time makes the benefits of insurance available to more people. This is why in health insurance, health care providers cost need be kept at the minimum possible.

Types of Health Insurance
Health Insurance may be defined as that type of insurance which provides indemnification for expenditures and loss of income resulting from loss of health. In general, there are five different types of health insurance benefits which may be offered on separate contracts or in different combinations on a single contract:

a) Hospitalization plan
b) Surgical plan
c) Regular medical plan
d) Major medical plan
e) Loss of income.

a) Hospitalization Plan is intended to indemnify the insured for necessary hospitalization expenses, including cabin cost in the hospital, laboratory fees, operation charge and certain medicine and supplies. Typically contracts offered by insurance companies may state that the insured will be indemnified say taka one thousand (1000.00) per day.

b) The surgical plan provides set allowances for different surgical operations performed by professional surgeons. In general, schedule of different operations is set forth together with the maximum allowance for each operation.

c) Medical plan (regular or major) refers to that contact of health insurance which covers physician’s services only whether, visits are made in hospital, at residence or in the doctor’s chamber. Normally, regular medical insurance is offered in conjunction with other types of health insurance and is not offered as a separate plan.

d) Loss of income plan agrees to indemnify the insured for loss of income due to illness or accident. Usually there is waiting period before the income payments commences and the disability must be one that prevents the insured from carrying on his usual occupation.

All individual health insurance contracts define both specifically and by exclusions what perils are intended to be covered. Two general forms may be found. Those insuring accidents and those insuring both illness and accident. All individual health insurance contracts are extremely careful to define just what type of health loss is intended to be covered. The policy also defines when one loss ends and when another begins. In order to specify what losses are to be paid, the insurance contracts generally provide definition of eligible hospitals. In addition, the policy covers only bills of legally qualified physicians.
In loss of income polices, two classes of disabilities are usually recognized total and partial. In order to reduce controversies over whether or not a disability is really permanent, the contract states that the disability will be presumed permanent after the lapse of a given time period. Sometime a reduced premium may be guaranteed, if the insured specifies a waiting period longer than the normal waiting period. Sometime a disability policy contains a limitation which place an upper limit of total liability on the amount of income benefits payable.

Health insurance policies present serious problems to underwriters because of the difficulties in controlling both moral and morale hazards. In order to address these problems, underwriters place not only definite maximum limitation on losses payable, but also generally require the insured to bear a portion of his own loss in the form of a deductible. In addition, a health insurance contract may contain two types of waiting periods. There may be a waiting period after the contract is in force before any benefits are payable for certain perils. A second type of waiting period clause is found in loss of income policies which specifies that no benefits will be paid until the disability, once it has accrued, has lusted a certain length of time.

Because of several major adverse factors, chiefly less cost and easier administration, group coverage has been very popular in the field of health insurance. Some of the basic reasons for the growth of private group health insurance plans are:
   a) Group insurance is available at lower cost than individual contracts.
   b) Group insurance usually provide more benefits than individual contracts.
   c) Group insurance have been actively promoted by organized groups.

The sources of savings in group health insurance arises from several factors:
   a) Group health contracts enjoy relative freedom from adverse selection because the covered group exists for some other reason than to obtain insurance.
   b) Administrative costs in group health insurance plans are lower than those for individual policy holders.
   c) Acquisition costs are much lower for group insurance than for individual insurance
   d) Medical and hospital services can be obtained at wholesale price.

**Disability Income Insurance Policies**

There is a wide variation of disability income coverage and related disability policies. Many of these variations involve the definition of disability itself, the duration of benefits available, the waiting period, how partial disability benefits are provided, how recurring disability is handled, and waiver of premium etc. Insurance companies that offer disability income policies are very concerned about over insurance and consequently limit the amount of benefits relative to the individual’s income.

1 A moral hazard stems from the mental attitude of the insured, while moral hazard is the result of a subconscious desire for a loss.

The primary objective of disability income policies is to replace lost income when an individual is no longer able to continue earning that income because of injury or illness. The concept is simple, but the variations of both risk and coverage provisions make disability income insurance very complex. There can be multiple claims, and in most cases separate claims are mutually exclusive. One way that insurance companies differentiate between risks is by the definition of disability they use in their contracts.

The most generous benefits are available under disability income policies utilizing an “own occupation” definition of disability. Much more common in private insurance is a definition stating that disability is “the inability to perform the duties of any occupation for which the individual is reasonably suited by reason of education, training or experience”. This type of coverage will not provide benefits if the insured is able to enter a new career that is reasonably comparable to the one in which he or she was engaged prior to the disability.

Disability income policies generally have an elimination or waiting period before benefit payments begin. Insurance companies generally give the purchaser an option to select the duration (30 to 120 days) of this period. Obviously the longer the elimination period, the more severe a disability must be before benefits will be payable. Just as disability income policies differ according to definition of disability and length of elimination period, they also differ according to the duration of benefits that they will provide once the individual becomes disabled.

Benefit periods are one of the most important factors in deciding the level of premiums. Short-term (2-3 years) disability policies do not provide comprehensive protection against disability, but their main appeal is the premium savings associated with the relatively short maximum benefit period. Some companies may provide disability income coverage with benefit periods of 10 years or up to age 65.

Premiums for disability income policies are similar to life insurance premiums in that they are based on the policy holders age at the time of policy issuance and remain level for the duration of the coverage. Premiums can be paid on an annual, quarterly or monthly basis.

Some insurance companies may offer on an optional basis a policy provision that will return some portion of premiums at specified intervals, such as 5 years or 10 years, if no claims have been made during the period. The return of premium option has the strongest appeal to individuals who are convinced they will not become disabled. In fact, it may be the inducement necessary to convince those people to purchase disability income insurance. Insurance companies some time may provide participating contracts that pay policy owner dividend or bonus.

In Bangladesh, neither private health insurance by commercial insurers nor social health insurance by Governmental initiatives have been offered to people. Ministry of Health and Family Welfare and the Ministry of Labor recently undertook initiatives to introduce social health insurance for the civil servants and the formal sector employees, but no initiatives have been taken by the Government of Bangladesh (GOB) to introduce social health insurance for the common people, perhaps because
most of the people are in the informal or un-organized sector, which includes self employed workers, such as agricultural laborers, carpenters, cobblers, construction workers, handicraft artisans, handloom workers, tailors, primary milk producers, rickshaw pullers, street vendors, washer men, or such other categories.

However, over the last thirty years different organizations particularly NGOs have initiated various Micro Health Insurance (MHI) schemes. These schemes have been designed to provide essential health services to the poor people. MHI services are being provided by the NGOs in a limited scale alongside other services addressing the needs (credit, saving, water, sanitation, family planning, primary and non-formal education) of the poor communities. As most of the NGOs run MHI schemes evolved from various other community based programs and are intertwined with the existing social mobilization dynamics, these schemes appear to have potential with support of Government, Donor Agencies and World Health Organization (WHO).
Private Health Insurance Market and Practices

Asian private health insurance market is still in its early phase of development. It is relatively underdeveloped and undersold. However, this market is likely to grow faster than the Gross Domestic Product (G.D.P) growth rate. It is expected that health insurance will be the next frontier for the insurance industry in Asia. There are several reasons for this development. The reasons may be summarized as follows:

a) Private health insurance sector will grow further simply because it is insignificant now. For example, in Bangladesh we spend much less on health care in comparison to others. With the increase in health expenditure the demand for private health insurance will increase.

b) With the shifting of health care provision and financing from public to private sector, the demand for private health insurance will increase.

c) It is likely that health care benefits will be an essential part of employee benefits. This will in turn will help to enhance the demand for group health insurance.

d) The middle and upper income population will grow in Asian countries. These groups will have in their hand disposable incomes, a part of which will be spent for health insurance.

e) The ageing people will be increasing in Asia, who will require health care resulting an increase in demand for health insurance.

Despite potentials in general, much will depend on Government’s social policy and the professional capability of the private insurers to tap this growing market potentiality.

In Bangladesh, quite a few insurance companies are now offering different health insurance products. These products are being offered both by the life insurance and non-life insurance companies. In order to assess the present state of affairs and to know the viewpoint of our insurers, a study was made in 2002 by Bangladesh Insurance Academy Structured questionnaires for the chief executives of different organizations was prepared. The purpose of the set questionnaires was to inquire and assess as to whether the insurers felt that health insurance scheme could be introduced in Bangladesh on a sustainable basis.

In 1972, The Bangladesh Government nationalized all insurance companies in the country. However, in 1948, it allowed the formation of private insurance companies. At present there are 62 insurance companies (18 Life and 44 Non-Life) including two public sector Corporations.

The Bangladesh insurance sector remains underdeveloped compared to that of neighboring countries. Insurance premium as percentage of GDP is Bangladesh in approximately 0.60% only. Per capita insurance premium is approximately US $ 2.00 compared to $13 for Pakistan and $ 16.00 for India.

K.M. Mortuza Ali (author of the present study) conducted a survey on the private health insurance in Bangladesh in 2001 in order to assess as to whether the insurers (both life and non-life) felt that health insurance schemes could be introduced in Bangladesh on a sustainable basis. Ten life insurers and twenty Non life insurers responded.

Out of ten life insurance companies only three had already introduced health insurance products for their customers. The remaining seven companies stated that in future they might consider to introduce health insurance scheme.

Out of twenty non-life insurance companies, it was observed that seven had already introduced a few product of health insurance. Out of thirty life and non-life companies that did not introduce any health insurance scheme, only two companies stated that in future they do not intend to offer any health insurance scheme or product for their customers. According to them they were not interested for non-conventional business and there being lack of all sorts of logistic support for introducing health insurance scheme, they felt that this might be introduced on experimental basis by the public sector insurance corporations.

According to them, because of high moral hazard and possibilities of false claims, market was not suitable for health insurance, and, therefore, this business would prove non-profitable. However other companies stated that they might consider to offer health insurance schemes in near future.

Majority (53%) of the twenty companies who did not introduce any health insurance scheme, felt that unwillingness of the buyer and because there was no demand for the product, they did not introduce any health insurance scheme. While they were asked to express their views towards health insurance, one third of the respondents opined that possibilities of fraudulent and false claim was more in health insurance. Twenty nine percent felt that market was not suitable for health insurance. However majority (48%) of the non-providers of health insurance felt that health insurance scheme should be offered by the private/mutual insurance companies.

Lack of public awareness was identified as the main reason for non availability of health insurance in Bangladesh. Only sixteen percent of the non-providers felt that lack of trained and suitable executives was the main reason for not providing any health insurance scheme by the insurers. Majority (53%) of the non-providers felt that health insurance should be offered both to individual and to group.

The private health insurance market in Bangladesh is relatively underdeveloped compared to life insurance. The Government’s current accelerated privatization program is expected to stimulate growth in the health insurance sector. There is also a general belief that in the near future, the process of globalization will bring foreign insurers in country and a positive change is likely to happen in private health insurance market of Bangladesh.

Φ Prime Islami Life Insurance Ltd., is considering to introduce health insurance in the near future for all family members as a unit.
Mr. Ali while conducted the survey on private health insurance collected detail information including product literatures from different companies and based on those branches, product literatures, policy documents a brief description of private health insurance product of Bangladesh has been prepared as follows.

**PRIVATE HEALTH INSURANCE PRODUCTS IN BANGLADESH.**

A) **DELTA CARE (Hospitalization Plan):**
Delta Life Instance Company is the pioneer in providing health insurance scheme. It introduced DELTACARE hospitalization plan in 1994. It is a group insurance plan and is suitable for organizations who want to insure their employees/members aged between 18 and 60 years. The total number in a group should not be less than 25 and at least 95% of the total eligible employees/members should join the scheme.

Normally no medical examination is required, but insurer reserves a right to ask for a medical examination if necessary. The employer/organiser may or may not contribute towards the cost of such insurance, but should collect and pay the premium and communicate with insurer on behalf of the insured.

This scheme covers the hospitalization expenses and includes cost of accommodation, consultation, investigation, surgical operations, medicines and ancillary services like, intensive care, blood transfusion, oxygen therapy etc.

The insured should take prior approval from the insurer before admission to a hospital. However, in case of emergency a member may seek admission to any of the enlisted hospital/clinic or to any Government hospital or to any hospital/clinic registered under Directorate of Health Service.

Total premium against this scheme is less than 1% of Delta Life’s annual total premium. Delta Life Insurance Co., felt that this was a fast growing and popular scheme of the company.

B) **Comprehensive Major Medical.**
ALICO (American Life Insurance Co) the only multinational life insurer in Bangladesh introduced a group plan in October, 1998 for 100% reimbursement of any kind of hospitalization expenses caused by sickness or accident. Benefits have been grouped into three different plans called “gold” “silver” and “bronze”. In each group maternity benefit is optional, benefit limits are as given below:

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Gold</th>
<th>Silver</th>
<th>Bronze</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Maximum benefit per insured per disability</td>
<td>Tk.1,50,000</td>
<td>Tk.80,000</td>
<td>Tk.45,000</td>
</tr>
<tr>
<td>b) Daily Hospital Room limit</td>
<td>Tk.2,500</td>
<td>Tk.1,100</td>
<td>Tk. 650</td>
</tr>
<tr>
<td>c) Daily intensive care</td>
<td>14 days</td>
<td>14 days</td>
<td>14 days</td>
</tr>
<tr>
<td>d) Hospital services excluding B &amp; C above.</td>
<td>Tk. 90,000</td>
<td>Tk.50,000</td>
<td>Tk.25,000</td>
</tr>
<tr>
<td>e) Normal Delivery</td>
<td>Tk.15,000</td>
<td>Tk.10,000</td>
<td>Tk.7,500</td>
</tr>
<tr>
<td>f) Cesarean Delivery</td>
<td>Tk.22,500</td>
<td>Tk.15,000</td>
<td>Tk.11,250</td>
</tr>
<tr>
<td>g) Miscarriage/Legal Abortion .</td>
<td>Tk.10,000</td>
<td>Tk.5,500</td>
<td>Tk.5,000</td>
</tr>
</tbody>
</table>

This plan is also targeted towards the employers for the benefit of the employees. Bills are settled directly with the participating hospitals and covers expenses for reasonable and customary charges for room, board, general nursing, services and supplies for medical care, treatment by x-ray, physiotherapy, drugs, medicine, physicians services for surgery, artificial limbs, eyes, post hospitalization follow up etc. Major exclusions are as follows:

(a) Pre-existing conditions, (b) Outpatient treatment, (c) War risks,
(d) AIDS/related diseases, (e) Congenital birth defects, (f) Self inflicted injuries
(g) Psychiatric benefits, (h) Alcoholism & Addictions, (i) cosmetic or plastic Surgery
(j) Dental treatment, (k) Injury or illness covered under workmens compensation or similar laws.

C) Dread Diseases Policy (Life Underwriter).
In the public sector, Jiban Bima Corporation launched a product, where the insurer would pay a fixed capital sum upon diagnosis of certain dread diseases of the insureds. Under this scheme any person between the age 30 to 57 years can purchase a policy against the specified diseases such as heart attack, stroke, cancer, kidney failure, multiple sclerosis, organ transplantation & paralysis. The minimum sum insured is Tk.50,000 and maximum is Tk.1,00,000.

For policyholders below 50 years of age need no medical examination before buying a policy, but must submit a declaration of good health by himself.

The annual premium for such a scheme varies between aprox taka 2.00 to taka 22.00 per thousand sum insured depending upon the age of the insured.

The insured can cover hospitalization expenses and also death risk for an amount of Tk.25,000 only. The insured must have to admit into a government hospital or any enlisted hospital of the insurer. Exclusions are similar to those of ALICO save that no hospitalization or surgery arising form any cause within the period of 30 days from the commencement date of the policy except arising from accident is covered.

D) Hospitalisation Plan
In addition to Dread Diseases Policy J.B.C has planned to introduce two hospitalisation plans, one including death risk and another excluding death risk. The policyholder is entitled to a maximum annual hospitalisation benefit of Tk. 30,000 under scheme ‘A’ and Tk. 50,000 under scheme ‘B’ as per schedule of benefits as shown below:

<table>
<thead>
<tr>
<th></th>
<th>Scheme-A</th>
<th>Scheme-B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital room rent</td>
<td>Max. Tk.700 per day</td>
<td>Tk.1200 per day</td>
</tr>
<tr>
<td>Doctors fee</td>
<td>Max. Tk.300 per day</td>
<td>Tk. 500 per day</td>
</tr>
<tr>
<td>Examination fees</td>
<td>Max. Tk.1000 per day</td>
<td>Tk.1200 per day</td>
</tr>
<tr>
<td>Minor operation Charges</td>
<td>Max. Tk. 10,000</td>
<td>Tk. 10,000</td>
</tr>
<tr>
<td>Major operations</td>
<td>Max. Tk. 15,000</td>
<td>Tk. 15,000</td>
</tr>
<tr>
<td>Death Risks</td>
<td>Max. Tk. 25,000</td>
<td>Tk. 25,000</td>
</tr>
</tbody>
</table>
Annual premium for this type of cover varies between Tk.1000 to Tk.5500 depending on age of the policy holder and scheme chosen by him/her. The insured must have to admit into a government hospital or any of the enlisted hospitals of JBC. The payments will be made direct to the insured on reimbursement basis.

E) Overseas Medi-claim Policy (OMP)
Non-life insurers in Bangladesh in the recent past introduced Overseas Medi-claim policy. The objective was to provide emergency medical treatment taken abroad while on a business/pleasure/study/social visit. Sadharan Bima Corporation(SBC), the public sector operator introduced two different schemes in 1997 one for the travellers going abroad for business and holidays and another for the persons who were residing in abroad for employment and studies. Both of these schemes are divided into two plans one is meant for persons who are traveling or residing in USA & Canada and another is for those who are traveling or staying in countries other than USA & Canada.

In Case of Overseas medi-claim policy for business and holiday maximum limit of SBC’s liability is US $ 50,000 for countries other than USA, Canada and US $ 1,00,000 for USA & Canada.

The period of insurance is normally the traveling period as specified in the policy cover but is automatically extended for a period of 45 days for treatment of covered illness or accident. These policies cover the risks of a sudden and unexpected sickness or accident arising when the insured is staying outside Bangladesh.

OMP(business and holiday) is not a general health insurance policy and is not designed to provide an indemnity in respect of medical services, the need for which arises out of pre-existing condition and, therefore, no claim will be paid in respect of medical condition that has been treated by physician in the one year immediately preceding the first day of insurance.

It provides indemnity for expenses incurred for medical treatment for illness, diseases contacted or injury sustained during overseas travel and which is primarily in the nature of an emergency and which is necessary to be undertaken immediately and without which the proposer is not able to leave the overseas country under medical advice.

OMP for employment & studies cover reasonable and customary fees, medical services by a licensed physician and approved by the claims administrator appointed by the insurer. This insurance is specially designed for those citizen of Bangladesh residing or will be proceeding for abroad for a temporary period only for the purpose of education, research or employment in non-manual work. Spouse and children can also be covered. This cover is provided to the insured against the risks of sudden and unexpected sickness or accident arising when the insured is staying outside Bangladesh and also covers 50% of hospitalization expenses due to mental, nervous or emotional disorders, expenses for evacuation, if necessary and also transportation and funeral costs in case of death upto US $ 8000 and medical emergency reunion expenses upto US $ 5000.
F) **Dread Disease Insurance (Non-Life Underwriter).**

Sadharan Bima Corporation (SBC) has introduced a medical expenses policy entitled as Dread Disease Insurance. Any citizen of Bangladesh between age 18 and 65 may obtain this insurance cover both on an individual or on group basis. There is no requirement for medical examination prior to risk and, of course, no cover is available for pre-existing conditions. Normally, the insured selects a sum which will be payable to him/her should he/she be diagnosed during the period of insurance as suffering from a dread disease (coronary heart disease, stroke, cancer, kidney failure, organ transplant, multiple sclerosis) symptoms and or treatment thereof. Coverage is on an annual basis and a tariff rate between 0.1625% to 2.5840% on the policy amount is applicable depending on the age of the insured. There is maximum limit of policy amount which is a half million taka to 2.5 million taka.

Apart from SBC a few private insurance companies such as Reliance Insurance Ltd., Green Delta Insurance Co. Ltd., Progati Insurance Ltd., are also offering OMP & DDI policies under similar terms and conditions. On an average SBC has sold more than 1000 OMP per year but claim ratio appears to be very high which is 175% to 200% of premium-earnings.

G) **Health Plan**

Recently United Insurance Co. Ltd. and Prime Insurance Co. Ltd.(Private operators of non-Life insurance) have introduced group health insurance called the Health Plan Insurance (HPI). Under this scheme the expenses for treatment in a hospital for an illness or injury are insured. It does not cover for any expenses in respect of domiciliary or out door treatment. The HPI is issued for one year and is renewable every year. If there is no claim in a year the insured is allowed a “no claim discount” (10% to 20%) on renewal premium for the following year. Normally no medical examination will be required but insurers reserve the right to ask for a medical examination.

Under this scheme, there are three different plans and benefits which vary according to the plan chosen by the insured. The total maximum amount of cover to each insured shall be limited to for each plan year which is Tk.25,000 for basic plan. Tk. 50,000 for standard plan and Tk. 75,000 for executive plan. The premium will vary depending on the type of plan, age and terms and conditions applying to the plan.

The H.P.I covers expenses of medical treatment of a hospital upto 15 days of each confinement and include costs of accommodation, consultation fees, investigations, surgical operations, medicines and ancillary services like labour room, intensive care room, post operative room, blood transfusion, ambulance service etc. The normal exclusions are as follows:
a) Congenital infirmity  
b) any pre-existing condition  
c) mental emotional or psychiatric disorders  
d) alcoholism or any other narcotic addiction  
e) routine examinations, immunization  
f) cosmetic or plastic treatment/surgery  
g) abortion or miscarriage except accidental  
h) radio therapy  
i) dental treatment  
j) injury arising due to unlawful activities  
k) attempted suicide injury due to insanity or under the influence of a drug  
l) circumcision  
m) AIDS and HIV related diseases  
n) injury or disease attributable to civil commotion, etc.

Benefits provided under different plans can be shown form the following chart.

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<tr>
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</thead>
<tbody>
<tr>
<td>Total cover per year</td>
<td>25,000</td>
<td>50,000</td>
<td>75,000</td>
</tr>
<tr>
<td>Hospital accommodation</td>
<td>600 per day</td>
<td>1200</td>
<td>1500</td>
</tr>
<tr>
<td>Conduction fee</td>
<td>300 ,,</td>
<td>400</td>
<td>500</td>
</tr>
<tr>
<td>Routine investigation</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
</tr>
<tr>
<td>Medicine</td>
<td>2000</td>
<td>4000</td>
<td>6000</td>
</tr>
<tr>
<td>Major surgical operation</td>
<td>15,000</td>
<td>15000</td>
<td>15,000</td>
</tr>
<tr>
<td>Intermediate Surgical operation</td>
<td>10,000</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>Ancillary services</td>
<td>80% of total 3000</td>
<td>80% to total 6000</td>
<td>80% of total 8000</td>
</tr>
<tr>
<td>Cash benefit for the use of government hospital (where the services are provided free of charges)</td>
<td>300</td>
<td>400</td>
<td>400</td>
</tr>
</tbody>
</table>

If any of the insured in a group needs to be hospitalized he/she shall have to satisfy the insurer through the plan coordinator. The insurer will issue an authorization letter to enable him/her to seek admission in the hospital. When the insured is discharged from the hospital, the coordinator (employers representative) will seek reimbursement on behalf of the insured and normally the claim is likely to be settled within 3/4 weeks.
An Overview of Social & Community Health Insurance

The three determining factors which influence health insurance are:

a) The macro economic context
b) The demographic structure and
c) The public system for health care.

The higher the income in a country, the greater the demand for health insurance. It is observed that in most cases health insurance is conceived as additional insurance to life insurance. The poor people are not interested in health insurance because their income level is low. High rates of inflation normally acts as a damper on demand for life, health and accident insurance. However, people in general, are interested to have health insurance coverage, if the income level is higher and a higher standard of health care, specially during hospital days can be ensured.

Generally, older persons are more susceptible to illness than younger contemporaries. In a country like Bangladesh, as a result of medical progress and the falling birth rate, ageing process is growing more rapidly. This demographic change will make it increasingly difficult to finance their health care needs. Furthermore, absence of social security system is likely to increase potential for private health insurance. There are good chances of growth for private health insurance only and when the economic growth is higher and the cost of health care increases more.

In Bangladesh, we do not have any social insurance scheme to the contrary that many of the Asian countries have obligatory public health and accident insurance. However, in the majority of Asian countries having obligatory social health insurance; plans are associated with employment. This means, the unemployed, self employed wage earner which together make up majority of the population are excluded from social health insurance schemes. For example, in China, around 64% of the rural population has no health insurance. These segments of the population rely on their families and pay their health care cost themselves, and in part, they may receive health services gratis from government institutions.  

The development of Social Health Insurance (S.H.I) in China has followed two separate and parallel paths; one is directed towards rural people and another one is towards urban salaried employee. Both schemes target individuals rather than families. The Ministry of Health is responsible for health care and financing for the rural population, while social protection for the urban population is the responsibility of the Ministry of Labor.

In 2003, the Chinese Government formulated new design for rural health care which emphasized the need for government subsidies. The current reform efforts in Social Health Insurance in China are focused on expanding the coverage in each of the two defined population groups which suggest to plan and implement pilot project with integrated health insurance systems in both urban and rural areas, with universal coverage as the ultimate goal.

Public health system in Hong Kong is ideal for many countries. Hong Kong does not have obligatory health and accident insurance but puts a good public health care infrastructure. A third of the physicians and 88% of all hospital beds in Hong Kong belong to public health clinics. In Indonesia, South Korea, Malaysia, Philippines there are obligatory public(social) health insurance schemes. In Singapore, Taiwan and Thailand public social security system covers financing for health.

In India, during the last decade, there is increasing collaboration between state and N.G.Os to extend the social protection, through state-sponsored, community-based or micro insurance schemes. India is responsive to greater involvement of NGOs.

Population coverage by any form of health insurance is still very low in India. In 1954 the Government of India (G.O.I) created a compulsory health insurance scheme for central government employees. The opportunities to extend such social health insurance coverage through mandatory system is limited since salaried employees do not constitute the majority of workers.

In the Philippines, National Health Insurance Act was promulgated in 1995 and National Health Insurance Corporation (NHIC) was created to administer the SHI scheme. The N.H.I. Act provides that universal coverage should be reached by 2010. A priority area of the N.H.I.C has been the coverage of the indigent population, through subsidization of the contributions for the poor. Despite all these efforts, the overall coverage is about half of the population.

Vietnam introduced compulsory S.H.I in 1992. The Vietnam Health Insurance (VHI) was set up as a national administrative structure, under the Ministry of Health. The government insisted on maintaining national scheme with compulsory and voluntary components. In 2001 the V.H.I. was merged with the Vietnam Social Insurance Agency, directly under the Prime Minister's office. The Government has set up a special health care fund, 75% of which comes from the Government Budget to provide a social safety net for about 15 million people. The principle of having one system is maintained. Decentralization of the major functions of the S.H.I scheme was carried out in a planned and rational way.

Ibid-P. 21  
WHO, Regional Overview of Social Health Insurance in South East Asia. July-2004 P-92  
WHO- Social Health Insurance, March-2005 P-255.  
Ibid
**Need for high political commitment**

In Indonesia, the National Social Security Bill was passed by the parliament in 2004, covering social health insurance. The Government of India has recently introduced an insurance scheme called “Janaraksha” designed to provide financial protection to the needy population. They have also planned to provide community based universal health insurance scheme. In order to ensure the affordability of the scheme to below poverty line families, the Government of India would contribute Rs.100 (one hundred) per year per family towards their annual premium cost. Similar contribution by the GOB can help to develop an ideal SHI for Bangladesh.

If the Government of Bangladesh is to ensure health care for the poor by protecting their health and financial risk either through S.H.I, or other means of financing, political commitment is necessary for initiating and sustaining the program. An appropriate policy framework leading towards the enactment of appropriate law for S.H.I is essential to ensure the wide acceptance of the basic concept and general rule for S.H.I. This is necessary to provide and guarantee equitable health benefits to all those with similar health care needs, regardless of the level of income and contribution.

The essential features of a successful S.H.I. scheme, therefore, need to be well understood. If we are to introduce a pilot scheme in a poverty prone sub-district, there must be compulsory or mandatory membership of individual or groups of individual through legislation or through a community involvement where people should regularly contribute according to the ability to pay. Funds thus collected from contributions to be pooled and administered by a quasi-independent body.

The administrator should be responsible for ensuring health care for all its members according to the health needs by providing a pre-set basic benefit package and also by allowing the members to purchase supplementary health care services by making additional co-payment contributions. The administrator must be able to achieve stable financing for a package of health insurance benefits, while at the same time ensuring greater access to health care for the target group of population.

Therefore, it is felt that we shall have to consider introducing and expanding SHI slowly and steadily. At the same time, some form of risk pooling system such as community based health insurance (C.H.I), Trust Funds and Foundation could be introduced so that the financial and health risks of the poor are adequately protected. While SHI scheme is a promising alternative financing mechanism, it can not be the only solution to bridge the financial gaps for resources required for additional health funding. The government can not shirk its responsibility to ensure and regulate the provision of health care, including essential public health functions. The Government should ensure health care for the poor through various means of financing.

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Community Health Insurance (CHI):

Community based health financing covers different mechanisms of mobilizing resources such as micro insurance, community health funds, mutual associations, cooperatives etc. Community financing arrangements can significantly differ from each other in terms of their objectives, structures, management, organization etc, but the primary consideration of a community finance scheme is not commercial. It is not driven by profit motive but by welfare motive. Evidence suggests that cost recovery level of these schemes are very low. Therefore, government need to play a positive role to offset the gaps. Sustained donor and or government support is necessary to make CHI successful in the long run.

Most community financed program are run by NGOs or non-profit organizations. Some of the community schemes are established and managed by community leaders. Community based funds refer to those schemes, where members prepay a set amount each year for specified services. These schemes are typically targeted at poorer population living in communities. The benefits offered are mainly in terms of preventive care. Ambulatory and in-patient care is also covered. Such schemes are usually financed through minimum fees from insured, grants and donations. Many community based insurance schemes suffer from poor design and management and fail to include the poorest of the poor, have low membership and require extensive financial support.

In Bangladesh, different NGOs and community based organizations have come forward with their own schemes. These schemes are generally based on pre payment ones. The mode of collection as well as the administration and other details differ. Almost all the schemes are created in response to the needs of the most economically vulnerable population of a particular area or areas. However, one inherent problem of the various schemes continues to be the financial sustainability over the years. Outside funding or subsidies seem to be a real felt need. In general, it is observed that, the larger the pooling, the higher is the probability of self sustainability and lower the need for outside funding. However, the main strengths of community financing schemes are:

(a) High degree of outreach penetration through community participation,
(b) Contribution to financial protection against cost of illness,
(c) Increase in access to health care by low income rural and informal sector.

When community schemes are established and managed by community leaders, community involvement in management allows social control over the behavior of members and providers, that mitigates moral hazard, adverse selection and induced demand. Success story of Self-employed Women’s Association in India is well known. This scheme was established in 1992. It provides health, life and assets insurance to women working in the informal sector and their families. Present enrolment is near to a million. The scheme operates in collaboration with two national insurance companies ⊙.

In order to provide CHI, organizations such as cooperatives or mutual associations may be formed. Cooperatives and mutual insurers may prove to be an effective vehicle for the benefit of their members. However, advantage of the cooperative structure in serving the poor diminishes as the organization grows larger. Moreover, cooperative structure is known as prohibiting the growth of the organization due to its lack of access to technical and financial resources. It is important to accumulate experience and expertise in providing health insurance over a time. Cooperatives may succeed with outside expert knowledge and innovation. However, the costs of external consultants is likely to be cost ineffective. Training of cooperative leaders in insurance knowledge is a costly process as well as time consuming.

An alternative to overcome the complexities, it has been suggested by some experts that health insurance provider become an agent or partner of an existing and established insurance company. The partner insurer is ultimately responsible for maintaining reserves, setting the price, paying claims, dealing with external service providers (reinsurer) and complying with legal requirements. Private health insurance providers are, however, not keen to embark upon such a venture, because of non-commercial nature of SHI or CHI. What is, therefore, needed is a strategic partner, as an alternate, who can provide advises through short-term or long term arrangement. Donor agencies need to finance and government can act as reinsurer if and when private insurers support is not available.
Problems involved in providing CHI (Community Health Insurance)

Constraints
The poor in general do not have access to basic health care. Even when public financed facilities are available, usually they are too far from the health centres. Introduction of user fees, further limit access of health care services for the poor. The perils of sickness, injury, disability are more among the poor. Without investment in health, the productivity of poor diminishes gradually. The high risk of death and disability due to sickness and accidents causes loss of income for the entire family. Considering the plight of the poor, it has been recognized that insurance is the most effective mechanism for reducing the vulnerability of the poor from the impacts of disease, disability and other hazards.

Generally, protection by health insurance is restricted because insurers require large start up costs and long-term financial commitments. It also requires experienced and qualified work force. Community based health insurance schemes are being run on low premium with low coverage. Furthermore, those who live far from health care facilities usually do not feel to avail the services because of the cost involved for traveling to the health care centres.

Qualified staff both for insurer and health care provider is most important. Due to high levels of risks and volatility of the client base, management of CHI program requires greater level of technical expertise and actuarial capacity. Strong underwriting procedures are required when only a small percentage of the prospects are insured. Managers have to be able to predict future costs and claims. They ought to have an effective and continuous market research program to ensure sustainability of the scheme and efficient pricing provision of health insurance for the rural poor is specially difficult due to the range of cases of health risks and knowledge required to identify fraud by the policy holder and the health care provider. The lack of knowledge and skill to effectively price the products also weakens the financial sustainability of the scheme.

Insurance has a very poor image amongst the people, specially among the uneducated poor. Moreover, they find it difficult to understand and accept the risk pooling concept. Policy exclusions and conditions are unclear to them. Clarifying insurance terms and conditions is an additional cost and burden, specially because most of the poor policyholders may not be able to read and let alone understand the terms and conditions. Since CHI is not a mandatory and the poor have many other items to spend, the little or no disposable income they have.

Therefore, premiums have to be affordable and the benefits of health insurance need to be presented to prospective policy holders clearly. Marketing of health insurance products to poor is more than just selling insurance policies. There is a need to create awareness and educate them on the benefits of the product, the coverage it provides and how to make claims. The poor people have to be convinced to pay premiums on a regular basis for long period. Therefore, communication techniques have to be more conducive and effective.
CHI schemes for the poor are supposed to be financially unsustainable due to high overheads, low premium and high claims. In the initial years of operation, the costs of acquiring and servicing customers, start up cost of operations, inexperienced underwriting and premium setting and a small community base may lead to financial constraints. Therefore, there is a need for a large capital base or prolonged donor contribution in the initial years to give time for the correct infrastructure and large number of policyholders. Otherwise, financial constraints will hinder smooth growth of the scheme.

While premiums need to be kept affordable, it should also ensure the financial sustainability of insurer. A sufficiently large pool size is required. However, as the scheme is voluntary, it is likely that those who are most likely to make a claim will be the first to cover their risks. Reaching a sufficiently large pool size of the right mix of risks is difficult to ensure. Further, the lack of reliable data of policy holder’s age & health status make it difficult to determine appropriate premium and eligibility of coverage.

It is also most likely that many claims will have to be paid without proper verification due to high cost of documentation and procedures. As a result, the insured is likely to change his/her behavior which increase the possibility of fraudulent claims. The CHI provider, therefore, needs, an effective claim verification system but without delaying settlement procedure. Appropriate internal control and management system need to be developed and corporate good governance practices need to be ensured.

There are many challenges facing CHI providers. Over the years many schemes have failed, but many of the CHI providers have adopted innovative techniques, to achieve sustainability and viability in the long-run. While designing a pilot scheme of SHI for the poor in Bangladesh, we shall have to replicate some of the techniques used by more or less successful CHI providers.

It is observed that CHI providers are smaller organizations. They are more responsive, efficient and flexible and have a closer relationship with the users. But the two biggest problems faced by most CHI providers are financial sustainability of the organization and affordability of contribution by the poor users.

**Gaining Credibility**

For any scheme to be sustainable in the long-term, there is a need for access to a sufficiently large group to spread the risk and costs. An efficient and effective CHI requires sufficient premium to cover the cost, which would effectively mean excluding access for most of the poor. One solution to the problem is different coverage for different premiums. This can bring in people at the lower level with a view to encouraging them to take on additional coverage for additional premium later on.

The poor people need to be educated how a small amount of premium can build a common fund for all the participants. They need to be assured on the integrity of the system and there will be clear accountability and transparency. Building trust among the users is most important. In this respect a very high challenge for the
CHI providers is to find staff who has the integrity and inter personal skills to effectively undertake the role of real and ideal service provider.

Maintaining the credibility of the organization is paramount in ensuring that people have faith in the protection promised. The organization need to be accountable and transparent in its operation and employees need to be adequately paid to deter corruption and high turnover. In an environment, where corruption is in highest scale, there is very little trust in any institution. This is more a problem in the informal sector where the poor have no rights at all and are constantly manipulated by village touts and social elites.

In order to overcome the situation, it is felt that participatory independent non-profit organizations be created, which need to be based on the principles of brotherhood & solidarity. This would ensure better quality and more equal access to medical services for the poor. Mutual or group insurance service provider and community-based Health service providers, perhaps can combine the concept of insurance at low cost and mass participation of the poor.

In most cases, it is observed that low-income group or the poor are initially reluctant to accept the idea of paying in advance for services that they may or may not use. As a result the sale process should focus on educating the people about the collective benefits of insurance. Once a family is interested in becoming a member, they may be induced to motivate several other families in the area to join as a group. Forming these groups, reduces the acquisition costs, decreases the risk of adverse selection, facilitates premium collection and reduces transaction costs as the group pool their premiums to make a single payment.

Community based health insurance scheme for the poor which is affordable, adequate, and sustainable is difficult to achieve due to lack of financial capital, technical supports, qualified and honest staff, adequate numbers, trust & transparency. The road to provide a comprehensive health insurance coverage for the common mass in a poverty prone Upozilla is supposed to be full of pitfalls and, therefore, must be undertaken cautiously and carefully with good corporate governance at the heart of each step.

Mutual or cooperative concept of the scheme will make it easier to win the heart of the members. Trust is major factor as it encourages a greater number of transactions and commitment from the members and to act in the best interest of their organization and improves its efficiency. Peer pressures from within established social groups can encourage members to avail morally hazardous behavior particularly in small grouping and communities.

In community based mutual health insurance system, each member virtually, become an owner of the scheme. It must be understood that the primary consideration of community health insurance scheme is not commercial. It is not driven by the profit motive, but by the welfare motive. The concept of risk sharing leading to an innovative premium setting, can be used in such a way as to entail a subsidy from the healthy to the sick. This will help to grow stronger community feeling.
Ensuring long-term viability

Generally in a community health insurance scheme, members prepay a set amount each year for specified services. Making profit is not the purpose, but rather improving access to services. This creates an adverse effect on the ability of the insurance fund to meet the cost of benefits. Such schemes, therefore, are financed through contributions, donations and grants. If and when donations & grants are not available, it become difficult or impossible to run the scheme.

If and when donors fund is withdrawn, if the scheme is continued, it can result in depletion of reserves and may lead to insolvency. While, premiums need to be kept minimum and affordable for the poor, the fund generated for providing benefits should also ensure the financial sustainability of the insurer. In many cases, irregular flows of income in low income households make it difficult for them to continue regular payment.

Consequently, a sufficiently large pool size is required to justify the substantial resources to market and administer products, to a largely uneducated, skeptical group. Over use of services, escalating treatment costs and fraudulent uses of services in many cases have caused CHI schemes to incur large loss. It is obvious that CHI schemes for the poor are financially unsustainable due to high overheads, low premiums and high claims. The majority of schemes rely on funds other than those received from premiums. There is no other alternative to maintain sustainability.

The providers face a huge challenge to penetrate among the poor and to recover costs. They need qualified and motivated staff, who should be remunerated well. They need efficient administration system and corporate good governance. They also need sufficient resource for marketing and educating the people. All these need to be met as well as high commitment and huge fund are required so that CHI schemes eventually achieve sustainability in the long run, while still providing access to the poor. It is, therefore, necessary that the pilot scheme in a poverty prone sub-district of Bangladesh ought to be designed to make it most convenient, flexible and affordable. It has to adapt some innovative techniques to achieve sustainability and viability in the long run.

In order to reduce fraud, moral hazard and adverse selection of risks any or some of the measures may be taken:

a) Differential pricing for different types of risks and on the basis of claims experience
b) Exclusion of pre-existing conditions in health
c) Exclusion against drug abuse, injuries form strikes, riots etc.
d) Introduction of co-payments on varying degree of diseases/costs involved in hospitalization.
e) Fixed waiting period before enrolment under the scheme.
f) Terming all policies inactive until a certain number enroll into the scheme.
g) Requiring the whole household to enroll as a unit of membership.
h) Group based insurance cover against personal accident and dread diseases be provided.

i) Close monitoring of treatment costs and types of treatment to be ensured

j) Application of underwriting standard and use of deductible has to be made.

Different coverage for different premiums can bring in people at the lower level with a view of encouraging them to take on additional coverage for additional premium later on. There should be continuous product development (inclusion or exclusion of risks) and innovation to meet the emerging needs, lifestyles and habits of the poorer classes and the rural sector. In this respect, flexible payment systems would allow them to pay when and how much they can. Monthly or even weekly payments are often the key for ensuring full participation.

For any scheme to be sustainable in the long term there is a need for access to a sufficiently large sized group to spread the risk and cost of the scheme. While an efficient and effective CHI scheme demands high premium to cover the costs, this would effectively mean exclusion of most of the poor. Similarly, use of deductibles, co-payments to take care of moral hazard and fraud may lead to further exclusion. It is a dilemma.

**Community Involvement**

CHI requires a physical closeness between the users, providers of health care and insurance services. It is observed that smaller organizations are more responsive, efficient and flexible and have a closer distribution relationship than larger players. Closer distribution relationship is also required for a detail understanding of clients needs and an efficient delivery system. We need to have a right match and mechanism to achieve the two conflicting desire; mass participation as well as closer distribution relationship. By creating community spirit and organizing the poor in small groups to access necessary services we can overcome the dilemma and this will ensure the schemes affectivity and efficiency. Voluntary small organizations need to be created for integration into a large scale insurance mechanism.

We have observed with much interest that group based lending mechanisms have proved to be the most effective and efficient means in providing financial services to the poor at minimum costs and risks. These groups also act as a good forum for education, information sharing and solidarity. Some form of small association (samity), clubs on the basis of cooperative or mutual help can help to ensure mass participation.

Area-based voluntary association need to be formed because the state does not or can not provide sufficient quantity and quality health care services for the poor. These associations will assists the households to organize and solve their health financing problems, through education, dialogue and access to health insurance and health care services at the least possible cost.

Micro finance institutes have realized that savings and credits are not sufficient on their own to prevent people from falling back into the vicious circle of poverty in
times of crisis or service loss caused by sickness and or accident. Providing appropriate health insurance can ensure that the foundations on which the poverty alleviation is built is strong enough to keep them out of poverty. The role of micro health insurance be given equal or more importance to that of micro credit.

It must be realized that the success of credit and savings schemes depends on the availability of appropriate micro life, health and personal accident insurance. Protection against the cost of health services through insurance mechanism will enable the poor to participate more in the economic activity. Schemes such as SEWA in India is one example of many, how insurance can support gender equality and empower the women to achieve a better standard of living.
Mandatory & Voluntary Health Insurance:  
Experience of Other countries

Health insurance may be of different types such as social, private, community, mutual, cooperative, micro etc. Recently various voluntary mechanism and schemes of health insurance have emerged in many developing countries. We need to evaluate both the social(mandatory) and voluntary mechanisms of health insurance schemes, since coverage of informal sector by compulsory health insurance scheme may not be viable and feasible if a very large portion of costs are not subsidized by the Government or donor agencies.

The basic characteristic of SHI is compulsory or mandatory membership of individuals or group of individual. This is normally feasible for formally employed people. The members of the scheme must make regular contributions according to ability to pay and there has to be an appropriate collection mechanism. Funds collected from contributions need to be pooled as a single or multiple fund arrangement administered by an independent third party administrator/organization. Experience of social and voluntary health insurance in the neighboring countries of Bangladesh are narrated hereinafter:

India
India being a neighbor country of Bangladesh there are many common features in the arena of health care. It is observed that the poor in India have a higher burden of disease, but they have lower access to health services. The poor are less likely to get hospitalized than the rich and they have least insurance cover. The poor in India are more likely to fall into further poverty due to health related expenditure. Also the public spending on health is least likely to favor the poor. As per World Bank statistics, the country spends aprox 6% of GDP on Health care of which nearly 78% is private expenditure and 22% public expenditure. The poorest 20% of the population with per capita real GDP of $ 527 can not afford insurance coverage as per their need.

Social health insurance schemes in India are constrained by the fact that most of the work force is in the informal sector. The share of formal sector is only about 8% of the labor force in India. According to a rough estimate, less than 10% of the work force have some form of health insurance coverage. There are several Government run social or mandatory health insurance schemes which include the Central Government Health Scheme and the Employees State Insurance Scheme (ESIS). Eligibility for coverage under ESIS are the employees (and dependents)working in establishments employing ten or more persons (with power) and 20 or more persons (without power) and earning less than Rs.6500 per month.

S. Ganesan and S. Jayprokash. Ibid P-59  
WHO- Social Health Insurance-Selected case studies from Asia and the Pacific P-124
The enactment of Employees State Insurance Act 1948 led to the formulation of the ESIS. The scheme provides protection to employee against loss of wages due to inability to work due to sickness, maternity, disability and death due to injury. It offers medical and cash benefits, preventive and promotive care and health education. Under this scheme employees contribute 4.75% of wages and employers contribute 1.75% of wages. State government contribute a minimum of 12.5% on ESIS expenditure. Although number of beneficiaries is over 33 million under this scheme, it is reported that the services are not up to mark and there is wide criticism due to low quality and impudent behavior of personnel.

In 1997, a National Illness Assistance Fund (NIAF) was set up by the Government of India. Several Central Government hospitals and national level Institutes have been sanctioned one million rupees each at a time from the fund (NIAF) to provide immediate financial assistance to the extent of 25,000/- rupees per case to poor patients living below the poverty line and who are undergoing treatment in these hospitals/institutes.

Recently, in the year 2002-2003 an insurance scheme (Janaraskha) was introduced, with the aim of providing protection to the needy population. With a premium of one rupee per day it ensured indoor treatment upto Rs 2000 per year at designated clinics and hospitals. Govt. of India in its budget for the year 2003-2004, came out with a community based Universal Health Insurance Scheme (UHIS). Basically, in this scheme, the policy holder will pay a premium of one rupee per day for an individual (Rs. 1.50 for family of five and Rs.2.00 for a family of seven) will entitle eligibility to get medical reimbursement up to Rs.30,000/- towards hospitalization, a cover for death due to accident for Rs. 25,000/- and compensation due to loss of earning @ of Rs. 50 per day up to maximum of 15 days. For below poverty line families, the Government is to contribute Rs. 100 per year towards their annual premium. This scheme is also being criticized as the premiums so valued are not actuarially calculated and pose a threat of failure of the scheme in the long run.

Recently another pilot project on health insurance was launched by the State Government of Karnataka and the United Nation Development Program (UNDP) in two blocks (since October 2002). The aim of this project was to develop and test a model community health financing suited for rural community, thereby increasing the access to medical care of the poor. The beneficiaries include the entire population of these blocks. The premium is as low as Rs.30.00 per person per year, with the Government of Karnataka subsidizing the premium of those below poverty line and those belonging to scheduled casts. This little premium entitles them to hospitalization coverage in the government hospitals up to a maximum of Rs. 2500 per year, including hospitalization for common illness, ambulance charge, loss of wages at Rs 50.00 per day as well as drug expenses at Rs. 50 per day.

① WHO Regional Overview of social health insurance in South –East Asia P-91
② WHO regional Overview of Social Health Insurance in South-East Asia-P-94-95.
Apart from many Government initiatives during the last decade, there is increasing collaboration between States and non-government organizations to extend the health-care financing through state sponsored, community based or micro insurance schemes. Through the various compulsory and voluntary health insurance schemes, they have covered approximately 90 millions of beneficiaries. According to recent country study by WHO, India is responsive to greater involvement of NGOs. Various interested parties are now looking at the potential of NGOs to extend coverage through promotion of health care as part of social protection schemes.

**Philippines**

In the Philippines, the department of health is the lead public agency in health care. However, the private sector plays a huge and significant role in maintaining the peoples health. This includes, providing health care services in clinics and hospitals, health insurance etc. Approximately 4% of the country’s GNP are spent on health by both the Government and the private sector.  

In 1995, the Philippines National Health Insurance Corporation Act was promulgated and the Philippine Health Insurance Corporation (Phil Health) was created. This Government Agency is responsible for the implementation of social health insurance in the country. Presently, the coverage of Philippine Health is estimated about 45 million privately employed and govt. employees as well as the destitute poor sector of the population. A much larger segment, the workers in the informal economy remain highly vulnerable because they lack access to formal public institutions that provide social security.

Despite efforts to expand coverage to the informal sector workers, a huge gap remains. There is a large portion of the population comprised of the informal sector, that remains unprotected and unnoticed by the social health insurance program.

A priority area for Philippines has been the coverage of the indigent population, through subsidization of the contributions for the poorest families. But a major problem is the inadequacy of funds to support the entire indigent population particularly with the high administrative cost involved. The high proportion of the population living below the poverty line has led to considerable delays in this effort as it involved developing appropriate mechanism to identify the poorest families and to develop fair guidelines for allocation of funds.

The NHIC cover employed public & private individuals and indigent members, who are entitled to subsidized premiums. The premium is discounted in accordance with the income classification of the Local Government Unit (LGU) where the indigent enrolls reside. The premium discount is then paid by the Government


WHO - Social Health Insurance-Selected case studies form Asia and the Pacific. P-261-262.
In the recent years, Philippine Health has initiated concrete efforts and discussions as to how the community based health care organizations can be phased in with NHIC. It has been envisaged that Community Based Health (CBH) organizations can act as health care providers and or financial intermediaries. More recently, Phil health with the support of German Technical Cooperation (GTZ) has identified and worked closely with the community based health care organizations to enable a smooth integration and phasing in Community Based Health Organization (CBHO)s into the social health insurance program of NHIC.

Nearly 60% of CBHOs are being run by religious, civic and non-government organizations. Benefit packages of NGOs vary and generally complement those offered by the NHIC. Contribution structure also vary but typically much lower than Phil health premium. Membership varies from low to super middle income group that include both the formal and informal sectors. It is evident from the many years of experience and operations of CBHOs that these schemes can be well integrated with National Health Insurance Program (NHIP) in reaching out to informal sector, the poor and the vulnerable sectors of society. The Phil health has recognized this and has thus initiated efforts to formulate concrete programs to integrate these groups. The different alternative health financing schemes that the various CBHOs in the country are implementing are examples that these groups are indeed potential suppliers of site specific health insurance.

In 1995 a German funded project called (Social Health Insurance Networking Empowerment) SHINE was set up to provide technical assistance to community based organizations providing health insurance. SHINE now works closely with Phil health to facilitate the extension of health insurance to those working in the informal sector. An important part of their program is to lobby Phil health to strengthen insurance coverage for those working in the informal sector. SHINE are advocating that Phil health recognize the multitude of community based organizations that provide insurance coverage to informal sector workers. They propose that Phil health accredit these organizations as financing intermediaries.

**Nepal**

Presently, in Nepal the formal sector health insurance as such, exists in a limited scale. There are a small member of agencies which provide medical benefit packages. Recently the Government has committed to the introduction of SHI for the people. They have promoted SHI by implementing a few pilot schemes and by replicating the appropriate schemes based on experience. While a true SHI does not exist in Nepal so far, support is growing for this.

At present, there exist several alternative models, which largely are variations of the CHI. The CHI schemes are attractive in providing an opportunity to link the activities into local management process. Ministry of Health seems interested to work closely with different CHI schemes.
Nepal has an opportunity of expanding and integrating the existing community based health financing schemes into the community based health insurance schemes so as to have higher proportion of coverage. In Nepal, NGO offers health service through cooperative society with the members maintaining a daily saving of nominal amount as contribution for health care services. Community clinics provide primary services with referrals for Katmandu Model Hospital. Subsidy is provided to the poor on referral cases.

**Thailand**

Thailand has a long history of health insurance. A heterogeneous and largely informal population led to development of piecemeal approach of the health insurance mechanism. The advantage is that it has enable the system to cover the majority (75%) of population, but benefit packages are different. While it is possible to be covered by more than one scheme, a significant minority still remain uncovered. The population is still largely rural with just 33% living in urban area.

Of the 60 million people approximately 10% is covered by social security scheme which provides health insurance for those in the private sector. In addition to health care, the Social Security Scheme (SSS) also pays for maternity, invalidity and health benefits. Sickness benefits constitute the largest expense accounting for about 90% of the fund. The administrative costs are low. The financial contribution is progressive with a five fold gap between the contribution of the highest and lowest wage earners. One main drawback of the scheme is that it covers only the employees as beneficiaries and not family members. Further, under this schemes, preventive and positive health needs are not adequately addressed. An interesting feature of the system is the participation of the private for profit hospital sector. Currently, about half the number of contracted hospitals is in the private sector and these receive the same capitation payment as public hospitals.

The first voluntary community based health insurance scheme in Thailand was started in 1983, which was initiated by the Ministry of Public Health. The scheme initially covered mother and child care in rural areas. The original scheme was developed as a pilot project. The current scheme (Health Card Scheme) was initiated in 1993 and based on a contribution of 500 Baht with a counterpart contribution by Govt. of a further 500 Baht. This covers up to five family members. The aim is to cover the non-poor with no insurance coverage. This has led to several important implications, as it creates adverse selection and limited risk sharing. The sick usually joined while the healthy opted out. The financial viability is a major concern.

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1. WHO-Regional Overview of Social Health Insurance P-32
3. WHO- Social Health Insurance P-302
Thailand’s Universal Coverage Scheme (UCS) known as “30 Bahts scheme” began in 2001 with the idea of replacing the voluntary Health Card Scheme. It now covers almost all citizens except civil servants and their dependents. The UCS provides comprehensive health care with virtually no co-payment by users apart from a nominal 30 bahts per each visit or hospital admission. The scheme is mainly funded by general tax revenue, with an estimated budget of 14000 bahts per capita per year which is paid directly to designated providers as a capitation payment.

The scheme demonstrates a long term financial sustainability and affordability by the government, which in fact applies the same approach to all beneficiaries, regardless of income. The scheme requires a firm commitment that has to stand up to economic shocks. Government has already laid down the legal framework for universal coverage by promulgating the National Health Insurance Act in November 2002. The coverage of “30 baht scheme” by the end of 2002 was around 77% and the remaining 23% is still covered by Civil Servants Medical Benefit Scheme and Social Security Scheme. Thus Thailand has reached universal coverage through a mix of public and private financing and public and private health care providers.

Attempt to achieve universal coverage has had a long evolution, but it has been speeded up during past few years. The policy seems to have a sound direction which is a result of accumulated experience and knowledge in the society. It is obvious that this policy is welcomed by the public and is well supported by the politicians both from the govt. and the opposition parties.

At the beginning of the scheme, the policy development and policy decision making process was participatory. However, it has been now assigned to Ministry of Public Health (MOPH). It is apprehended that assigning the whole responsibility to MOPH may limit the system capacity to handle the challenging policy. Therefore, it has been suggested that establishment of the National Health Insurance Organization, a new national body coupled with an efficient management system can be an immediate solution to implement the system more effectively.

**General Observations.**
Most countries in the South-east Asia including India, Myanmar, Nepal, Philippines and Thailand employ mixed health care financing mechanism. Some have implemented various mixes of social health insurance schemes covering certain segments of the population such as employees of public and private enterprises, workers from formal and informal sectors and their families. Only a few countries have tried to expand the social health insurance schemes to achieve universal or near universal coverage (for example Thailand). Some countries of South-East Asia have introduced cost recovery and cost sharing mechanism by charging for publicly provided health services. Such reforms in health care financing however, were, carried out without adequate measures to enhance financial and social protection system for people who can not afford the charges and fees for services. Therefore, there has been growing interest in social health insurance not only as a financial mechanism but also as an effective social safety net that provides greater protection for the poor and the low income population against health care cost.

WHO-Social Health Insurance Ibid P-302
Successful introduction and expansion of SHI depends to a large extent on the income level of a country. According to the World Health Report 2000, while more than 50% of industrialized countries had social health insurance schemes as their health financing system in 1998, not a single developing country with a per capita GNP of USD 760 or below had a full fledged social health insurance scheme.

The two most common mechanisms of health financing that incorporate pooling are social health insurance and government tax funding. While these two mechanisms share some common characteristics, they also have some important contrasts. In tax based systems, people contributes the health funds only indirectly via taxes, whereas in social health insurance schemes, people as members contribute directly to the health fund. It is an explicit contribution.

The common aspect in the development of SHI systems in South East (SE) Asian countries was that it started to accelerate economic growth. In process, it was recognized that social protection was necessary for health and productivity of workers to further strengthen sound economic growth. SHI is now being recognized as part of the development of social protection, especially for people who can contribute for health care as prepayment on a regular basis.

The process of development progressed through stages by covering both salaried and self employed workers and their family dependants in both the public and private sectors. However, the opportunities to extend social health insurance coverage through mandatory system is still limited, since salaried employees do not constitute the majority of workers and the tax base is still relatively low. This is why population coverage by SHI is still very low in India, Bangladesh and many other S.E Asian countries. But during the last decade and more, there is increasing collaboration between government and NGOs to extend health insurance coverage through state sponsored, community based or micro insurance schemes. It must be noted that Government is mainly responsible to initiate, implement and oversee SHI development in collaboration with all stakeholders.

It is observed that health care financing through social health insurance for the formal sector and for the informal sector should be given parallel priority. This is why in the Philippines the National Health Insurance Act was promulgated and the National Health Insurance Corporation was created to provide universal coverage within 15 years. They also realized and recognized the role of community based schemes in reaching the entire population. In Thailand also the Royal government has laid down the legal framework for universal coverage by promulgating the National Health Insurance Act 2002. The National Health Security organization is now fully operational to undertake fully universal coverage.

Thailand has a long history of health insurance beginning in the middle of 1970s and has so far achieved a very successful universal coverage of health care. Although it is early to comment on their success or failure, we can learn from their experience and their commitment for the cause. The policy has been adopted and implemented incrementally in terms of area and comprehensive of policy package, and has reached the national coverage vary rapidly. Definitely, there are several lessons to learn from them.
Community Based Micro Health Insurance
Schemes of Bangladesh

In Bangladesh, there are a number of notable and innovative community insurance schemes, largely run by civil society welfare organizations. Most of these organizations follow the integrated model of insurer and health care provider. In some cases schemes are run on the back of micro credit schemes.

Gonoshasthya Kendra (G.K)
This is the first NGO in Bangladesh who initiated health care and health insurance scheme by charging nominal user fees. It started the scheme back in 1975. It particularly aimed at increasing access of the poor to the health care system and recovering part of the recurrent costs of health care delivery. GK’s health care system has since gradually been expanded and currently covers more than two hundred thousand inhabitants in the suburb of the Dhaka City.

The health care system of GK consists of two tiers viz one central hospital and several sub centres. A subcentre is managed by a team of several (8-10) paramedics, who perform door to door visits of the member families and provide preventive and simple curative care. A doctor visits the sub centre twice a week to see the patients referred by the paramedics. The central Referral hospital receives patients referred by the paramedics.

G.K is providing preventive services, family planning and health education, free for all irrespective of family subscription to the health insurance scheme. Enrollment in the scheme is voluntary, per household and based on the signing of contract. Coverage starts immediately for clinic attendance, but only after one week for hospitalization.

G.K aimed at increasing access for the poor to the health care system, and also at recovering major part of the costs of health care delivery. In addition to health care services and financing, it provides vocational training program for women and handicapped and also provides micro-credit to over 2000 poor families identified by the G.K health workers, and gathered in cooperative groups of five to ten persons.

It appears that the affiliation rates amongst the 2000 families engaged in the G.K. credit program is about 80%. However, receiving credit from GK does not label families as GK members nor does it give them any advantage in the GK health insurance scheme. Under health care scheme, GK is providing preventive service, family planning and education, free for all, irrespective of family subscription to the health insurance scheme. ☐

☒ Health Economics Unit-Designing a pilot of Rural Social Health Insurance in Bangladesh.
The fee structure of GK health care system is characterized by sliding scales of premiums, and itemised co-payments for the insured households and, for the uninsured households, by flat fee for services. The scales are based upon the socio-economic groups such as ‘A’ (poor), B (middle income), ‘C’ (rich)’O’ (destitute) etc. For premiums and renewal fees the difference between the lowest and highest group is a factor 10. For instance, while the fee for a cesarean section in the destitute group is taka 50.00, it is taka 500.00 for group A (poor) and taka 1500.00 for group B and taka 3000.00 for Group C. Despite great efforts by the managers of the scheme, to include the poor, approximately 50% of the poor have not subscribed to the scheme mainly because of long distance of the centres from where they reside.

**Rural Health Clinics of Dhaka Community Hospital (DCH):**

Dhaka Community Hospital (DCH) started working under the management of a Trustee Board in the year 1988 through a hospital set up in the Dhaka City, which acts as the referral hospital for rural, school and industrial health clinics. The trust was established to provide quality medical services at low cost so that most of the poor people could afford them. They attributed due importance in community participation in running the system.

The DCH system operates a health insurance schemes at its clinics, known as Health Card Program. There are five types of health cards such as family, school children, workers, sport and destitute. Family Health card is intended for rural households @ 40.00 taka per month for an initial enrollment and 20.00 taka for renewal covering up to twelve members per household, including servants living in the households. The scheme provides free medical consultation and a monthly home visit by health workers. While the family members do not pay additional fees for consultation, but have to buy medicines. School children card is free to school children living nearby the health clinics and provides free physical examination and health education. Workers Health Card is provided to workers in the enterprises near the clinics with a premium of two taka per month per worker. Premiums are paid by the employee or the owner association. The benefit package includes free consultation but no monthly home visits by health workers.

The poor families in the villages receive a special “Destitute Card” free of cost, which allows the poor household members to visit the clinic at five taka per visit. The village committees decide which families in the village are considered poor and should receive destitute cards.

The Rural Health Card schemes do not cover inpatient care and the costs for drugs or medical tests. Doctors in the Rural Clinics refer patients to the Community Hospital at Dhaka and patients pay for hospital care at a reduced rate. In deserving cases, it allows the patients to pay the hospital bill in installments after the treatment. Patient’s community provides guarantee for the payment.

*Health Economics Unit. Designing a pilot of RSHI in Bangladesh- 1998.*
Rural health clinics recruit mostly female health workers from within the community and provide training to them. One health worker is responsible for approximately 200 households. Each of these households gets a weekly visit by the health worker who teaches basic health care and suggest preventive measures and does simple check up by measuring blood pressure, sugar of urine etc. A clinic enrolls approximately 2500 families. Specialist from Dhaka visits the clinics periodically and provide medical treatment to the villagers.

**Grameen Micro Health Insurance (GMHI)**

Health program of the Grameen Bank was initiated in 1993 as a complementary program of micro finance to address the health problem of the poor members in a sustainable and affordable way. Grameen Kalyan a sister concern of Grameen Bank(GB) was registered as a “not for profit” company in 1996 with an endowment fund from the Grameen Bank. Grameen Kalyan introduced health insurance program for the Grameen Bank member’s families as well as to other villagers. It provides quality health care to the less privileged section of the population in the rural areas of Bangladesh through micro health insurance scheme. It provides health care at very low price so that the poor and vulnerable section can afford it. It now operates through 30 health centres located in Grameen Bank’s operational areas. Each health centre is headed and operated by a qualified medical graduate. A commerce graduate serve as manager in each centre.

Under the card based micro health insurance scheme GMHI provides health care by categorizing the patients into four categories:

1) Grameen Bank members
2) Non-Grameen Bank members
3) Students (11-15 years)
4) Sangrami members (Beggar and Destitutes).

A membership allows the members to avail different services. The non-card holders are to pay for services at the market rates. The G.B member card holders pay an annual contribution of taka 120.00 and non G.B. member card holders pay taka 150.00 per year. Generally, six members of a household are entitled to receive health care by one card, and additional taka 20.00 is charged as premiums, for each additional member. Annual premium under school health program is taka 10.00 per student. Consultation fee for G.B. member card holders, non-G.B. member card holders and non-G.B non-card holders are taka 5.00, taka 10.00 and taka 50.00 respectively. The Sangrami members, who have no source of income get limited free treatment and medicines from health centres.

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ILO-WEEH-Grameen Kalyan- A case study-P-12.

Ibid-P-13.
Pathological services are provided to members at 30% to 50% reduced rate than the standard market rate. Medicines are also provided at 10% to 25% off the market retail price. In addition to the basic package, additional packages are available for safe motherhood, diabetic patients as well. The whole package of safe motherhood costs taka 1000.00 and only the safe delivery package costs taka 500.00. The diabetic package allows member to avail blood glucose and urine tests twice a month and GB members have to pay taka 80.00 and non GB members are to pay taka 100.00 in addition to annual premium.

Each health centre organizes approximately twenty satellite clinics in a month. Their satellite clinics provide services in areas far away from the health centre. Patients with acute emergency, or chronic conditions requiring special surgical or medical care are referred to a better equipped hospital at the district level. The doctor at the health centre decides who should be referred and when.

The referral centres provide services at half of the cost to the G.B. member patients. In addition members can claim some of the expenses incurred for treatment at other facilities maximum taka 2000.00 and subject to proper verification from headquarter at Dhaka. The GMHI scheme has no provision of benefits for death and disability. Basically, it aims to provide a combination of preventive and curative services.

When the scheme started, the cost of running a centre was approximately taka 2.5 lakhs per month. Now, it is in the range of six to seven lakhs per month. GMHI scheme aims that each of the health centres is able to generate enough income to sustain their activities. Contribution levels are based upon a number of factors. Amongst these, the ability and willingness to pay is an important one. Primarily all the Grameen Bank members are considered as the target group and more than 80% are card holder. But non Grameen Bank (GB) member card holders are below 10% of the target group. It appears that the renewal of card is to some extent dependent upon distance of members residence from the health centres. Almost all of those who have used the services renew their card.

It is obvious that poverty is the major factor preventing people (non GB member) from subscribing or renewing the card. For some people, to spare taka 120.00 or taka 150.00 for a future episode of illness is difficult. Although the annual contribution and user fees are considered affordable to majority, for a segment of people even these are high. Despite these odds, the program policy makers expect that they will achieve 100% recovery rate within 4/5 years.

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1. ILO-WEEH-Grameen Kalyan - A case study P-13
Micro Health Insurance of Bangladesh Rural Advancement Committee (BRAC)

BRAC is a NGO registered under the Voluntary Services Act with the NGO Affairs Bureau. In July 2001 a 36 month pilot project of micro health insurance scheme named the “Micro Health Insurance for Poor Rural Women in Bangladesh” (MHIB) was initiated at Narsingdi and Phulbari. MHIB was initiated as a pilot micro health insurance scheme to provide health care services at an affordable cost to community members (in particular women and children) with better access to affordable and good quality health services. The scheme has been implemented with the financial and technical support of the ILO’s Women’s Empowerment through Employment & Health as well as using BRAC’s existing program network.

The development objective of this project was to contribute to the empowerment and improvement of the well being of the rural poor women and their families by promoting access to quality health care through an affordable micro-insurance initiative. The program offers voluntary enrolment in the health insurance scheme on an annual renewable premium and differential co-payment schedule.

The size of the family and membership status in the “Village Organization” determines the amount of annual contribution and co-payment charges. Ultra poor people are covered under an equity package free of all charges. Each registered household receives an insurance card as proof of enrollment.

At the outset, MHIB offered two benefit packages, the General Benefits package and the Equity package. The main factors which determined the choice of benefits, are the principal diseases faced by the community and the services required to treat these as well as the availability of services at the BRAC health centres. Under the General Benefit package (GBP), for a differential premium payment depending upon their socio-economic status, members receive subsidies on consultation, pathological tests, normal child birth deliveries and medications. Also a free medical check up for all members of the household is covered.

Members receive taka 1000.00 for any service obtained at govt. or other private health centres. Upon renewal of the card, members are eligible to receive a 25% discount if services were not used during the period of cover. Under the Equity Package no contribution is required to be paid, nor any co-payment is required to be made for consultation with the doctor.

In January 2002, MHIB launched the Pregnancy Related Care package (PRCP) to provide coverage to pregnant women through all stages of pregnancy. In addition, the Package provides coverage for new born children in the neonatal period.

The BRAC Health Centres in Madhobdi (Narsingdi) and Phulbari (Dinajpur) are the direct providers of health care services of MHIB members. These centres provide technical and clinical back up to community based health interventions. One of the most important factors that has led to the success of the scheme is the fact that it has been integrated with BRAC’s health program structure in the target areas. This has greatly facilitated the smooth implementation of the scheme. The health centres provide outpatient and inpatient services.

I: ILO WEEH- Micro Health Insurance of BRAC- P-10.
2: Ibid-P-19
3: Ibid-P-20
4: Ibid-P-22
The centres have a five bed capacity and is staffed with two MBBS qualified doctors, one laboratory technician, three nurses and one support staff. MHIB received financial and technical support of ILO for development of work plan, training materials, capacity building, networking with government and other organizations working in the field of micro health insurance both nationally and internationally.

As MHIB is open to all Village Organization (V.O) members, both of BRAC and other organizations, MHIB staffs attend staff meetings of other NGOs, to brief them about the scheme’s concept and operation and gain consent to involve their members in the scheme. MHIB staffs also promote the scheme through individual contact and group contact. However, the main forum used for promotion is the V.O meetings.

Premiums paid by the policy holders and the financial assistance provided by the ILO WEEH (Women’s Empowerment through Education & Health) project constitute the main financial resources of the scheme and payments made to the BRAC health centres for providing services to the policy holders and family members and operation cost for running the scheme forms the principal costs of the MHIB scheme.

**Observations**

In Bangladesh, community based health care and the concept of micro health insurance has emerged as a way to provide health care facilities to the poor who cannot afford to seek professional medical assistance in case of illness. The MHI schemes, in general aim to reach the poor, as a tool to fight poverty and to promote equal access to health services. The organizations providing MHI are mainly targeting the beneficiaries of their development program. Generally, the MHI program benefits are open to all but with some variety in the service packaging and with differently applicable program for members and the non members. Although prices are invariably low compared to market rates, the coverage of existing MHI schemes is still very limited.

Most of the agencies have their community based mini clinics with limited laboratory facilities staffed by medical professionals and paramedics. The organizations that do not have their own clinical and tertiary level hospital facilities are maintaining different types of contractual arrangement with other organizers. Generally these organizations maintain formal and quasi formal relations with GOB agencies at every level.

MHI schemes are marketed through an elaborate program of social mobilization. In most cases, the group dynamics of micro credit program effectively suit social mobilization and marketing strategies in favour of these schemes. In other cases, organizations that are mainly health services focused, have clinical facilities of various types at the community level or tertiary level hospital facilities. This also creates conducive program arrangement, community support and the necessary institutional structure for the MHI schemes.

ILO WEEH- Micro Health Insurance of BRAC. A case study- P-38.
Role of Government in Implementing SHI scheme

Social health insurance, if successfully implemental could satisfy the needs of the insured population, while at the same time reduce government’s financial burdens for providing health care services. It would become a promising resource mobilization vehicle. However, two basic conditions need to be fulfilled. Firstly, contribution by subscribers need to be based on ability to pay and secondly, access to health care service should depend on the need of the insured. If these conditions are fulfilled, the members of social health insurance could be in a situation of mutual help through pooling of their risks and combining their abilities to pay to finance the services they need.

The potential buyers of SHI will make the decision of purchasing health insurance only when the expected benefit of having the insurance cover exceeds the expected costs. It is natural, that the poor rural people of Bangladesh may be hesitant to make a decision for participation, because they do not understand and visualize the potential income loss will be caused by debilitating disease episodes.

When only the poor are persuaded to join in SHI scheme, the costs of insurance will go up, because of the lower health status of poor. It is a dilemma. While, the pro-poor orientation is the prime objective of social health insurance in a poverty-prone sub-district, cost recovery will be easier if the insurance scheme can have more of the better off as members, as their health status would tend to be better.

Moreover, the conditions in rural Bangladesh are seen as serious obstacle to the introduction of social health insurance. The seasonality and uncertainty of incomes of the rural people specially in the northern districts makes it difficult to design and administer a social health insurance scheme. The high number of agricultural workers and self employed people in small and informal businesses render the administration of any social health insurance scheme extremely difficult.

Considering all these conflicting objectives and difficulties, some of the remedies can be identified as follows:

a) The proposed pilot insurance scheme should not only be open for all the population group in the project area but it should also ensure that all the households participate in the scheme equally and equitably.

b) In order to ensure regular contribution of the poor, an ideal mechanism need to be evolved. This can be done by creating a revolving fund, which generates earning to meet the premium costs needed for the extreme poor.

c) A qualifying period before the insurance cover starts would help to prevent abuse of the scheme by joining only when it is needed.

d) The benefit package should cover a full range of services i.e. primary, secondary and tertiary.

e) The services could be segmented into different benefit packages with different premium range.
It is extremely difficult to assess a realistic premium range for different groups as assessment should be made on the basis of households ability and willingness to pay for health care services. Prospective buyer’s willingness to pay is dependent on their perception of the utility and benefit both direct and indirect. Community participation is, therefore, highly required. Mass population in the projected area need to be educated and motivated. It is expected that the more the people understand the potential benefits of the scheme vis-a-vis the insurance system, the higher is the willingness to use. Community mobilization is therefore, of utmost importance. Community mobilization helps to remove the barriers of demand side. Once the community groups are organized and facilitated, it is expected that they will come up with innovative ideas and full support for the project.

The most common form of pro-poor health care financing in Bangladesh is supply side financing. Generally, a health care provider is funded directly by the NGO/donors, who then in turn provide service to the poor. These NGO/donor based organizations are supposed to ensure that poor have access to free or subsidized services. However, many experts think that demand side financing can offer greater potential for government and or donor agencies to attract the poor people and can strengthen and expand the role of private sector/NGOs. It is argued that demand side financing can pave the way of establishing link between government and private sector.

In demand side financing, the resources go directly to the beneficiaries. The role of funding agency is to identify the beneficiaries and arrange a system through which beneficiaries receive resources and can have access to quality services and utilize services properly. Unfortunately, in Bangladesh there is little or no example of demand side financing in health care sector. However, the best practices of demand side financing are in operation in the education sector and development sector.

In Bangladesh, public health care services were supposed to meet health care needs of every citizen, free of charge. But this was a difficult job to perform, because of the financial constraints of the Governments. This is why, users fees were introduced in tertiary and higher level public hospitals in Bangladesh. NGOs are also playing a positive role in health care delivery and financing. In fact, NGOs started charging user fees long before the public sector introduced token user fees in the district and tertiary level hospitals.

They have captive group of beneficiaries, for whose protection basically the micro health insurance schemes have been emerged. It has been estimated that these schemes cover approximately only one-third of population of their catchments area. It has been observed that most of the micro health insurance schemes in Bangladesh are covering the risks which are high in terms of frequency and low in terms of cost. This is just the opposite of basic insurance principle where low frequency and high cost risks are generally insured.
It has been observed that most of the resource drainage and asset losses of the poor take place due to catastrophic illness, which are low in frequency and high in cost. This is simply because the poor people do not have any cushion to absorb shock of this kind of illness. This is the type which entraps the poor into vicious cycle of poverty. Unfortunately, most of the MHI schemes do not have adequate coverage to offset this vulnerability factor. Therefore, it is of utmost importance that the proposed SHI schemes in Bangladesh in the poverty prone sub-district must cover costly risk and they protect the poor and vulnerable.

Another striking feature of MHI in Bangladesh is that all the schemes do adverse selection knowingly or unknowingly. This is against the basic principle of insurance. It is also observed that paradoxically, the MHI providers in Bangladesh are running their operation without any legal framework and or regulatory supervision. Under the present regulation, insurance services cannot be provided, without being registered under the Insurance Act 1938. This is urgently needed for protecting the interest of the customers as well as for the interest of the service providers. Further, there is no initiative for transferring the risks of MHI providers to private or public sector insurer or reinsurer.

The hard reality is that most of the people of Bangladesh (not only the ultra poor) usually do not come forward to cover their risks on health, because they do not consider it worth to invest in risks as the savings, if any, can be used to cater some other needs like food and clothing’s etc.

This phenomenon is considered as an inherent problem for Bangladesh Insurance Sector as a whole. Even, if they are covered by insurance, the members show their reluctance to renew their policies, specially where they find that they did not utilize the health facilities in one insured year. In order to overcome this situation, it is extremely necessary to mobilize and motivate the members of the society to subscribe the ideas of risks sharing, cross subsidization and the principles of brotherhood and solidarity.

It is also expected that being part of the scheme, people will be aware of their health rights and entitlements. While the people are well informed about the services provided they will make full use of them at the time of the needs. If the public and religious leaders are motivated they might consider that helping the community is a matter of social and moral responsibility and this could raise their social status and leadership quality.

**Role of Government and Policy makers**
The large rural important workforce in Bangladesh makes it difficult to offer work based social health insurance and therefore, health insurance provision should be incorporated within the framework of overall national health policy and treated as a social security program. Unfortunately, the governments in the past failed to incorporate it due to misplaced priorities, poor planning and scarcity of resources.
In 2003, GOB has developed and approved the Health, Nutrition and Population Sector Program (HNPS) and considerable efforts are now being made to control the contributing and attributable factors of malnutrition, population growth and health risk burdens with the view to have a sustainable socio-economic development of the country. With the realistic vision of the Government, “Nutrition” for the first time in the history of this country has been identified as one of the sub-sectors of the MOHFW.

It is observed that the public health administrators, health economists and the bureaucrats do realize that pooling is a major way to spread financial and health risks among the mass population. By pooling of the financial resources, the risks of health i.e. the financial burden of diseases is not tied to a particular contributor but to a common fund created for the purpose of the social health insurance scheme. The larger the pooling of the financial resources the less the people will have to bear the financial burden of their own health risks.

While the government contribution to the SHI scheme is generally financed from taxation, contributions from the members of the scheme are based on income. It is obviously different from direct fee-for services payment, in which people are responsible to make payments for health care from their own pockets. In SHI people as members of insurance scheme generally contribute depending on the ability to pay. It is generally associated with compulsory membership, and should ensure inclusion of the poorest. The compulsory scheme would also guarantee the mix of good and bad health risks.

In Bangladesh, where health care by the Government health institutions is provided free at the point of use (although the expenditure is paid through general taxes) the establishment and expansion of SHI will need a lot of education campaign for people to accept. There is the possibility of resistance to a changing system. In a country like Bangladesh where a system of unofficial under the table payments for health care is well established, it is urgently necessary that we eradicate corruption from all sector and specially from the health sector. It is expected that introduction of SHI will be facilitated, with the eradication and reduction of corruption in the health sector.

In Bangladesh, like many other developing countries, voluntary community based health insurance has emerged. It is now the responsibility of the Government to ensure that the financial risk sharing is extended to the vast rural population. Community based health insurance is in reality voluntary social health insurance in different forms.

CHI schemes have been initiated for non formal sector on non profit basis, to cover certain targeted groups. None of these schemes cover the larger proportion of population. In the absence of compulsory social health insurance, the government should play a positive role to accelerate development of community based health financing initiatives and to facilitate the broader coverage of population. Governments active support is required for sustainable growth of these schemes.
It is obvious that larger financial pools are better than smaller ones as they can provide for a better sharing of health risk, and at the same time, generate more revenue. Universal coverage is the ultimate goal of SHI. Therefore, the Government must have appropriate strategic development plans to reach that goal within the shortest possible time. This requires a lot of political will and phase by phase implementation.

According to the ILO convention no. 130, Bangladesh as a member country is obliged to introduce social health insurance scheme to cover at least 75% of economically active population and at least 75% of all residents. In all cases, the spouse and children of insured persons must be covered by social health insurance. Therefore, there is an urgent need to have a nationwide consensus to accept the concept and basic rule of SHI to provide universal coverage regardless of the level of contributions. The Government with its limited capacity must start the process.

There has to be a general consensus as to what type of social health insurance to be adopted, what proportion of contribution to be made by the Government, local bodies, employer, employees and what benefit packages to be offered to different sections of population. The government should also take an initiative for establishing an appropriate authority/committee for monitoring and evaluation of existing voluntary SHI schemes and to prepare a policy framework for good governance and management of these private initiatives.

We know that only a few NGOs and micro credit institutions are trying out voluntary health financing schemes on trial and error basis. All of them are performing dual role of insurer and service provider. NGOs in the long-run may find it difficult to perform with excellence in managing an insurance scheme without appropriate professional knowledge and training. Insurance is highly a technical subject and need to be managed professionally. It is therefore, not advisable to perform the dual functions. Government should regulate the health insurance service provider as well as the health care service provider. While designing a pragmatic SHI scheme, it would be better, if we develop a separate organization or two separate wings of the same organization for providing insurance service and health care service.

Monitoring and evaluation of the performance of both health care provider and insurer is important to improve and refine insurance mechanism. This is also necessary to ensure that insurance effectively responds to its members health needs and to expand coverage to new segment of the population or new geographic areas over time. The insurance design phase is particularly important to ensure that the insurance scheme responds to overall sustainability and equity objectives. An important role of Government is to establish a framework for monitoring community based health insurance schemes and also to encourage those schemes through an enabling framework that encourages public-NGO-private collaboration and quality services.

WHO-Social Health Insurance in WHO South-East Asia-A policy Brief 2002-P-6
The government is now working on the framing a new law on Insurance. There have been several studies by insurance and regulatory experts with view to modernizing the insurance law. The new draft of Insurance laws have been submitted to the Government and it is expected the significant progress in this area will help to grow the industry. It has been proposed that an independent autonomous Regulatory Authority be established for supervision and regulation of the growing insurance sector including micro insurance scheme.

The NGO’s involved in micro insurance are not registered with the department of insurance and are not regulated or supervised under the Insurance Act. The NGO’s are of the view that since the NGO regulations do not prohibit such a service, it is not illegal to provide micro health insurance to its members. This controversial issues need to be addressed properly in the new insurance law.

Presently, the Department of Insurance (DOI) has the authority to regulate mutual and cooperative insurers. Confusion over whether micro insurance activities of NGOs falls under the jurisdiction of the Insurance Regulator need to be addressed properly. It appears that under the Insurance Act no one can offer any insurance service without having a certificate of registration for that class of insurance business. Unfortunately none of the NGO’s providing MHI have so far taken any such registration certificate.

HPSP for 1998-2003 focused on the policy and regulatory action for enhanced sustainability, accessibility, affordability and quality of services. The component includes, the adoption and implementation of policies related to cost recovery and health insurance. The government views health insurance as an effective health care financing mechanism and therefore should support existing and future health insurance schemes operated by NGO’s.

In Bangladesh about 68% of the population are Children and married women. Unfortunately Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) are high among them. The Government could not produce optimum number of committed and skilled service providers for children and women. This persistent problem should be addressed with greater importance.

① Ahmed M.U. Health Micro Insurance, P-11 , Case study no-13- CGAP working group on micro insurance.
② Section 2A & Section 3 of Insurance Act 1938.
Although social micro health insurance has not been incorporated in National Health policy, the concerned Ministry and Health Economics Unit have shown sincere interest in the concept. There is also a great interest and feeling among the health service providers that a legal framework should be developed to facilitate the expansion of NGO provided health care services and introduce standardized operational procedures.

The Government of Bangladesh has articulated its health sector financing strategy to enhance the financial sustainability with special attention to poor and vulnerable groups. To achieve this, the conceptual framework has been outlined and the tasks of the concerned Ministry of Health and Family Welfare ought to be as follows:

a) Explore the potential advantages of SHI as well as its impact on equity and institutional reform and review the existing community health insurance schemes.

b) Explore the provision of financial subsidies to community health insurance for covering the poorest and to investigate how to provide public support to facilitate scaling up of community health insurance.

c) Pilot and launch community health insurance scheme for organized local groups of sub-districts.

On the basis of these conceptual framework as envisaged in the Health Nutrition and Population Sector Program (2003-2006) it is necessary to explore the feasibility of the linkage between the public sector and community health insurance schemes. The Government should also explore the feasibility of providing public subsidies through demand side financing in order to pay the health insurance premium on behalf of the poorest and the vulnerable groups.

It is also necessary that the Government should take appropriate steps to develop required human resources and infrastructure that are needed for management of social health insurance. The major challenge for GOB in this respect is how to accelerate development of community based health risks sharing schemes and to facilitate the broader coverage of people. Ultimately, it is the government that must provide subsidies for the poor to ensure that those who can not afford to fully finance their own insurance are protected.
Designing an Appropriate Pilot Scheme

Hard Realities

Normally, CHI providers use a trial-and-error approach to determine their service coverage. During the implementation period several adjustments are made based on the feedback from clients. Some providers take a conservative approach and limit the range of services to reduce its risk and gain experience gradually. In both cases, the operators need to monitor closely the results of its initial coverage package and make adjustments, as they gain more experience. Another approach appears to be more useful is to invest initially a reasonable amount of fund in understanding and prioritizing households health care needs, through several detailed surveys to assess:

a) impact of illness, injury and related risks upon the target household group.
b) households interest and ability to pay for health care services and

how households are currently paying for and receiving treatment of illness.

It must be realized that a variety of different health care services can be covered. Coverage can be complete only when full costs can be met, which is unlikely. Therefore, a partial coverage should be given depending on the needs of the prospective policyholders and the capacity of health insurance and health care service provider.

The extent and level of coverage to be provided requires a balancing act between the demand for health care from low income and other income group and their ability to manage required premiums and the operators ability to offer the services. Recognizing that the majority target clients can not afford to pay the required contribution for complete coverage of all health care services, we need to design an insurance plan that covers at-least four or five highest priority illness or medical treatments. In this way the prospective policyholders can be provided with the greatest value possible for their limited budget.

Considering the hard realities, it is advisable to provide preventive& primary care, essential drugs, laboratory test at reduced rates and top up insurance coverage for reimbursement of major hospitalization cost and loss of income caused by illness and accidents due to permanent total and partial disability of the family heads including accidental and or natural death.

Health Care Services:

Modus operandi of providing services is an important decision for the scheme operator. In order to make the system easier, it is advisable that each household is provided with an Identification Family Health Card (IFHC) which would entitle the incumbent family members to get specified health care services from the designated health care providers. In case of illness, they need not pay to the health care providers except the co-payments as and when required as per terms of the plan. The required premium or contribution to be paid to the operator of the pilot scheme. The household members may be supplied with the “voucher” for having consultation, medication, laboratory tests and hospitalization costs against those vouchers.
The operator of the scheme shall pay to the health care providers on submission of utilized vouchers. However, in order to make the services available at the door steps of the members, the health care provider or the operator of the scheme should have arrangement of ambulatory services in each village on weekly basis.

An ambulatory team equipped with instruments should visit at regular intervals to the villages and should provide educative, preventive, curative and primary care services directly to members. Since all the services can-not be provided in a cost effective manner by the ambulatory team there should be one or several “dedicated” health care centres in the sub-district which will be providing convenient and quality health care services. Experienced micro health or community health care providers such as Grameen, Dhaka Community, Gono Sasthya or BRAC can act as health care providers at the agreed cost and mechanism. The price and mechanism may be in line with their existing practices with slight modifications if and when required.

**Contribution**

The most important consideration for an operator is to determine the insurable unit. Based on the experience of CHI schemes in Bangladesh and abroad, it is suggested that providing coverage on a family basis would be ideal and convenient for the users as well as for the providers. To become a member of the scheme, all family members must agree to be a member of the scheme and contribute according to their ability.

However, the definition of family is very important. In Bangladesh context apart from mother, father and children it may include parents, brothers, sisters, in-laws, servants etc. Everyone “who eats from the same pot” would be perhaps too wide a definition of family and may lead to misuse by the members. This demands an acceptable definition of family and a limit on the size of each family. Regardless of how a family is defined, contributions may be collected either on a flat rate for the entire family or per family member with lower per person rates for larger families.

Flat rate collection is simpler and easier to explain, while per person pricing eliminates operators need to cap the member of family members included on a single card or policy cover. Considering all these aspects, a family of five or six members may be enrolled on a flat rate and fee for other members if any should be as per fixed rate per person.

Another important factor in connection with collecting contribution is the frequency. It may be either weekly, monthly, quarterly or annually. Setting an appropriate frequency of premium collection requires consideration of households ability to accumulate the required contribution, collection cost and financial soundness of the operator. It is obvious that less frequent collection gives the operator an opportunity for investing the collected fees, which in turn helps to cover the costs of the scheme. Therefore, it is advisable that an annual contribution should be encouraged with the provision of more frequent intervals i.e. monthly or quarterly. For example, if an annual contribution is fixed at taka three hundred only per family for the entire package of services under the scheme, monthly rate may be fixed at taka thirty and quarterly contribution of taka Eighty five only may be fixed.
**Revolving Fund**
Whatever may be the mode of payment and the amount of contribution, the extreme poor people cannot afford to pay at all. Therefore, it is necessary to set sliding scale according to the participants income. If and when annual contribution is fixed for example at taka 300.00, it would be advisable that the operator creates a revolving fund for the extreme and moderate poor participants. In this case, for example if taka 300.00 is to be generated for contribution against an extreme poor family, an annual fund of taka 3300.00 per family will be required. Taka three hundred will be contributed as first year premium and balance taka 3000.00 will be invested to generate at least 10% return to cover future costs of premium. This is just an example.

In case the operator needs to bear entire contribution of 1000 families in the sub-district, an initial revolving find of (3300×1000) taka 3.3 million need to be kept reserved for the purpose. In case, it is decided to subsidise 50% of the annual premium for further 1000 households, an additional fund of (1170×1000)taka 1.7 million to be kept for the purpose. Investment of total five million taka will generate profit to cover the full and partial subsidy of approximate 2000 households of the target group. Remaining households of the target group will be required to pay full amount of contribution per annum.

**Range of Services:**
A variety of different health care and related services can be provided under the pilot project. These may include health care services, health insurance services to cover personal accident and loss of income for the family head. The type of preventive care and educative services should include the following:

- a) Education programs of household: This service need to by provided to educational institutes in the locality and to the members of the group (family heads/parents)
- b) Educational program on family planning, AIDS prevention to married/adult members of group.
- c) Education program to mother and housewives regarding nutrition, pre-natal & post natal care for the mother & the child.

Apart from these educative service, the scheme should cover:

- a) Primary health care i.e. regular medical examination, consultation with paramedics and certified doctors.
- b) Diagnosis and treatment of common illness, including prescription on medications.
- c) Assistance with natural child birth at home
- d) Supply of medicines at subsidized rates from health centres and or pharmacies.
- e) Laboratory tests, x-rays, electrocardiograms, ultra sounds etc. as and when needed.
- f) Provision of minor surgeries, optical & dental care, insurrection of childs at local clinics.
- g) Inpatient care at local hospitals for a few days and treatment of minor diseases.
The members of the households having a valid family health card, will have to choose, which of these services to be availed, when and for whom. They will be required to make a balance between the demand and the amount of co-payments required for the services availed. Each household member may be supplied with “voucher” to be used for reimbursement by the suppliers of services.

Apart from educative, preventive, curative and primary medical services, the scheme should cover for reimbursement of major hospitalization expenses if availed from Government hospitals and recognized clinics at the district or division headquarter level. This service may be bought by the operator of the scheme from local private insurance companies by paying premium on behalf of the members. This can also be covered on voluntary basis by the well off members to cover cost of hospitalization, medicine during treatment, major surgical operation, intermediate surgical operation and ancillary services.

Total maximum amount of cover to each insured between age 18 to 59 may be limited to taka 5000 (five thousand) per member per year. The willing members of the household will have to pay premium according to age of the insured. They will be compensated by the insurer on submission of required papers, documents as per terms of the policy. This top up cover will help to attract members from middle income group and upper strata of the society, who can afford to pay for such services.

**Life and Accident Coverage**

Apart from top up health care services from insurance companies the scheme may avail a flat rate cover against risks of accidental and or natural death, permanent total disability and permanent partial disability of the family head. Maximum amount of benefit may be fixed at thirty thousand taka (Tk. 30,000) per member (the family head only). This cover can be purchased by buying a group accident benefit scheme from a private insurance company. Annual premium of such a policy, should not be more than taka 150.00(one hundred and fifty) per person per year.

Under this group accidental insurance cover each nominee of the insured shall receive taka thirty thousand in the event of insured’s death from any cause (except suicide in the first year of policy) In addition to that, the insurance company will pay in one sum taka thirty thousand for loss of either both hand, both feet, sight of both eyes, one hand and one feet, one hand and sight of one eye or one foot and sight of one eye.

In case of loss of either one foot, one hand or sight of one eye, a sum of taka fifteen thousand will be paid in lump sum. The loss must be caused through external, violent and purely accidental means. Further to above, insurance company will cover risk for permanent total and partial disability. This will ensure payment if the insured becomes totally and permanently disabled from bodily injury or disease so as to be wholly prevented from performing any occupation for remuneration or profit.
Reimbursement against permanent, total disability will be made in sixty equal installments (five hundred taka per month) on expiry of waiting period of twelve months. In case of claim against partial permanent disability, the insured will get reimbursement of lump sum amount as percentage of sum insured depending on the kind of loss due to complete and irrecoverable physical loss or loss of use of specific parts of the body. A typical example of reimbursement against permanent partial disability can be shown hereunder.

**Permanent Partial Disability**

- For loss of arm between shoulder & wrist **50%**
- For total loss of hand below wrist **50%**
- For total loss of four fingers and thumb **40%**
- For total loss of four fingers **35%**
- For total loss whole thumb **25%**
- For total loss of whole index finger **10%**
- For total loss of whole middle finger **6%**
- For total loss of whole ring finger **6%**
- For total loss of whole little finger **4%**
- For total loss of middle finger **6%**
- For total loss of leg at hip **50%**
- For total loss of leg between knee and hip **50%**
- For total loss of leg below knee **35%**
- For total loss of all toes **15%**
- For total loss of one eye **50%**
- For deafness of both ears **50%**
- For deafness of one ear **15%**
- For loss of great toe **5%**
- For loss of other than great toe if more than one toe, each **1%**

**Salient features of proposed Pilot scheme of SHI.**
Based on the suggested plan of action for providing health care and insurance services some of the features of the proposed scheme of SHI are narrated below:

**Objective of the Scheme**

a) To provide the best possible health care services to all the members of a household at the least possible cost.

b) To promote and develop an appropriate health financing scheme and facilitate a sound and sustainable mechanism to serve the best interest of the users & providers of health care services.

c) To ensure that all sections of the society participate in the scheme based on the principles of brotherhood, solidarity and mutuality.

d) To organize the incumbents into small self-help groups through community spirit and thus encouraging them to participant in the proposed pilot scheme.

e) To establish an organization of the civil society for easy administration of health care financing on an accountable and transparent way.

f) To mobilize fund during initial years of pilot scheme in such manner and means so that the scheme can be continued to serve the entire community.
Eligibility
All the households in the sub-district of the pilot scheme should be eligible to participate in the project through their affiliation or membership in the local group (solidarity club). The members of the local group will be eligible to join in the health care financing scheme by paying (or even not paying) contributions according to affordability to pay. At least thirty/forty households in a particular locality can form a group and enroll for enjoying health care services and benefits of health insurance mechanism.

Health Care and Insurance Cover
Every member family of the local group will be provided with an Identification Family Health Card(IFHC) for all the household members against payment of an annual fee and contribution. The Family Health Card will enable any of the household members to avail consultation from local practitioners, medical professionals of health care provider and or the operator. Family members of the card holder must present their I.F.H.C before consultation service is availed. Cards will not be transferable. In case of loosing the card, the member can purchase replacement by paying penalty and required card fee.

a) For Medication & Primary Health care service each family card holder should pay an annual contribution according to their ability to pay which enables them to avail the health care services from local clinics against “voucher” and co-payments as fixed by the operator of the scheme. This will also enable them to purchase medicines at subsidized prices from the enlisted sellers/coordinators/mobile ambulances.

b) For hospitalization cost & Personal Accident benefits all insured family card holders should be entitled to get benefit/reimbursement of hospitalization cost and personal injury benefits for loss of income due to accident/illness up to a fixed amount during the period of cover by paying an annual fee (according to ability to pay)

c) Family head or any of the earning members of the family should be entitled to cover the risks of life & personal accident and obtain benefit up to a fixed sum in case of death or disability of the insured.

Benefit
According to willingness and ability to pay (and or subsidies provided) every household member should be entitled to get free consultation from registered doctors as and when necessary and according to their convenience. Moreover, they should be entitled to required pathological tests, x-ray, ultrasound, electrocardiogram, etc. and the drugs prescribed at the subsidized rates. Local hospitalization cost per day up to a certain amount per incident will be also available.
Normal exclusions

The pilot scheme should specifically exclude certain losses and claims such as optical appliances, hearing aids, cosmetic surgery, intentional self inflicted injury or illness, alcoholism or drug addiction and their consequence and injury or illness arising out of intentional involvement in strike, riot, civil commotion, political activity, terrorist activity, illegal activity of any kind and nature, unauthorized treatment and their consequences etc.

Limitations

The pilot scheme should limit maximum cost per incident, per person, per family during the period of cover.

Waiting period

For hospitalization & injury benefits waiting period approximately of two weeks will be required before entitlement. However, for disability benefit (permanent total) waiting period may be six months to one year.

Return of Contribution:

There will be no return of contribution, in case of cessation, cancellation or at the expiry of the cover. However, for members who renew the cards and pay contribution for continuous three years, will be entitled to get a discount on the contribution if the family members did not avail during the period an amount of benefit in excess of a slab fixed for the purpose.

Application

All intending members should provide full and accurate information required for the membership card and entitlement of benefits under the scheme. Application forms be countersigned by the group leader/motivator and accepted by the operator of the scheme. Application should include membership fee and preferably an annual contribution to be paid to the operator through the motivator/group leader.

Coupon/Voucher

The operator may provide coupon to all the members in order they can avail health care services from the designated providers. The coupons to be presented along with (FIHC) card. The providers will get reimbursement of their service charges by submitting bills to the operator along with the coupons received against treatment and services given to the participants.
A flow chart of cash, coupon, claim and health care service can be seen from the following diagram: (Diagram –A)

**Flow Chart of Cash, Coupon, Claim & Service**

![Flow Chart](image-url)

- **Cash**
- **Coupon**
- **Claim**
- **Service**

- **Participants (Family Units)**
- **Healthcare Association**
- **Operator of Pilot scheme**
- **Healthcare Provider**
- **Referral Hospital**

*Diagram -A*
Modus Operandi of Ideal Pilot Scheme

In quest of an Ideal Model
There can be different models for providing health care and insurance services. For example, the health care provider can perform all the ancillary services i.e. designing product, managing risks and funds. The activities involved in health care provision are those typically associated with operating a clinic or hospital. This includes providing professional medical advices, providing equipments and supplies required for medical care, maintaining staff of medical professionals, maintaining quality of care, controlling cost of delivering the services and determining the services to be provided.

The operator as provider will receive contributions from the users and generate incomes through receipt of co-payments for services provided. These organization are typically a trust or non-profit organization and do not have insurance expertise, nor do they have any arrangement with insurance or re-insurance companies to transfer risks. They are more a health care provider and manager of the fund, but definitely they are not the typical insurer.

Another model, which are often being used and advocated by many are the cooperative or mutual association. This model is a replication of mutual or co-operative insurance companies in developed insurance markets. This is a model, where the organization is owned by the members and provide health care and health insurance as a benefit of membership. As owners of a mutual health insurance organization, the policy holders or the members are supposed to determine the services to be provided, set the premiums or contributions to be made and manage the day to day operations including fund management, risk management and servicing.

Since all members can not participate in making all these decisions, normally an executive committee from among the members is elected or selected to manage the society or association. This model may not be suitable for Bangladesh because there is little or no success story of co-operative or mutual model at least in the health and insurance sector. Moreover, managing a health plan and insurance scheme requires skills and knowledge, which can not be found within members of poverty prone and mostly illiterate people.

An alternative model of mutual or cooperative organization is to manage the health care and health insurance services by two separate organizations. In this case the operator will provide both services of health care and health financing respectively. Two separate organizations may perform the responsibility of providing health care services and the insurance services. In this model, the members or the policyholders pay directly to the service provider and receive benefits from them directly. This model has its advantages and disadvantages. Direct providers can plan, organize and manage more suitably to match with their capacity, but there is strong possibility of customer dissatisfaction, because the provider customer relationship will be based on a buy & sale contract.
In order to overcome the challenge of understanding policyholders needs, the scheme operator need to work as third party administrator with potential policy holders to define and decide what services to be provided, what risks to be covered and to assess how much the different family groups can afford to pay for health care services and insurance services. In this case the operator will be a non-profit civil society organization.

A further modification of the above model can be done to operate the scheme with more sophistication by making use of professional separate service providers, one for health care and another for health insurance. This is suitable for those who have an existing base of clients. They can arrange an agency agreement with an established health care provider and insurance provider. The health insurance provider may only provide the insurance cover or it may be the provider of health care services as well. In that case hospitals who have an insurance plan or an insurer who have hospitals would be suitable as partner. In this model the operator focuses on group mobilization, fund procurement, scheme operation and the partners focuses on providing the health care and health care financing through insurance mechanism.

Which of the different models to be used is the most crucial decision. There are several criteria for selecting or using a particular model. The prime criteria, however, is the objectives that have to be achieved through the scheme. The prime objective of the pilot SHI scheme is to develop a sound and sustainable mechanism of health care financing at the least possible cost for the entire target group. In order to achieve this objective, mass participation is of prime importance. At the same time, we shall have to have an organizational structure which is easy to administer and can prove its efficiency and affectivity. Considering all these we can perhaps use an “ideal” and “appropriate” model which may called the “solidarity” model. An operational mechanism and flow of cash, coupon, claims and services of solidarity model has been depicted in with following diagram. (Diagram - B)
Suitability with objectives

The very basis of insurance and for that matter Social Health Insurance is to ensure that all sections of the society participate in the scheme on the basis of solidarity and mutuality. A cooperative structure is ideal for the purpose. But, such an organizational structure is unlikely to mobilize huge capital required for operating the scheme. Moreover, social health insurance requires a greater level of technical expertise and actuarial support, which is extremely difficult to obtain by such a society or association. It is also evident that the advantage of the cooperative structure in servicing the poor diminishes as the organization grows larger. The principles of brotherhood, solidarity, members participation, member driven services, etc are not evident once the organization expands beyond the local village.

It is, therefore, felt that cooperative philosophy need to be maintained at the local village level so that everybody feel that it is their own organization and everybody has access to the scheme through local groups and can afford to join by contributing a little amount of money. Membership in the local village group may be of maximum Tk. 50 to Tk. 100 per family unit. If there are three thousand households in the sub-district, approximately 30 to 60 local groups need to be organized through the motivators/local leaders/social worker.

These local village groups should be organized by one/several “motivators” in each locality. They will visit and meet the family members, explain the objectives of the scheme and motivate the household members to join with the “Samity” for the purpose. These local groups may be termed as solidarity club (াভ্যাস or কুঞ্জ) or any other suitable name to suit the objectives of the scheme. The motivator leader of the group will be the key person in the scheme, and will be representing the group for proper feedback to the organization.

The main body of the organization may be termed as operator which will be set up with representatives from different sections of the society. The “operator” at the sub-district level may have an “Advisory Board” and an “Executive Committee”, or “Management Committee”. “Advisory Board” will be mainly responsible for fund mobilization from different sources and formulation of policies and strategies to achieve the objectives of the operator. This Advisory Board shall comprise of representatives from local bodies such as Upozila Parishad, Municipality, Union Parishad and so on. Government representation in the Committee can be ensured by inducting the Upozila Nirbahi Officer(UNO) and Medical Officer(MO) of the Upozila Health Complex. The committee can be further extended by having representation from different professional groups such as teachers, imams, social workers, etc.

Representation from different walks of life will enable the operator to motivate people. Because, people in general and specially the low income families will be reluctant to conceive the idea of paying in advance for services that they may or may not use. Therefore, a strong team of motivators and or social health workers shall have to educate the family heads about the benefits of health insurance and health care services.
Once a family is interested in becoming a member, he will be induced to motivate several other families in the area to join as a group. A group of one to hundred families will make a local unit of Solidarity Association. The leader of the local unit will represent the group in the Upozila Solidarity Association (Upozila Sasthya Seba Samity). He will guide the members regarding availability of health care services and insurance services under the scheme. He will maintain relationship with the designated health care providers and shall collect premiums from the members for timely deposit to the manager of the “Upozila-Sasthya Seba Samity” (USS).

Besides maintaining relationship with health care providers, the motivator/group leader need to maintain very close relationship with all the members of the local unit and visit the Upozila Sasthya - Seba Samity (USS) once in every month to provide and receive feedbacks.

The proposed solidarity model structure, appears to be very simple to understand and easy to operate. This is illustrated in Diagram C.

![Diagram C](image)

It appears from the above diagram that the “Motivators” will play a key role in the system. The operator will be in a better position to identify the needs of their customers and community due to the closer links through the motivator. The resulting increased awareness and understanding will enable the operator to provide a more personalized flexible and appropriate services. The operator will try best to provide affordable premium for different groups of the society and at the same time should ensure participation of the motivator in formal and informal meetings frequently. This will enable the operator to distribute, promote and develop the scheme to the benefit of all households in the community.
**Concept of Mutuality & Cooperation**

The strong community relationship, and motivator’s involvement will help to grow a feeling of trust and building a social capital to develop a vibrant and users friendly social health insurance scheme. Trust is a major requirement. This will create a greater participation and commitment from family members to act in the greater interest of the organization which is meant for their betterment. This will decrease motivation for morale hazard and fraud by the users. Peer pressure from within local groups of the society can prevent members to avoid morally hazardous behavior. Each family as a member of the local association will be represented through the motivator. This will enable the poor households to grow a sense of participation dignity. Instead of asking helps or begging from individuals, they will be getting help as member or subscriber of the scheme. This trusted relationship and solidarity of all the fellow members will provide an unique opportunity for the operator to build a stable policyholder base. Membership based organizations will thrive when the members join in a group or association to achieve a common need.

The negative attitude towards insurance will be mitigated to a great extent, when they will find that insurance is based on the concept of mutuality, whereby risk is shared by many to protect the few. The poor common people are familiar with traditional mutual self help mechanism. As the poor members of the scheme are the ultimate beneficiaries of its success, they will have a strong incentive to educate themselves, and to propagate the idea to others.

The group-based “Solidarity Model “ will help to reduce the costs of labour and resources needed for information collecting, educating, marketing, motivating and monitoring the members. Costs thus saved can be utilized for research, health promotion and preventive cares.

The group leaders, of course, are not health and or insurance professionals. They are also not supposed to have managerial experience and capability to manage the scheme effectively and efficiently. This is why the “operator” as suggested in this model is a different legal entity (non profit company or society). However, the group leaders as member/representative in the general body of the USS, will be the nucleus of the SHI scheme

While the local groups may be formed either in an informal or formal fashion, the operator who is entrusted to implement the pilot scheme ought to be a non-profit legal entity, which will have a regulatory framework and guidelines for auditing, accounting, and maintain a transparent mechanism. Without being a legal entity, they can not attract technical assistance and financial support to enable the operator to manage the scheme on a long-term basis. The operator, therefore, should have an Advisory Board as well as a Management Committee, apart from a general body of members from amongst the group leaders.
Management committee should comprise of a small team of salaried professionals. The management committee should be entrusted with the responsibility of implementing the scheme, to achieve and maintain the social objectives by adhering to the principles of good corporate governance, proper form of accounting and practising an open voluntary and transparent operation. Although the scheme will be voluntary, it will be the responsibility of the operator to ensure that every household has access to and can afford to join in the social health insurance scheme. If this is done, universal coverage will be automatically ensured.

**Need for Good Governance**

In order to make the pilot scheme vibrant and sustainable, application of the principles of good governance is a prime necessity. Because, in due course, the project is to be handed over to the government or to the civil society, who under the supervision of a regulatory body, will be able to run it on a viable basis. The pilot project of SHI shall have to meet specific public needs, within a specific time frame and to bridge the gap on health care and health financing services in a particular area comprising of at least one or two sub-districts, so that the government, or the body entrusted to replicate this program in other sub-districts and eventually to institutionalize this vital scheme for the society at large.

This raises the need for strengthening the governance of the scheme from the very beginning. Preventive and proactive approaches to organizational probity is much desired than dealing with collapse of the pilot scheme due to the absence of good governance system. Good governance will not only help to raise the performance standards of the operator but also will increase accountability and act as a tool for detecting and preventing loopholes and flaws in the day to day operations. This in turn will promote an evaluation of the system and will make the institution capable of sustaining performance whilst maintaining greater accountability and transparency based on stronger ethical foundations.

Good governance is essential for all successful organizations and schemes. The core objective of governance principles should be to provide a structure through which the mission and objectives of the pilot scheme are set and performance monitoring is carried out. It is expected that the governing principles will guide the “management committee” and the “advisory board”. The sponsor of the pilot scheme along with donors and all stakeholders should work together towards improved governance structure and serve as a model. It should provide a direction for exemplary corporate governance system to promote organizational accountability and effectiveness from a future oriented perspective.

The main purpose of the governance principles should be to maximize corporate value by enhancing the transparency and efficiency to promote a sustainable scheme and institution for the future. The principles should highlight the establishment of an efficient managerial system that promotes creative and dynamic enterprise to operate the S.H.I scheme. The principles should aim to promote the organization that exhibit a sense of social responsibility with strict sense of morality. The governance principles should recognize all the diverse stakeholders in the health care and insurance sector so that the operator can mediate their interest through a rational and fair means to achieve stakeholder and social representation to strengthen the viability of the scheme.
A sustainable civil society organization can evolve from the founder driven organization by defining the role of the Advisory Board as well as the professional managers and staff and thus to ensure financial sustainability. In effect, the Governance principles of the pilot scheme should seek to promote and implement the following:

i) To develop and to process organizational mission/goals.
ii) To ensure public disclosure of organizational mission, its program, methodology and impact.
iii) To ensure financial sustainability and appropriate use of funds.
iv) To develop an internal governance for organizational effectiveness, beyond financial and managerial accountability.

**Basic principles and guidelines:**

The pilot S.H.I. scheme will be established for a social mission, which is to be achieved through programs and services. The mission statement, therefore, acts as a guideline for achieving this social mission. The founder sponsors, should clearly articulate their mission, programs and services in a manner that enables the operator to operate efficiently and effectively towards achieving the mission and vision.

The well defined mission and vision of the scheme should be clearly documented and communicated to all stakeholders. Advisory Board members should subscribe the mission and vision so defined and must be committed towards achieving the objectives. In order to achieve the objectives, the Advisory Board (AB) shall have to prepare a periodic strategic plan to ensure that its operation and programs are directed towards achieving the stated mission.

The AB shall have to ensure that the organization has sufficient resources to fulfill its mission to a satisfactory degree. The A.B shall have also to ensure that the available resources are utilized for the operations and programs according to the stated mission and that such resources are effectively managed. The AB shall also ensure that the organization has an evaluation system that can measure the effectiveness and efficiency of programs and their outcomes in line with the mission and objectives and meet the priority needs of society and the intended beneficiaries of the pilot scheme.

The Advisory Board ought to be composed of a mix of qualified individuals of integrity, each of whom should be able to add value and to bring independent judgment to bear on the decision making process. The responsibilities of the Advisory Board should be as follows:

a) Setting guidelines for management and review/approve the strategy of organization prepared by management.
b) Establishing principles and policies for running the organization effectively.
c) Protecting against bad publicity by acting as good ambassadors for the cause of the SHI scheme.
d) Building relationship with donors and all stakeholders.
e) Maintaining awareness of government and other external factors.
The AB will be also responsible to communicate on matters relating to its mission, program or activities to the public and stakeholders. The AB shall adopt appropriate procedure, to ensure honest and ethical fund raising policies destined solely for the causes of the S.H.I scheme. The pilot S.H.I scheme will be operating to provide the most important services to all households. It is therefore, necessary that the operator of the scheme have frequent communications with motivators to ensure that clients views are represented in the strategy.

**Internal Control**

The existence of an effective internal control system is indispensable for the safety and soundness of the institution. Such a system can help to ensure realization of the institution’s goals and enhance its long-run sustainability. Internal controls are also necessary for ensuring management oversight and developing a healthy culture within the institution. They are necessary for recognizing and assessing risks, detecting problems within the institution and correcting deficiencies.

It is essentially the function of the Advisory Board to ensure that an effective system of internal controls is laid down and observed. Once such a system has been laid down, it is the job of the management committee to develop processes, that identify, measure, monitor and control all the risks that affect the realization of operator’s goals. The Advisory Board and the Management Committee should be jointly responsible for promoting integrity in the institute and creating a culture whereby all personnel understand the need to fulfill their responsibilities honestly and efficiently.

The internal control system needs to be monitored on an ongoing basis to ensure compliance with rules and procedures. It will be not possible to implement the control system successfully without an effective channel of communications as well as prompt and timely availability of crucial information about all significant activities that are relevant to decision making. Furthermore, the members of the Advisory Board and Senior Management must be qualified enough to be fully aware of the risks involved in health care and health insurance operation and should make the development of a risk management culture as an integral part of responsibility.
Funding of SHI Scheme and Fund Management Issues.

Since independence, the Government of Bangladesh has been carrying out various health care programs. A large network of health facilities have been established and a vast army of workers have been employed at the village level. Allocation of fund to the health sector is also increasing, albeit at a slow pace. But, this did not significantly improve service delivery except in few respects such as child immunization and reducing the incidence of some communicable diseases.

Today, the vast majority of people virtually remain outside the coverage of the health care services. The magnitude of health care services delivered per person is quite small, quality of care is poor, economic inefficiency in service provision is acute and inequity is high. The proposed pilot scheme, therefore has to address all these issues. The task is vast and surely ambitious. Yet, it is felt that if appropriate funds can be made available from different sources, there is no reason as to why the scheme can not be operated successfully.

It is obvious that the health sector requires much more fund than currently available if the Government wants to achieve the objective of “health for all”. Traditionally tax revenue and donors assistance are the two sources of public finance for the health sector. It is true that the taxable capacity of the people is limited and at the same time tax evasion is high. Therefore, the government is not in a position to allocate the required amount to the health sector. So, there lies a huge financing gap in the health sector. Unless, the alternate financing sources are found, the gap will widen, in which case, the sector will not be able to improve further.

User fee & co-payments

The government, is supposed to ensure better utilization of the existing fund and to look for other sources of financing for the health sector. One of the possible non-tax sources is the introduction of user charges. However, in a poverty prone sub-district, introduction of user charges will definitely further reduce access to health care for the poor and lower income group of the society. This would also enhance inequity.

An alternate to user fee, it is felt that community financing of health care services is much promising and can be used successfully. However, one problem of community financing is that it requires the existence of popular community organizations and dedicated community leaders.

Unfortunately in most cases leadership in rural Bangladesh is either in the hands of touts and corrupt people or in the hands of village politicians. Public leaders in many cases are not free from corruption. Therefore, one of the prime tasks for the operator before initiating the pilot scheme would be to find out the most ideal leaders as motivator and or the group leader of the local “Samity” (club).
**Private Insurance**

Some of the researchers in Bangladesh have opined that private health insurance and or quasi private health insurance seemed to be the best among the alternative sources of health care financing. This appears to be not true simply because private insurers are yet to develop appropriate product and could not penetrate even in the formal and urban sector. There is a long way, if and when private sector would be able to provide suitable health insurance products for the rural poor and the informal sector. Moreover, there is no persuasion by the Insurance Supervisor vis-a-vis by the Government so that the private insurers design and market their products towards the rural poor and disadvantaged groups.

The rural people and the poor people being not protected against the health and other risks, the broader segments of the population remain caught in a continuing cycle of vulnerability and poverty. At the same time, the most disadvantaged groups are facing increasing difficulties in accessing to health services.

**Aid & grant**

The resource gap can be bridged by appropriate inflow of foreign aid, or grant from development partners, donors and aid giving agencies. It is true that too much dependence on foreign aid is not a healthy sign for the economy, but under the present circumstances, Bangladesh needs it very badly. We need both technical and financial support.

However, it is apprehended that foreign assistance may not continue for long and this source will be not sufficient to meet the requirements. The donor agencies have expressed serious concern over the wide spread corruption in Bangladesh. In aid negotiations, the donors have made it point that continued assistance will depend on more effective anticorruption measures and if it receive the focus they deserve. This is extremely necessary, because corruption has a devasting impact on the poorest people in society, by denying them access to public services, since they are frequently unable to pay the necessary bribes.

The quality of services and the efficient allocation of resources are both adversely affected by corruption. The baneful effects of corruption are evident from the unprecedented crime, terrorism, violence and insecurity gripping society today. Corruption has brought down the ethical and moral standards of society by rewarding the corrupt, while discouraging the better elements who would uphold the noble principles of honesty, integrity and hard work. By eroding the moral fiber and tarnishing the country’s image, corruption has disturbed the stability of the present and future society. No foreign aid can help to bridge the gap unless we fight corruption by tooth and nail.
**Welfare contribution (Zakat & Sadaka)**

The resource gap can be bridged by raising local funds from individuals and institutions. In general, people of Bangladesh are poor, but a large section of the society is God fearing and love to help their near and dear ones in times of need. Although charity is not always spontaneous, it can be mobilized through organized efforts. For example, many Muslims make an annual welfare contribution (Zakat) on their savings and wealth, including cattle and agricultural produces.

Zakat is religious obligatory contribution to be paid once a year at the rate of two and a half percent, when an individual possesses the wealth of required value or quantity on which Zakat is payable. Normally, it is payable on agricultural produce @ 5% in case of irrigated land and @ 10% of produce from natural rain fed land. For gold, silver, ornaments of gold and silver, cash in hand or bank or trading goods the rate of Zakat is 2.5% when the wealth remains in the hands of the owner at least for one year, beyond a fixed amount of the wealth. Payment of Zakat is a means of keeping the wealth of the rich people clear of greed and selfishness.

Zakat is a compulsory payment and is neither charity nor tax. It has to be spent under fixed heading like helping the poor, the needy, to free captives and debtors, to win over hearts of fellow and for the cause of God. Zakat thus provides an opportunity to the God-fearing people of sharing their excess wealth with the less fortunate.

Zakat is one of the fundamental principles of Islamic teachings, which aim at the establishment of welfare society. In addition to compulsory payment of Zakat, Muslims are encouraged in the holy book (Quran) to make voluntary contributions to help the poor and needy and for other social welfare purposes. This voluntary contribution is called “Sadaka”. Zakat and or Sadaka has not been well organized in Bangladesh. Major portion of Zakat is contributed to the individuals in small amounts which do not help make them self reliant.

It is, therefore, necessary that Zakat and Sadaka be contributed to a common fund or to an institution or organization. The wealthy persons who are required to pay Zakat should be encouraged to pay Zakat to a welfare fund, which can be channelised to provide health care and or to meet health care financing needs of the poor. When the amount of Zakat is spent to meet the needs of the community in the same region from which it is collected, it will create a healthy feeling of solidarity between the rich and the poor of that region. The role of Zakat in risk management for the poor can be seen in Annex ‘D’ which briefly outlines the experience of a Zakat Centre in Malaysia.

**Local Funding/Alternate Government Resources**

Apart from compulsory Zakat payments, the resource gap can be bridged by receiving financial aids from different institutions as part of their corporate social responsibility. Non-Government sources such as corporate body, non-profit institutions, pharmacists, physicians, pharmaceutical manufacturer can come forward to
donate and or offer their products and services at subsidized prices. For example, physicians and health practitioners in the region may agree to offer their services to the poor people at a subsidized price or fee. Manufacturers and or Pharmacies can agree to sale medicines for the poor people at a reduced rate. Voucher can be donated by corporate bodies or the philanthropists. Role of private medical practitioners in Kolkata (India) may be an example for us, while using voucher. This may be seen in Annex-’E’.

Some NGOs are already providing health care services to common people at a reduced rate. They may be induced to become a partner of the SHI scheme and offer their services in a coordinated manner so that the operator of the SHI scheme can avail their experience, expertise as well as subsidized services to make the scheme sustainable.

Government has already built the required Thana Health Complexes, Health Centres and Community Clinics. It is an open secret that these are not being managed properly because of bureaucratic administrative problems. Salary structure and short of supplies has made these health care facilities a symbol of non-functional institutes. These infrastructures may be handed over to the operator of the SHI scheme in order to convert those as privately managed health institutions. If and when those infrastructures are handed over to the operator of SHI scheme, they will be paying for the doctors, paramedics, equipments, medicines on a regular basis and should ensure proper functioning of these health care facilities.

We shall have to realize that ultimate goal of the Government is to ensure health care for entire population. Since SHI schemes will be sponsored and supported by Government it would be better to utilize its limited resources in the best possible way. If we are to ensure optimum utilization and good governance of Government-run institutions, the best way would be to organize and manage those at the local level. The Government shall have to provide the infrastructure and equipments as it is and services to be contracted out to private-autonomous provider (operator).

Additional resources for the health sector can also be mobilized by diverting small fractions of the budget allocations of other ministries such as Ministry of labor, Ministry of Social Welfare, Ministry of Education, Ministry of Women & Children Affairs as part of implementing their program through the Ministry of Health and Family Welfare. These ministries normally are responsible for the welfare of labour, disadvantaged group of the society, students, children etc. There are many projects which are related to health. Therefore, there is no reason as to why these funds should not be mobilized to provide health care and health insurance through SHI scheme specially when the scheme is designed to provide universal coverage.

**Coordinated Efforts**

In Bangladesh, ILO launched a project named Womens Empowerment through Employment & Health (WEEH) to empower the poor women in Bangladesh by their access to decent employment, income opportunities and viable community health insurance systems and quality health care services. The funds for this project or similar other projects could rightly by used for SHI scheme to be implemented by the Ministry of Health. This means, the matter of health care and health insurance need to be implemented by a single governmental agency or Ministry.
When similar service is handled by several agencies in a piecemeal fashion, it is most likely that none of the agencies can give a full and final shape of the scheme for the betterment of the mass people.

The Government has a responsibility to implement plans, programs and projects in a more coordinated way and provide a permanent modality. Health is so important an issue that need to be implemented through a national integrity system. A well developed coordination mechanism would lead towards a potential and effective utilization of limited resources. Therefore, there is a need for a high powered consultative group in the Ministry of Planning, with several sub-groups of related issues, who should meet on a regular basis to find out the opportunities for coordinated and integrated mechanism of providing public services like health, health care, malnutrition, social insurance, security environment, mass education, social reform, corruption etc. The consultative group need to find out ways and means of an integrated approach to those national issues which are important and associated with the overall national growth of the country.

For example, health, disease, productivity, socio-economic development, quality of life index etc. are directly related and dependent on nutrition. Without an acceptable nutritional status of the population of the country at large, no nation can expect to be a healthy nation. Women and children are the major victims of malnutrition leading to high mortality and morbidity rates. In Bangladesh, every alternate child is stunted, every alternate child born with Low Birth Weight (LBW), more than 55% of women of child bearing age are suffering from chronic malnutrition, about 40% of them have iodine deficiency disorders and nutritional anemia and so on.②

May be the Ministry of Women and Child Welfare has plans and programs to address these problems. But ultimate responsibility lies with MOHFW. Recently in 2003 GOB has developed and approved the Health, Nutrition and Population Sector program (HNPS) under the Ministry of Health and Family Welfare. Therefore it is highly desirable that any project or scheme relating to malnutrition by any other Ministry be coordinated and channeled to Ministry of Health & Family Welfare.

When we are talking about SHI we need to focus on the problems of malnutrition and its impact on health, mortality, morbidity and related socio-economic effects. We must note that more than 55% of childhood mortality is directly linked to malnutrition②. In addition, malnutrition among pre-school children is associated with increase of morbidity, low i.q., lower learning potential, poor school performance, lower productivity in adulthood, socio-political unrest and so on. The nutritional status of young children is the most sensitive indicator of changes in food supply, availability/consumption, health services they enjoy and the overall socio-economic development. As a result, primarily child nutrition is being identified as the core indicator to monitor economic and social development.

① Awal A.M.M. Anisul-Nutrition. The Foundation of Health Development-2004
② Ibid.
A separate Directorate or Department under the Ministry of Health is not the right solution, unless an integrated system of fund mobilization is done to address this important national issue.

While Ministry of Education is providing free-education and providing fund for school teachers a small fraction of those grants may be spent for students health care also. We must prevent our children from malnutrition, otherwise, a large portion of resources will be wasted. The economic cost of malnutrition to the country is estimated to be more than two billion dollar per year. It is, therefore, advisable that Ministry of Education, Ministry of Women and Child Welfare should work together with Ministry of Health & Family Welfare to address this bulky adverse health situation manifested due to malnutrition.

It must be realized that 68% of the population are children and married women. Infant mortality rate and Maternal mortality rate are the two most important direct indicators of malnutrition and are unacceptably high among them. Hunger (Malnutrition) and ill health are interrelated. Both food and health related intervention are needed to change the food insecurity. The pilot SHI scheme in the poverty prone northern district shall have to address the issue of hunger and malnutrition. The burden of hunger and disease will take its toll on the vulnerable and the ultra poor people. The operator of SHI scheme shall have to address effectively both the issues in a scientific manner. We can not tell our people that we will provide medicine and health care services only when you are ill but unable to provide food when you are hungry. SHI scheme should be integrated with the food security & food fortification program of the local or central institutions for food, relief etc. GOB realizing the gravity of malnutrition, has already launched Bangladesh National Nutrition Program and National Nutrition Program. These programs need to be integrated with HNPSP.

Fund mobilization for health sector development ought to be given a priority and a single source would not be sufficient to meet the need. SHI operator shall have to coordinate with the agencies involved in providing food security for the household specially during the period of “Monga” (Adverse season, when people are unemployed and without earning). Although, SHI scheme is not meant for ensuring enough food at all time for all members in the household in order to be healthy, the pilot scheme should not ignore the hard reality of seasonal adversity of the local people. When we are talking about household food security, we mean access by all members of a household at all times to the food needed for healthy life contributing to controlling starvation, malnutrition and micro nutrient deficiencies.

It may also be noted that old age is basically a health hazard and need to be addressed by social insurance scheme. Government is providing old age assistance in a limited scale. The fund thus required to be spent for the purpose can also be diverted to SHI scheme and assistance of old aged people be channeled through SHI operator.
**Funding policies & sources**

It is evident that a single source of fund is not sufficient to meet the huge requirement, but when several sources are used simultaneously, fund mobilization for the health care purpose will be much more easy. Apart from fund mobilization from different sources, the SHI scheme operator shall have to ensure sound financial fund management. The operator of the pilot scheme shall have to demonstrate its openness to the public by providing with information about finances and its uses in the program.

Since donations and grants including compulsory and voluntary welfare contributions shall form an important source of financial support for the operator, they shall have to adopt proper procedure and guidelines to ensure honest and ethical fund raising policies destined solely for the causes of fulfilling its objectives. An appropriate guideline of fundraising policies may be outlined as follows:

a) All solicitation approach and materials should consist of accurate information and reflect the schemes mission and vision and intended use of the solicited funds.

b) The operator shall ensure that the donations and funds are properly managed and accounted for.

c) The operator shall ensure that the funds and donations are used in accordance with donor’s terms and conditions.

d) The operator shall not pay, seek or accept any donation related to any political party at any time.

e) The overall administrative cost compared to the operators annual expenses should not exceed 15% or an amount fixed by the Advisory Board.

While evaluating the problems and prospects of fund raising alternatives from Government and other sources, it becomes clear that proper monitoring of the scheme is required in order to analyze the financial sustainability, quality of services and size and composition of enrollment. Fund will be required not for fund’s sake, but for fulfilling the objectives and to ensure the scheme’s sustainability.

Initial funding will not be a difficult task. But that is not all. The funds raised initially be spent in right manner and in right directions. An important role of government at the initial stage should be to establish a framework for monitoring SHI scheme. An appropriate evaluation of the scheme should take into account of the design, total fund requirement to operate the scheme during the project period, size and strata of the population to be covered by the scheme, quality of the services and finally plans and strategies to ensure its sustainability.
Both government and the civil society have an important role to play in the
development of SHI. The overall objective should be to extend health care
financing to a wide cross section of the society in a pragmatic way. For this to be
successful, a true coordination of efforts is essential between public and private
organizations. Considering all these, a model of resource mobilization for the SHI
operator has been illustrated in Diagram D which emphasize that all the available
and probable sources be explored for fund raising.

![Diagram D](image)

**Diagram D.**

**Monitoring Financial Performance**
Whatever may be the sources of fund, it will be required mainly to subsidize the
project. Cost recovery at the initial stage of the pilot scheme will be insignificant.
However, in order to determine financial performance of the operator, it is necessary
to separate out and adjust the financial statements for subsidies provided, as if it
were operating with market debt and equity rather than donor funds. This will help
the operator to determine its financial viability when sponsors funds and or foreign
donors funds will be unavailable. The operator will initially require two types of
donated funds viz (a) funds donated to cover operational costs and donations in
kind; (b) donated equity (revolving fund) which will be invested for generating fund
to provide subsidies.

Funds donated to cover operational costs are a direct subsidy to the operator. The
value of the subsidy is, therefore, equal to the amount donated to cover expenses
incurred during a period. When donations are received to cover operating shortfall,
over a period greater than one year, only the amount spent in the year is to be
recorded on the income statement as revenue. Any amount still to be used in
subsequent years to be shown as a liability in the balance sheet as deferred revenue.
Donated funds for operations need to be shown on the income statement separately
from contributions received from the participants in order to reflect the accurate
earned revenue of the operator. These donated funds should be deducted from revenue or net income prior to any financial performance analysis, because they do not represent revenue earned from operations.

When funds are donated in kind, such as free space, office building equipments, medicines, vouchers (instead of cash) ambulances, these need to be treated as subsidy to the operator and should be recorded as expense on actual use basis. This will truly reflect the true level of expenses that would be incurred if the operator was to operate without any in kind donations. Funds denoted as equity be treated in the balance sheet as an increase in equity (fund capital) and an increase in assets (investment).

Donations for fund capital differ from donations for operations in that the total amount received is meant to be used to fund assets rather than to cover expenses incurred. Donors will not be looking for any return on their funds nor they will be expecting to receive the funds back. However, they are interested to see that the operator can maintain the real value of the donated funds, relative to inflation, so that it can continue to provide subsidies and premiums required to be paid on account of poor participants even with the increase in cost of health care and health insurance.

Therefore, the argument goes that donations for fund capital need to be adjusted for increase in future costs of operations and not for subsidies. It is advisable to increase equity at a rate at least equal to the rate of inflation, if the operator is to continue funding its portfolio out of this. The operator should adjust for inflation on an annual basis on the prevailing inflation rate during the year, regardless of whether the level of inflation is insignificant, because the cumulative effect of inflation on the equity of the operator can be substantial. To account for the devaluation of equity caused by inflation, the prior year’s closing equity balance should be multiplied by the current years inflation rate. The amount thus arrived at is to be treated as operating expense on the Statement of Accounts.

An operator of SHI scheme can not rely 100% on donor funding for an indefinite period to subsidize its operations. An operator also can not expect to achieve 100% financial self sufficiency, because the scheme is designed to subsidize the cost of health care and health care funding for the disadvantaged groups of the society. However, one of the prime objectives of the operator would be to achieve operational self sufficiency as far as practicable within the shortest span of time.

So long the operator is not financially self sufficient, the Subsidy Dependence Index (SDI) can be calculated to determine the rate at which the participants contributions be enhanced, if and when feasible. The SDI measures the degree to which the operator relies on subsidies for its continued operations. This index will help the operator to calculate the extent of subsidy is required. The objective of the SDI is to provide a comprehensive method of assessing and measuring the overall financial cost involved in operation and quantifying its subsidy dependence for tracking over time and to make the scheme sustainable and viable.
Suitability & Modality of Solidarity SHI Model

Organization
While providing social health insurance, different type of institutions may be better positioned to perform certain activities than the others. We have suggested for a community based third party administrator (operator) on the principles of brotherhood & solidarity considering its relative strengths in performing the activities required to design, monitor and deliver appropriate health care and insurance services for the household members.

Community organizations in most cases are the most trusted institutions for most low income households. Representation of the local households (through the leaders/motivators) in general body of the operator, it is believed will lead to a greater understanding and integration of household’s needs. Furthermore, group insurance against less frequent, high cost risks can be made available for these pre-established groups at the least possible costs.

It may be noted, however, that almost all the weaknesses of a community based health operator has been addressed appropriately. For example, in one sub-district there will be at least one local association for approximately 100 households. The leader of each group will keep liaison with the operator and shall act as agent of the operator. As a result, the weaknesses of limited geographical scope and small client base per unit (group) have been overcome.

Since small groups can not attract interest of commercial insurers, approximately 50 to 100 groups in one Upazila will be pooled together to get insurance cover for them by the operator. The operator in this case will buy and provide appropriate insurance cover for the entire population. This will also enable the operator to have greater access to required financing and thus the operator can provide services to entire community including the ultra poor.

Operation
The operator of the scheme will act as independent, non-government, non-partisan and non-profit organization with a vision & goal. The advisory body of the operator will be constituted from representation of the community groups (leaders of local community), government (U.N.O), politicians (member of parliament) civil society (teachers, imams traders, professionals); local government bodies (chairmen/members of Union Parishod/ Upazila Parishod/ Municipality).

The mission of the operator is to promote and develop local groups of households (°v°™ev mwgwZ) to organize and arrange participatory social health insurance scheme and establish an efficient and transparent system of governance.
The operator will provide the framework of guiding principles and practices aimed at ensuring highest standard of health care services and health care financing mechanism. Through a participatory process, the operator will develop need based action plans which will be implemented by a small team of management committee comprising professional manager/insurance professional, full time qualified community physicians, paramedics and health care volunteers.

**Service Delivery**

Based on the preliminary assessment of different models, it has been suggested to follow the “partner-agent” model of service delivery with established private insurers and non-government health care provider. In this case, the operator will act as distribution channel of health care provider and health insurer. It will organize groups, assess need and also pool the risk, collect contributions from households and other sources. When the operator act as agent of the insurer, it takes on none of the insurance risk, but is able to provide the benefits of insurance to all its household members.

This model allows the institutions involved (health care provider and private commercial insurer) to specialize and focus on tasks they know best and “doing what they do best”. This will be beneficial for the health care provider, insurer as well as the operator. The operator will not be required to hire actuarial experts for product design and fixation of premium and to build up reserves for meeting future liabilities. On the other hand the private insurer will get the benefit of large scale group with little or no expense for sales, marketing and servicing.

In Bangladesh, private insurers have not developed health products for low income group. This model of partner-agent service delivery will give them an opportunity to develop and provide a comprehensive health/accident/life insurance product for the rural poor.

Providing social health insurance for the informal sector will be extremely difficult for the government. Lack of experience and lack of good governance of a government institute will make this scheme not viable through public body. However, government can play an active and positive role by framing appropriate insurance regulation so that the private insurers are motivated and encouraged to develop suitable micro health/accident/life insurance plans for the rural poor.

The government can also transfer the management and operation of the existing clinics, dispensaries and the Upozila health complex to the operator or to a designated health care provider for the purpose of service delivery to the community.

Non-government Organizations have proved themselves as most trusted type of institutions for most low income households. Therefore NGOs like Gono-Sasthya, BRAC, Grameen, Plan International and others can act as partner of the operator. Household members will get health care services from the
outlets of these NGOs or from the Govt. infrastructures to be managed by operator/designated NGO.

Furthermore, in order to ensure service at the door step, the operator itself or the health care provider should have number of fully equipped ambulances. These ambulance alongwith professional medical practitioner, paramedics and technicians should visit on a regular basis (preferably once in a week) to the community clinics or to certain place of Union/Village or Club/Bazar to provide consultancy and primary/educative/preventive and curative health care services.

**Types of Coverage**

Usually micro health insurance non-government agencies provide a limited coverage mainly because they do not have sufficient fund and or they lac the mechanism to provide a wide range of health insurance cover or health care services. They feel that gradually they will increase the range of benefits with more complete risk management services. They feel that it is easier to steadily build on small success.

The arguments seems convincing but not free of its loopholes. The very mechanism of insurance require large number of exposures to apply the “law of large number”. When an institution can offer a wider range of services, it can attract a larger segments of the society. Different groups of people require different types of coverage according to their specific need and ability to pay.

Ideally in a social health insurance scheme an uniform coverage for all members need to be provided. However, in order to persuade each and every household owner to be a member of the scheme, it is advisable to offer a complete health and health related insurance protection covering curative health care, limited hospitalization cost, dread decease cover, personal accident risks (including total and partial disability) and small group term life insurance cover. The product should be designed in such a way that an uniform cover is given to all under the scheme, but additional top up cover can be extended to those who can afford to contribute more or when additional funds are available to subsidize the cost for ultra poor or vulnerable poor.

We are convinced that small coverage of personal accident and or term life insurance along with micro health insurance will be extremely helpful. Personal accident and or term life insurance (payment against death only) risks are low in frequency but may be catastrophic to low income household members when the breadwinner expires as a result of an accidental injury and or caused by illness leading to a total or permanent disability. This type of insurance cover is less costly and likely to be affordable by a large section of the target group.
Funding
It is understood that initial funding of the pilot scheme is the responsibility of WHO. However additional funds will be required for operating expenses, capital expense as well as for creating a Capital Fund. Capital fund will be used as revolving money for generating income to subsidize the poor and ultra poor. It is expected that the nobleness of the project and its unique operational mechanism will help to attract different aid giving agencies.

Contribution from the participant members will be very insignificant say approximately 10% to 20% only. But over the years, the amount of subsidy need to be reduced gradually by increasing the cover net and raising co-payments/user fees. The target ought to be to reduce subsidy by 5% annually over 15 years. This will turn the project near to self sufficiency and approximately 20% subsidy will be ultimately required from the Government/donor.

Apart from initiators fund, we have suggested for grants and aid from government and non-government sources. Charitable funds by way of contributions from well off people of the society and “vouchers” to be donated by corporate bodies. This will help to build up fund capital to be used as subsidies.

Funds can also be raised by creating savings scheme for the members. Members may be encouraged to save a small amount say one taka per day. A person saving one taka per day for fifteen years will get back say ten thousand taka. A person saving say two taka per day for eight years will get back taka ten thousand and so on. The savings will generate fund and can be used to provide loan or deduction for payment of members regular contribution to the operator.

Rather than accepting intermittent payment of contributions from default household members, the operator can deduct premiums on an annual basis from the funds accumulated in the Target Savings Account. When members can accumulate funds, they may be in a better position to afford top up voluntary insurance protection and pay required premium for the purpose.

Partnership
An important step in the process of implementation would be to look for partners. A private established insurance company can be a partner for providing group insurance cover. An appropriate agreement need to be signed regarding risks to be covered, mode of payment, procedure for settlement of claims etc. The policy wording should be clear and concise and covers ought to be flexible.

A second partner under the scheme can be a health care provider having experience, expertise and commitment for rural micro health care and health care financing. A detailed terms and conditions of services to be offered, quality of services to be maintained and procedure of reimbursement from the operator need to be formulated.
The GOB can be an effective partner of the scheme through funding and commissioning the pilot project. Public-private-NGO-community partnership is extremely essential to ensure access to health care services at the grass root level. This will improve health care services delivery through the already established and to be established community clinics.

SHI services can be easily adopted if the public private partnership can be formed and when the structures are handed over to the operator for delivering services through NGO as facilitator. This will ensure decentralized management practices, local level planning, resource pooling, stake holders participation, targeting the poor and subsidizing the ultra poor. It is expected that such a public-private-ngo community partnership will ensure viability of the SHI scheme by making optimum utilization of available public, private and donors resources.

**Governance Manual**

In order to catalyze and strengthen a participatory social health insurance scheme and establishing an efficient and transparent system of governance, a manual need be prepared based on the vision, values and mission of the scheme. The Manual should be a living guideline document to provide the framework of principles and practices aimed at ensuring highest standard efficiency, integrity, accountability and transparency in governance of SHI pilot scheme.

The SHI Governance Manual should consist of the rules and procedures for composition, tenure, turnover of the Advisory Board. It should also state clearly the powers, roles and functions of the members of the Advisory Board. The members of the Advisory Board will work on voluntary basis and therefore, will not be entitled to any form of salary, honoraria or compensation. They will be acting as trustees of people’s fund and no portion of the assets, income or any other funds shall inure to the private or personal benefit of any member or to any immediate family member thereof, who shall also not be entitled to any form of gainful employment of the operator.

The members of the AB should be firmly committed to take all possible measures to prevent actual, potential or perceived conflict of interest that could affect the integrity, fairness, transparency and accountability of the operator. A “code of ethics and conduct” can also be framed for the AB members and staff of the management committee. The code of ethics may be annexed to all contracts of appointment and signed by the incumbents.

**Sustainability**

Generally, households are slow to understand the concept of social insurance and are reluctant to commit for paying regular contributions for an uncertain benefit. The benefits of insurance need to be publicized in the widest way so that at least 50% of the target households enroll themselves and make regular payments. This is a necessity for long-term sustainability of the scheme. Publicity through audio-video materials, miking, social gathering has to be done on a continuous basis. Mass media publicity program has to be an integral part of the day to day operational activities.
The members of the AB must realize that if the seed money is withdrawn or exhausted, the sustainability will be in question. To ensure sustainability, the members should make a list of rich people of the locality and mobilize them to donate funds as Sadaka, Zakat or charity for the survival of the scheme. The members should exert all out efforts to mobilize and receive donations, contributions, grants, gifts and undertake any other means of raising funds from persons or institutions in the interest of achieving the objectives of the SHI scheme.

The members of the AB individually and collectively shall ensure that the operator has sufficient resources to satisfactorily fulfill its mission. The Board should develop fund raising plan & strategy and should take active part in implementing the same. It should regularly analyze outcome of operational activities, impacts and risks and should develop risk management strategies for promotion and sustainable growth for all the times to come.

**Launching**
Providing health care and social health insurance poses many challenges for the operator. Despite the schemes philosophy of providing self help mutual cooperation and cross subsidies for the poor, people in general will expect some material support from the project. They will be more interested to see some immediate tangible gain. Therefore, the process of providing services and gaining support of the community is likely to be slow. Since the people in poverty prone sub-district might have habitually received relief materials very often, it will be very difficult for the villagers to believe that material support would not be forthcoming from the project.

Moreover, the mechanism of social health insurance is likely to be misunderstood, because, insurance has a negative image in the society. It will require lot of literature, group meetings, miking, posting, alongwith exhibition of video, drama, musical soiree etc. to sale the ideas and philosophy of the project. However, before embarking upon publicity and propaganda for the pilot scheme, it would be necessary to undertake a detailed feasibility study. The base line survey in a sub-district give us an overview of several aspects, but can not be treated as final and conclusive findings for implementation process. (Summary of findings of the base line survey can be seen in Annex-A)

**Cost based feasibility study**
Each sub-district and each village is different and its requirements are also unique. Therefore, to put forward a standardized approach for piloting the scheme would be impractical. What the people really need, when they need the services and what are their perception about the scheme need to be studied on a systematic fashion. This is simply because health is crucially linked with the economic, political, environmental, cultural and social factors characterizing the people of a sub-district.
Therefore, before launching the scheme and formulating plans and policies for the scheme, it is necessary to assess the operational costs involved in the process. Operational cost of the project will depend on several factors such as:

a) Socio-demographic and economic levels of all the households.
b) Occupational category of household owner.
c) Distribution of household income based on different income group.
d) Distribution of household by disease category.
e) Distribution of household by types of health care services used.
f) Levels of expenditure incurred by households receiving health care per patient.
g) Distribution of population by the sources of treatment.

Detailed survey should include all the relevant aspects of all the households viz the target population group. The target of the scheme should be to have sufficient number (say 40%) of households enrolled before the scheme begins its operation for a group. A preliminary survey was conducted at Jaldhaka Upozilla of Nilphamari district has been conducted and summary findings is enclosed in ANNEX-A.

In Bangladesh, a high proportion of the rural and urban poor, particularly women and children do not have enough access to public health care facilities. Those who do have access receive little care and in most cases, they are not satisfied. As a result, it has been estimated that around 25% of the households seek treatment from these facilities. There are also many villages having no health care facilities at all. The villagers are to depend largely on quacks, traditional practitioners and other indigenous sources. People in general are not conscious about health issues. In cases of minor illness, they do not feel for going to doctors. In case of serious illness, they need to go all the way to Upozilla Health Complex or to a district level hospitals.

Bangladesh has signed up for “Health for All” and, struggling to achieve universal health coverage; trying to remove the rural-urban, poor-rich and gender biased inequalities; creating provisions for health care financing of rural population particularly to the poor. This has become difficult for the government and this is the major challenge of the health sector reform.

In order to address this major problem, we have suggested for implementation of an appropriate social health insurance scheme for a poverty prone sub-district of northern Bangladesh. The scheme has been designed in such a fashion, so that it proves to be sustainable and can be replicated gradually in other sub-districts and thus can cover entire population of rural Bangladesh. The model we have suggested has been based on the experiences of community micro health insurance operations by NGOs and public-private partnership model practiced in Bangladesh and other neighboring countries.
The model has been termed as “Solidarity Model” to reflect the inner spirit and idea of social insurance mechanism. This model, when implemented in its right spirit and as per guidelines provided in the study, we expect that it would be a milestone ahead to achieve the most desired goal of “health for all” within the short span of time (say fifteen years).

The last health sector program (HPSP) had been optimistic with expectations that community level Essential Services Delivery (ESD) outlets would be set up and run solely by the public sector and managed effectively. It has been alleged that the so called community clinics in most cases are misused and or not used at all for the purposes those were built. Management of Union Health centres and Upozilla Health Complex are also not up to mark and government alone can not ensure optimum utilization of these infrastructures.

Under the present circumstances, it is evident that public-private-NGO-Community partnership will help to provide health care services thorough community based health groups with the resources available. The solidarity model of SHI will provide an integrated operation, which places considerable importance on the involvement of local people in developing and implementing the project.

Integrating local people and local government institutes in health sector is possible only through a public-private-NGO partnership concept of SHI. This will help to make optimum use of available public and private resources. NGOs already involved in this sector, can play an important role for facilitating development of public private partnership. If and when this scheme is operated, it will ensure a cost effective affordable care through a wide safety net of poor otherwise they can not afford to access health care services through their own resources.
**Concluding Remarks and Recommendations**

Health insurance serve as a response to financing the access of individuals to health care. It is, therefore, logical to expect that health insurance scheme of a country like Bangladesh be treated as a social security programme and should be planned within the framework of an overall national health plan. Health Insurance need to be developed as a stable mechanism for financing personal health care.

Health insurance plans are highly susceptible to abuse through adverse selection and moral hazard. The requirement that policy holders enroll as a family reduces adverse selection to some extent. By enrolling entire family, a mix of high and low risk users within the insurance pool is created. However, policyholders can also abuse health insurance plans by attempting to obtain treatment for non-family members. This can be protected by providing photo-1D cards. Before receiving the insurance benefits, policyholders should present their valid photo-1D card.

We need to have an enabling framework for development of health insurance. In this respect the government has a key role to play in different areas. For example, legislation is required for the introduction of compulsory insurance. Successful introduction of health insurance requires the development of a range of management and administrative skill so that the health insurance system can function effectively. It is also necessary to establish a framework for monitoring the different health insurance schemes. A strong and effective regulatory structure is required for ensuring a quality and transparent system.

The regulators must realize that the insurance system, whether private or public, must strike a balance between economic efficiency and equity. This will help gaining social acceptability of private health insurance. Furthermore, the regulators must ensure financial stability of the insures and the integrity of insurance contracts.

The concept of a new social insurance scheme for Bangladesh need to be developed, because the government can not embark upon this responsibility alone by itself. The scheme should be State sponsored, community based and to be operated by independent quasi-government organization or friendly societies or micro credit operators. Co-operation between the government and non-government organizations will be required to provide social health insurance schemes through non profit institution.

It is felt that establishment of a single comprehensive system of social health insurance due to sickness, disability, premature death, etc. would prove to be economic and attractive. Social Health insurance should cover all the family members within the defined age limit. The proposed comprehensive group social health insurance system would bring simplicity and economy in operation. The cost of group comprehensive cover will be less in relation to the return to be anticipated in protection.
In order to make the social insurance (health and personal accident) schemes viable and effective, specialized insurance organization may be set up by GOB and NGO collaboration. The prime objective of the specialized organization should be to extend risk pooling to a wide cross section of society and offer comprehensive products with flexibility.

To popularize health insurance schemes, some effective mechanism should be evolved in order to create public awareness. The NGO’s may play a significant role in this respect. Proper motivation and publicity is necessary to make common people aware of the benefit of health insurance scheme. The operator should chalk out various pragmatic programmes in this respect.

Based on in-depth study, a policy framework has to be developed for introducing social health insurance by reaching to a consensus and steps should be explored to increase the public health expenditure by increasing and rationalizing the allocation of national budget. We shall have to adopt appropriate legislation for introducing SHI as an alternate to health care financing.

Health insurance requires specialist actuarial skills to undertake the complex calculation for pricing. Reaching a sufficiently large pool size of the right mix of risks is critical to ensure that there are sufficient funds to pay claims; particularly for new schemes, when lack of underwriting experience could endanger solvency. In the initial years of operation, high start up cost, and small market base is likely to lead losses, which acts as constraint for future growth. While premium need to be kept affordable, the pilot scheme need to ensure the long term financial sustainability.

In order to overcome the situation, a sufficiently large pool size is required to justify the substantial resources to market and administer appropriate product to a largely uneducated, half educated and skeptical diverse population. Establishing a sustainable and viable, health insurance scheme is almost impossible in the short term. Therefore, there is a need for a large capital base and donor contribution in the initial years to give time for building the appropriate infrastructure and ensure the number of policy holders at the maximum possible. Otherwise, financial constraints will hinder smooth growth of the scheme.

Maintaining the credibility of the organization is paramount in ensuring that people have faith in the protection promised. The organization(operator) need to be accountable and transparent in its operation and employees need to be adequately paid to deter corruption and high turnover. In an environment, where corruption is in highest scale, there is very little trust in any institution. This is more a problem in the informal sector where the poor have no rights at all and are constantly manipulated by village touts and social elites.
It is felt that participatory independent non-profit organizations be created, which need to be based on the principles of brotherhood & solidarity. This would ensure better quality and more equal access to medical services for the poor. Mutual or group insurance service provider and community-based Health service providers, perhaps can combine the concept of insurance at low cost and mass participation of the poor.

Different coverage for different premiums can bring in people at the lower level with a view of encouraging them to take on additional coverage for additional premium later on. There should be continuous product development (inclusion or exclusion of risks) and innovation to meet the emerging needs, lifestyles and habits of the poorer classes and the rural sector. In this respect, flexible payment systems would allow them to pay when and how much they can.

We need to have a right match and mechanism to achieve the two conflicting desire; mass participation as well as closer distribution relationship. By creating community spirit and organizing the poor in small groups to access necessary services we can overcome the dilemma and this will ensure the schemes affectivity and efficiency. Voluntary small organizations need to be created for integration into a large scale insurance mechanism.

In Bangladesh, a high proportion of the rural and urban poor, particularly women and children do not have enough access to public health care facilities. Those who do have access receive little care and in most cases, they are not satisfied. As a result, it has been estimated that around 25% of the households seek treatment from these facilities. There are also many villages having no health care facilities at all. The villagers are to depend largely on quacks, traditional practitioners and other indigenous sources. People in general are not conscious about health issues. In cases of minor illness, they do not feel for going to doctors.

Bangladesh has signed up for “Health for All” and, struggling to achieve universal health coverage; trying to remove the rural-urban, poor-rich and gender biased inequalities; creating provisions for health care financing of rural population particularly to the poor. This has become difficult for the government and this is the major challenge of the health sector reform.

In order to address this major problem, we have suggested for implementation of an appropriate social health insurance scheme for a poverty prone sub-district of northern Bangladesh. The scheme has been designed in such a fashion, so that it proves to be sustainable and can be replicated gradually in other sub-districts and thus can cover entire population of rural Bangladesh. The model we have suggested has been based on the experiences of community micro health insurance operations by NGOs and public-private partnership model practiced in Bangladesh and other neighboring countries.
The model has been termed as “Solidarity Model” to reflect the inner spirit and idea of social insurance mechanism. This model, when implemented in its right spirit and as per guidelines provided in the study, we expect that it would be a milestone ahead to achieve the most desired goal of “health for all” within the short span of time (say fifteen years).

Under the present circumstances, it is evident that public-private-NGO-Community partnership will help to provide health care services thorough community based health groups with the resources available. The solidarity model of SHI will provide an integrated operation, which places considerable importance on the involvement of local people in developing and implementing the project.

Integrating local people and local government institutes in health sector is possible only through a public-private-NGO partnership concept of SHI. This will help to make optimum use of available public and private resources. NGOs already involved in this sector, can play an important role for facilitating development of public private partnership. If and when this scheme is operated, it will ensure a cost effective affordable care through a wide safety net of poor otherwise they can not afford to access health care services through their own resources.

In Bangladesh, much of the population is rural and working in the informal sector. Traditional government led social security schemes are not generally appropriate for these groups because of the difficulties in identifying contributors and assessing and collecting contributions. However, the government, N.G.O., private sector insurer and community institutions can work together to extend coverage to these groups. Developing the scope for civil society organizations including consumer bodies, cooperatives or mutual organizations can be effective.

In order to make the system more attractive and acceptable by the people, the contributors should have some form of participation either through designated representatives or through an elected body. Participatory management approach of the social health insurance scheme can give a special impetus and help to create oneness with the organization. Community mobilization also helps to remove the barriers of demand side.

Both Government and civil society organizations have an important role to play in the development of social health insurance in Bangladesh. The overall objective is to extend risk pooling to a wide cross-section of society in a pragmatic way. For this to be successful a true partnership of public and private organizations is necessary to promote piloting of voluntary community based health insurance schemes. This is simply because of the structural diversity of the Bangladesh population, which is not conducive for unique social health insurance in Bangladesh.

Management of health insurance programme requires greater level of technical expertise. It requires specialist actuarial skills to undertake the complex calculation of pricing. Therefore, it is important that community health insurance providers create a strategic partnership arrangement with the private commercial health insurer. This will help the SHI provider to expand the areas and levels of insurance coverage at the least cost.
A large number of participation is necessary for more reliable prediction. One of the basic requirements of an insurable pool is that the losses can be sufficiently predictable so as to calculate the premium accurately. The basic objective of social health insurance is to secure access to basic health care for all at an affordable and subsidised price. It is therefore, advisable that all members of the society should be entitled to health insurance benefits.

If the government is keen to ensure health care for all, political commitment is of prime importance. An appropriate policy framework leading towards enactment of law for social health insurance is essential. This would provide equitable health benefits to all regardless of the level of income and contribution as premium. While S.H.I. is a promising alternative financing mechanism, it cannot be the only solution to bring the financial gaps for resources required. The government should explore and ensure health care for the poor through various means of financing.

Appropriate internal control and management system need to be developed for a viable S.H.I. scheme. The organization need to be accountable and transparent in its operation and employees need to be adequately paid to deter corruption and huge turnover. Participatory independent non-profit organization based on the principles of brotherhood and solidarity need to be created to enhance trust and confidence among the people.

While the pro-poor orientation is the prime objective of SHI, cost recovery from the users will be easier, if the insurance scheme can bring in its fold more of the better off people as members, as their contributions will be higher and health status would tend to be better than the poor people. This will help to minimize the claim costs. Therefore, it is necessary to ensure that all the groups of the society participate in the scheme equally and equitably. While the poor people cannot pay the required premium, it would be necessary to build up a revolving fund and generate earning out of that fund to subsidise and or to pay the required premium.

It is felt that demand side financing can offer greater potential for government and donor agencies to attract the poor people. It can also pave the way of establishing link between government and private sector. Although, there is little or no experience of demand side financing in health sector, it is recommended to explore this method, because of its simplicity and because the fund is channeled directly to the beneficiary.

It is necessary to establish a legal and regulatory framework for monitoring community based health insurance scheme. This is required for ensuring a transparent system as well as to maintain financial stability of the micro insurers. An effective regulatory body will help to maximize participation of the people and facilitate a sound mechanism to serve the best interests of the insured and the insurer.

It has been suggested that Upozila Sasthya-Seba Samity (USS) will act as operator, who will work on the principles of voluntary participation, solidarity, and risk pooling of members. By paying contributions, (subsidy for majority members) the members (family unit) will receive from the group as a whole financial aid when a risk materialises.
USS will be operating as a non-profit voluntary association of people on the basis of solidarity between all its members. By means of its member’s contribution and based on the grants, donations and charities received from individuals, institutions, the operator will organize health care and insurance services against risks relating to health, personal accident, consequences and promoting health education.

The function of the operator is to provide appropriate insurance, health care, mutual assistance and related services to its members. However, the operator should initially offer only a limited number of services. Once it has built up experience and set up a strong management system, it can then, if appropriate increase the areas of services offered.

The services which need to be provided by the operator should include:

a) Information on health, health care and nutrition.
b) Information on members rights and obligations
c) Health risks awareness and prevention campaign.
d) Providing health care at home, health centres, hospitals, pharmacies, mobile ambulance etc.
e) Reimbursement of medical expenses and payment against accident and disabilities.
f) Financial assistance to elderly ill or disabled persons.
g) Preventive care and health education.

The operator shall pay directly to the service provider and insurer. The operator must as far as practicable have competent and honest professionals and staff and the Advisory Board must closely monitor its performance.

In the process of establishing a viable solidarity model of social health insurance scheme, the operator shall have to organize meetings to raise awareness and motivate people. The operator also need to create a positive attitude of local authorities and bodies, whether political, commercial, social or religious.

The calculation of contribution shall have to be based the estimate of the frequency that the risk of illness materializes and costs of treatment. Since, there is little reliable data available to make accurate estimates, the amount of contributions to be calculated, will be imprecise. It is therefore, essential to closely monitor contributions and the cost of benefits in order to make necessary adjustments.

If the SHI scheme is to play an effective role in sharing risks between the members, the number of members must not be too small. The desirable increase in the number of people protected also allows economies of scale and provides for greater negotiating power. Therefore, it necessary that the scheme be operated initially at least in one or two sub-districts and be gradually increased to adjacent sub-districts.