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INTRODUCTION

REVIEW OF LITERATURE

NEED/IMPORTANCE OF THE STUDY

STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESES

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

CONCLUSIONS

SCOPE FOR FURTHER RESEARCH

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- Bowersox, Donald J., Closs, David J., (1996), "Logistical Management." Tata McGraw, Hill, New Delhi.
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- Garg, Bhavet (2011): Towards a New Natural Gas Policy, Political Weekly, Viewed on January 01, 2012 http://epw.in/user/viewabstract.jsp

HEALTH INSURANCE STRUCTURE IN BANGLADESH: A QUALITATIVE ANALYSIS

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ABSTRACT

Health care financing issues remain a key agenda in global health policy. Rising health care costs and the large share out of pocket expenses appear as among major hurdles for the poor to break out of poverty. The study shows the current formal and informal insurance structure in Bangladesh. Thus it reveals the scopes we have in developing economy like Bangladesh. The study has been carried out mostly on the basis of secondary sources of data on total health expenditure extracted from Bangladesh National Health Accounts, 2013. Others relevant data's have been extracted from Ministry of Health and Family Welfare, World Health Organization, Institute of Microfinance (InM), Different Insurance Companies websites. The study found that there are different types of health insurance in Bangladesh like Social Health Insurance, Micro Health Insurance, Private Health Insurance, Voluntary Community Insurance, and Medical Savings Accounts etc. It also gives us idea about the insurance scheme, types of disease they cover under their insurance policy and how much money they are collecting and paying to the policy holders. Based on this analysis it can be forecast that the government of Bangladesh will have to face tough challenges for providing formal health insurance to the poor. Recommendations for policy reforms in revenue collection, provider payment, autonomy of public providers, and the management, regulation, accreditation, and purchasing of health services are given.

KEYWORDS
Health Expenditure, Health Finance, Universal Coverage, Insurance Plans.

INTRODUCTION

A post-Millennium Development Goals agenda for health care in Bangladesh should be customized to encourage a second generation of health-system innovations under the clarion call of universal health coverage. This agenda should draw on the experience of the first generation modernizations program that underlie the country's remarkable health achievements and creatively address future health challenges. A realistic reform agenda for achieving universal health coverage in Bangladesh should include development of a long-term national human resources policy, establishment of a national insurance system, building of a health information system, and creation of a ministerial council on health. Greater investment to implement this reform agenda offers wills certainly the prospect of a stronger, sustainable, and equitable health system.

The most recent World Health Report puts greater emphasis on the country's health financing mechanisms in order to ensure universal coverage (WHO, 2010). Spiral health care costs and personal expenses appear as among major obstacles for the poor to wriggle out of poverty. Consequently, poverty reduction strategies within the view of the millennium development goals (MDG) demand a review and possible reforms of health care finance so as to arrest the growing insolvency on account of health hazards.

While primary health care services in Bangladesh, as in the most third world countries, are meant to be free, but in reality the poor sector of our society do not get proper treatment for lack of inadequate infrastructural facilities. As a result, they end up paying directly for most health services from the private and informal sector. The disproportionate reliance on out-of-pocket payments (OPP) represents a most regressive way of financing health care expenditures. Consequently, despite significant progress in health indicators, greater inequities in the access to health care still exist in Bangladesh.

In 2008, a total of $5,794 billion was spent on healthcare with an average of about $864 per person, of which government provided $3,503 billion constituting about 62% of total spending on healthcare services (WHO, 2010). Both out-of-pocket payments and private health insurers played equal roles to pay for the rest of the healthcare expenditure. In 2008, globally $1,034 billion was paid out-of-pocket in healthcare, averaging at about $523 per person (WHO, 2010). Private health insurance companies provided another $1,014 billion (WHO, 2010). Both these sources provided about 18% of the total healthcare expenditure in 2008 (WHO, 2010). Non-profit sectors (e.g. charities) and external sources (e.g. foreign donations and grants) played a minor role in overall healthcare financing globally. Thus, across the globe, estimates suggested that private health insurers provided much less than the government in overall healthcare expenditure while they were almost at par with private out-of-pocket healthcare payment.

Although the direction, speed, and scale of these 21st century challenges are obvious, the question is whether Bangladesh's health system has the capacity to respond appropriately, efficiently, rapidly, and equitably. The existing system of health-sector financing further hampers progress. Although Bangladesh currently spends about US$67 per head on health (adjusted for purchasing power parity), trends in national health accounts data suggest that the Government's share of total health expenditure is falling, from 36% to 26% between 1997 and 2007 (Government of Bangladesh, 2013). By contrast, private expenditure is larger ($32 per head) and has grown as a share of total health expenditure from 57% to 64% during the same period (Government of Bangladesh, 2013). This growing privatization of health financing, mainly through out-of-pocket expenditure, is both inefficient and inequitable. Roughly 4–5 million people per year are pushed below poverty line because of healthcare costs in Bangladesh, with millions more—especially poor people—deterred from seeking care (Government of Bangladesh, 2013).

SIGNIFICANCE OF THE STUDY

The study is very relevant as it will show the current structure of formal and informal insurance policies in Bangladesh. However it is important to study the existing structure to recommend for a new one. The purpose of this study is to fill the gap by finding the offerings we have in developing economy like Bangladesh. This will also contribute to knowledge and serve as a framework for government policies with a view to providing insurance scheme to the entire nation and achieve universal health coverage.

EMPIRICAL REVIEW

As Arrow (1976) had remarked, if the co-insurance exceeds 25%, the insurance principle, namely risk shifting, is lost. The point is that even 25% of a large bill may be so burdensome as to push the household below the poverty line or deeper into poverty. It is implicit in this arrangement that while bulk of the risk will be shifted in the process, a small share (typically 25% or less) is to be borne by the insured entity in order to minimize the chances of moral hazard (Arrow 1976).

Chowdhury has pointed out that launching of Health Insurance has added a new dimension to the Health Care Services in Bangladesh. Since Health Insurance is a valuable mean of getting Health Care Services for the fixed income groups, within a period of 4.5 years, Group Hospitalization Insurance (GHI) has been able to attract around 6000 clients. Amid of severe political unrest, mass unawareness of prospects, general apathy towards insurance, various fraudulent attempts and above all declination of The State Bank of Bangladesh to permit Reinsurance due to restriction of transfer of foreign currencies, Health Insurance is still marching forward penetrating the corporate market segment. More two marketers entered into the market with more aggressive strategy. The existing growth rate and future growth potential and increased competition reconfirms that Health Insurance will be a success story in the service sector of Bangladesh (Chowdhury, 1999).

Ensor and Sen argue that, both government and civil society organizations have an important part to play in the development of health insurance in Bangladesh. The overall objective should be 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 (Ensor and Sen, 2000).

Ahmed and others conducts comparative study which looks at three health insurance schemes in Bangladesh, namely those run by BRAC, Grameen Kalyan (GK) and the Society for Social Services (SSS). None of the organizations considers itself a health micro-insurance (HMI) provider in the strict sense of the term, as each model contains a mixture of social equity, service provision and financing. However, all three organizations pool risks over their target populations and provide health care services in exchange for membership or cardholder fees, which can be considered premiums. All three employ a co-payment system and/or a limitation on the amount reimbursed. None are associated with any insurance companies or outside service providers. There are no reinsurance arrangements (Ahmed *et. al.*, 2005).

Ensor found that, Social insurance has largely not developed although more rapid growth and an increased industrial sector means that there may be some potential for exploring ways of extending more risk protection to the formal sector using such mechanisms. In considering ways of increasing the level of financial pooling it is worthwhile also examining how the existing public sector might be enhanced to provide a greater level of protection from catastrophic costs. The hospital sector in Bangladesh remains small and largely unrelated to population need. The policy agenda for financing of the sector should explore how resource allocation, management and investment in this sector could be enhanced to provide for a greater proportion of catastrophic needs (Ensor, 2007).

For more than three decades microfinance has been one of the key development interventions in Bangladesh. This model of innovative financial services such as credit and savings in conjunction with nonfinancial components like capacity building have been playing instrumental roles in income smoothing and consumption smoothing of the low-income people. However, health shocks are unpredictable and eventually can trap poor and near poor households indefinitely into vicious poverty cycles. Therefore, a safety-net component against health shocks for the low-income groups and protecting the clients from catastrophic health expenditure should be an integral part of a development intervention like microfinance. This study is aimed to introduce the concept of 'Micro Health Insurance' as a tool for addressing the vulnerability context of low income households. Based on the analysis of growth in health expenditure and large portion of individual financing for health costs in the context of Bangladesh the study identifies a potential demand for health insurance and scope for providing such services through the existing wide network of microfinance institutions (Zaman, 2012).

METHODOLOGY

The study has been carried out mostly on the basis of secondary sources of data on total health expenditure extracted from Bangladesh National Health Accounts, 2013. Others relevant data's have been extracted from Ministry of Health and Family Welfare, World Health Organization, Institute of Microfinance (InM), Different Insurance Companies website. Also, the study incorporates existing literature on the health insurance.

CLASSIFICATION OF HEALTH INSURANCE IN BANGLADESH

It is important to note that different sources of financing played varied roles in terms of level of contribution depending on the level of development of the country. The government played a much bigger role compared to the global average in the more developed countries. An average high income OECD country spent about $4,753 per capita on healthcare (of which government's contribution is $2,959 per capita) (WHO, 2010). On the other hand, high income non-OECD countries spent much less on healthcare per capita domestically ($959), the governments in these countries paid even a larger share (69%) for healthcare (WHO, 2010).

However, it was important to note that private health insurers contributed unevenly as they contributed about 19% and 5% of total healthcare expenditure in high income OECD and non-OECD countries respectively (WHO, 2010). Private health insurers continued to play a significant role among the upper-middle income countries as 12% of total healthcare spending is financed by the private health insurers (WHO, 2010). Governments continued to bear the major share (55%) of total healthcare spending in the upper middle income countries (WHO, 2010).

1. SOCIAL HEALTH INSURANCE (PROVIDED BY THE GOVERNMENT)

Risk-pooling scheme based on proportional payroll deductions introduced on a compulsory basis for a defined group usually, but not always based on employee employment. Contributions which may be formed a combination of employee, employer and government, are paid into a fund that is managed separately from the government budget and exclusively to pay for medical benefits of the insured group. The principle that those earn high salaries pay more than those with low salaries is more or less assured through the proportionality of the system.

2. MICRO HEALTH INSURANCE (PROVIDED BY THE NGOs)

NGOs mainly use community-based approaches with trained community health workers (CHWs) to implement their programs. Micro health insurance (MHI) is primarily provided by NGOs, which also provide health services and microcredit. MHI covers basic and preventive health services including immunization, family planning, consultation, and normal deliveries. Discounts are also provided on medicine and pathology tests, where available. MHI of most NGOs specifically target women, micro credit members, and in many cases the poor and ultra-poor house-holds in the working area. In case of larger organizations having their own health service centers or hospitals, over and above basic services noted above, the card holders are able to receive more specialized services such as ultrasound and to avail surgeries (e.g., cataract, Csection and similar) either at their own premises or at referral clinics/hospitals. Some programs, however, do offer extremely low-cost products to the ultra-poor.

3. PRIVATE HEALTH INSURANCE (PROVIDED BY THE INSURANCE COMPANIES)

We generally define the private insurers as entities that directly pool financial resources in the form of premium from the private parties to pay the health care providers and as such not part of the entities that provide the health care service (e.g. subscription base hospital managed care). We also include risk-pooling entities that are commercial and primarily profit motivated. Typical of many less developed countries, Bangladesh has a private health insurance market which is in a very promising stage. Currently there are 30 insurance companies who provides health insurance services privately excluding 2 (two) publicly owned insurance companies in Bangladesh.

It is worth noting that only a handful of countries have truly provided an extensive coverage for healthcare cost through a third-party payment mechanism. The countries that have universal coverage are primarily high income countries with a strong institutional set-up in place for contract enforcement. Few developing countries have been successful in providing mass coverage for healthcare expenditure for population.

4. VOLUNTARY COMMUNITY INSURANCE

Scheme based on voluntary (often flat-rate) contributions made by a defined 'community' employed outside the formal sector. Schemes are sometime managed and developed by community groups or may be developed by government, NGOs or other civil society organizations.

5. MEDICAL SAVINGS ACCOUNTS

Medical savings accounts have been developed as a way of encouraging savings for health care. The principal idea is that regular contributions are placed into an individual account that can be used only for the medical care of the individual contributor. They are, therefore, attractive in countries where it is difficult to develop systems of social solidarity. It should be noted, however, that savings accounts work best where contributors can easily be transferred from the payroll and where there is a well-established technology to make use of the card (Pauly, 2001).

SERVICES UNDER INSURANCE PROGRAMS

Many developing countries, including Bangladesh, are affected by a "Double Burden" of disease and scare of resources (Government of Bangladesh, 2013). Unprecedented population growth and the emergence of new and chronic diseases have placed extra demands on health services. Despite massive efforts to combats such problems in Bangladesh, recent studies maintain that the resource base is sufficient studies to meet neither future needs nor planned services. In Bangladesh about 64% of the health expenditure come from the "out of pocket of the house hold" 33% is provided by the government sector and the remaining comes from the NGOs services (Government of Bangladesh, 2013). In a resource poor country, like Bangladesh, to ensure the compulsory health facilities for all, the government cannot bear such huge amount of money to provide the health services to the people.

Health Insurance is a risk sharing mechanism employed to harness private funds for health care and to reduce the financial barrier faced by individuals when seeking health care. The social health insurance has two prime functions that merits separate considerations, although they are intrinsically linked.

- The first is a financial function which is to provide a pool of funds to cover all or part, of the cost of health care for those who contribute to pool and to encourage providers and consumers to use health services in a very cost effective manner.
- The second prime function of the social health insurance scheme is social, including social equity. Health insurance is to remove the financial barriers to obtaining health care at the time of illness for the vulnerable groups in the society i.e. the very young, the elderly and chronically ill.

Social health insurance aims at protection from low probability and catastrophic loss like illness or injury. By pooling financial contributions from a large number of populations and pooling individual risk on a large scale (risk sharing), health insurance plans can cover the health expenditure, such as hospitalization, outpatients, medical care, drugs and sometimes also compensate the loss of revenues. Most of the countries have some forms of public provision of health services but less and less countries can provide a full range of health services, based on the needs of the populations.

In the present financial-social perspective of Bangladesh, Health Insurance has now become an essential, dependable, acceptable and the most cost effective means to make the modern treatment facilities affordable to the fixed income group. Generally Life Insurance Companies offer several Health Insurance Schemes, which are as follows:

HOSPITALIZATION (IN-PATIENT) TREATMENT COVERAGE PLANS

- Hospitalization Insurance Plan (Group)- offered to Members of a group and their dependants (if desired)
- Hospitalization Insurance Plan (Individual) – offered to an Individual as well as his or her dependant family members.

OUT-PATIENT TREATMENT COVERAGE PLANS

- Out-patient Insurance Plan - Offered as an adjunct to Group Hospitalization
- Out-patient Management Plan - Offered as an adjunct to Group Hospitalization

OVERSEAS TREATMENT COVERAGE PLAN FOR TRAVELERS

- Overseas Medic Liam Policy (OMP) – A pre-requisite for visa application offered only to Individuals traveling abroad.

HOSPITALIZATION INSURANCE PLANS

- Covers in-patient (Hospitalization) treatment expenses of an insured member

EXPENSES COVERED UNDER HOSPITALIZATION INSURANCE PLANS

- Hospital Accommodation
- Consultation Fee
- Medicine & Accessories
- Medical Investigations
- Surgical Operation
- Ancillary Services like Blood Transfusion, Ambulance Service, and Dressing etc.

EXCLUSION FROM COVERAGE: MAJOR EXCLUSIONS INCLUDE

- Congenital infirmity
- Pre-existing condition for certain period
- Psychiatric disorders and narcotic addiction
- Attempted suicide and self-inflicted injury
- Dental Treatment
- Pre or post hospitalization expenses and outpatient treatment expenses
- War risk, civil commotion or violence
- Routine health checkup
- Treatment for family planning purpose, contraception and infertility

GROUP HOSPITALIZATION INSURANCE PLANS

TYPES OF PLAN OFFERED

- Standard Plan: Distinctive Hospitalization Insurance Plan
- Customized Plan: Tailored to the need and desire of the client.

TABLE 1: BENEFIT SCHEDULE & PREMIUM RATE

Max. Benefit (Each Insured Per Year)	Tk. 25,000	To	Tk. 140,000
Hospital Stay (Maximum days)	10	To	20
Room Rent (Actual Expenditure upto a Maximum Amount Per Day)	Tk. 500	To	Tk. 2,000
Consultation Fee (Actual Fee upto a Maximum Amount Per Visit & One Visit Daily)	Tk. 300	To	Tk. 500
Routine Investigations (Actual Expenditure upto a Maximum Amount)	Tk. 1,000	To	Tk. 2,000
In Case of Surgical Treatment	Tk. 2,000	To	Tk. 10,000
In Case of Conservative Treatment	Tk. 5,000	To	Tk. 18,000
Major Intermediate	Tk. 12,000	To	Tk. 22,000
Charges included for Surgeon, Assistant, Operation Theater & Anaesthesia	Tk. 6,000	To	Tk. 15,000
Ancillary Services (80% of Actual Expenditure upto a Maximum Amount)	Tk. 2,000	To	Tk. 12,000

Source: www.deltalife.org

MATERNITY BENEFIT (MAXIMUM AMOUNT AS PER BENEFIT SCHEDULE ABOVE)

- Normal Delivery: Tk. 5,000 – 15,000
- Caesarian Delivery: Tk. 10,000 – 30,000

CHALLENGES OF PROVIDING FORMAL HEALTH INSURANCE TO THE POOR

There have been a number of challenges that significantly hinders the provision of formal health insurance scheme to the low income households. So far commercial insurance providers have not done much to reach out to sectors outside the formal economy. It seems that traditional formal insurance products have been designed with the middle and high income class in mind. On the other hand, despite their great need for some form of social protection, the poor lack the capacity to access formal insurance.

However, inadequacy in health infrastructures and poor provision of health services may create obstacles to provide health insurance scheme with assured quality of care in a large scale. Lack of adequate health infrastructure and quality of services will lead to client dissatisfaction and hence loss of interest in acquiring or renewing such insurance packages.

In Bangladesh, most primary healthcare is free at public hospitals and there is only a nominal registration charge for inpatient and outpatient care in secondary facilities. The study of EQUITAP (2005) also depicts that the share of total Out-of-pocket (OOP) payments is 70% or more in Bangladesh that goes on medicines only. In the absence of insurance cover, households with severe and immediate medical needs can be forced to expend a large fraction of the household budget on health care. Such spending must be accommodated by cutting back on consumption of other goods and services, by accumulating debt, by running down savings or by selling assets.

Recommendations related to financing for universal health coverage are unequivocal in their support of risk pooling and prepayment to cover the costs of services for the population and to reduce often impoverishing individual payments. To this end, raising public compulsory financing and creating a single national risk pool is widely advocated. However, with less than 1% of the population in Bangladesh under any sort of private prepayment scheme and only 15% of the workforce in formal employment, efforts around voluntary community health schemes have low uptake and a high turnover of members (HLSP, 2010). Chronic underinvestment in health by the Government is another challenge that needs to be addressed in the design and implementation of a national insurance system.

Substantial policy reforms in revenue collection, provider payment, autonomy of public providers, and the management, regulation, accreditation, and purchasing of health services are first-order priorities. A key task will be to ensure that necessary financial and management procedures and skilled managers and health workers are available to enable public-sector facilities to effectively compete with private-sector providers of secondary and tertiary services within the health insurance system.

The large informal employment sector will pose the biggest challenge to achieving universal health coverage in Bangladesh. Small-scale NGO health insurance initiatives have not been able to be scaled up in a way that meets the needs of the target population. More ambitious efforts to engage participation within the national scheme include the imposition of user fees as a disincentive to not joining the national system. A more structured user fee, customized incentives packages, and education about the benefits of insurance would be necessary to attract non-formal workers into the national insurance scheme.

CONCLUSION

In the past 43 years, Bangladesh has outperformed other countries and disregarded the expert view that improvement of population health is a straightforward function of reducing poverty and increasing resources for health. The high coverage of essential services and the innovative systems that have generated these results represent assets that can be built on for universal health coverage. By contrast, the second dimension of coverage related to financial protection seems to be lagging behind, with substantial prevention and hardship arising from the inequitable and inefficient financing of health care and, until recently, the absence of any long-term financing strategy for health that envisioned a major shift from the existing system. This issue needs to be addressed if Bangladesh is to remain on course in its health achievements.

The Bangladesh Health Care Financing Strategy (HCFS) 2012–32 proposes a national social health protection scheme that targets the formal sector with mandatory payroll taxation, subsidizes people below the poverty line from general revenue, and allows the large non-poor informal sector to join the scheme voluntarily (MOHFW, 2012). Although details are absent from the proposal, several key pooling, purchasing, and payment attributes need to be implemented in a coordinated manner: a single large pool to avoid fragmentation and unequal risk pooling; a comprehensive and standardized benefits package; an autonomous national body for the purchasing of all health services; a system that allows health services to be purchased from both public and private providers to create competition; and patient freedom to choose providers.

Creation of an independent body tasked with mandatory licensing and accreditation of public, non-governmental organization (NGO), and all private-sector facilities, with appropriate links to monitoring and supervision systems, would also be advisable. Such a body would enhance patient choice of health services and foster healthy public-private competition within the national insurance scheme.

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