Strategies for developing health insurance in Bangladesh

Research note 20

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Also available;

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Bangladesh National Health Accounts 1996/97, Final report, Data International/ Health Economics Unit.
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Executive summary

Introduction

During June the Health Economics Unit of the PRU held a workshop on options for developing health insurance in Bangladesh. The workshop included representatives from Government, NGOs, donors, international organisations, academic institutions and other civil society groups. The objective was to begin to develop a framework for extending health insurance to different population groups in the country.

Background: Policy context

There is evidence that many people make large and often unaffordable payments for catastrophic illness. Often this leads to debt and impoverishment. There is growing evidence that people are willing to pay for services provided that quality is ensured. There are a number of notable examples of NGOs establishing popular insurance schemes that offer good services at an affordable price.

Even if demand exists for greater risk pooling, it is important to consider the feasibility of establishing a scheme in a country with a heterogenous and largely informal workforce such as Bangladesh. International experience suggests that social health insurance based on compulsory, payroll related contributions is mostly suited to the formal industrial workforce. In Bangladesh this sector accounts for less than six per cent of the population. There is now considerable international and national experience of developing voluntary community insurance run by community or civil society groups as an alternative risk-pooling strategy for the informal sector. There is also evidence to suggest that where government undertakes to introduce and manage such schemes they often prove unpopular.

Health insurance in Bangladesh

In the short term a threefold strategy is recommended.

1. Develop a scheme based on compulsory health insurance for civil servants that can later be extended to others in the private formal sector. These groups represent around 6 per cent of the population perhaps up to 10-12 per cent if some direct dependents are included.

2. Encourage the implementation of pilot voluntary community insurance partnerships for the informal sector (which represents more than 35 per cent of the population) through an enabling framework that encourages public-NGO-private collaboration and quality assured services.

3. Monitor the development of multiple insurance systems and encourage the eventual convergence of benefits.
An enabling framework for health insurance development

The government has a key role to play in establishing an enabling framework for both social and community insurance. In many cases the role is not in the direct provision of services but by establishing a framework within which insurance funds can effectively purchase quality services from a diverse network of facilities. Without this framework, insurance could impose more cost than it yields in benefit through added administrative costs.

The following elements are required in establishing this enabling framework.

1. Governance framework for health insurance

This will require cooperation between a variety of ministries including Health, Establishments, Finance, Commerce and Labour. A number of areas require support and development.

- Development of concepts, rules and legislation for social insurance.
- Rules on the governance of the social insurance probably as a separate body accountable to Government.
- Rules on entry and exit of insurance organisations.
- Establishing sustainable benefits of insurance schemes

2. Developing the ability of insurance funds to contract for services

Many attempts to develop public-private partnerships and insurance fund purchasing have been less successful because skill in contracting are not sufficiently developed. These include:

- Ability of public provider organisations to manage resources and retain revenue obtained from non-government sources.
- Ensuring quality in private facilities (quality assurance and accreditation).
- Developing management skills for contracting.
- Payment systems that encourage quality but do not encourage excessive service provision.

4. Implementation of user charges

This is important both to encourage voluntary insurance uptake and to prepare facilities for the local management and use of non-government sources of income.

5. Monitoring the development of health insurance

Ensuring that evaluation of pilot schemes is conducted from an appropriate and consistent baseline. Ensuring that regular monitoring helps to inform the extension of schemes.
Next steps

In order to develop a enabling policy framework for civil servants health insurance and community health insurance in Bangladesh the following steps are recommended:

1. Establish an inter-ministerial committee to oversee the development of health insurance in the country, including desirability and feasibility of establishing compulsory insurance for civil servants. The committee will facilitate development of legislation, systems changes and regulation for health insurance.

2. Through the Health Economics Unit of the Policy Research Unit:
    - Support documentation of existing approaches and experiences with community health insurance in the country.
    - Provide technical assistance for developing community health insurance pilots, including systems and capacity development.
    - Support development of enabling policy for civil servant insurance and community health insurance, including legislation (where required), preparation of guidelines and facilitation for required systems changes.
    - Monitor civil servant health insurance scheme as well as a series of community insurance pilots.

Both Government and civil society organisations 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 organisations is necessary.
Introduction

The Health Economics Unit, PRU of the Ministry of Health and family Welfare hosted a seminar on strategies for developing health insurance in Bangladesh\(^1\). The aim of the seminar was to begin to think through different ways for extending health service access through insurance and related financing methods.

The workshop began by discussing approaches to insurance in the overall context of an extremely diverse population, particularly in terms of employment patterns. Some international experiences in developing health insurance coverage for both formal and informal sector were then reviewed. Experiences of a number of different schemes in Bangladesh were also described and discussed. Finally, seminar participants were divided into three working groups. Each group discussed the development of risk coverage for a particular group namely formal, informal urban and informal rural sectors.

This document summarises the results of the discussions and, in particular, begins to place the development of insurance into a broader policy context that describes the pre-requisites for successful implementation. It ends by outlining a number of specific steps for development of a enabling policy framework for introduction of health insurance in Bangladesh.

Policy context

The population of Bangladesh spend about 11 dollars per capita on health. Of this, about 35 per cent is spent by the public sector from government revenues and donor financing (Heath_Economics Unit and Data International, 1998), (Rahman, Ali et al., 2000)). Most of the remainder is spent by individuals when treatment is required (out of pocket charges).

That people frequently are unable to pay for health care at the same time they have acute need for treatment has been documented in both large scale quantitative studies and also in-depth anthropological investigations. Blanchett cites numerous examples of the large and unaffordable costs of acute obstetric care and emergencies (Blanchett, 1999). The 1999 CIET survey provides both quantitative and experienced based evidence that people make large unofficial payments in public facilities even when critically ill ((CIET, 1999), particularly pages 31-36). Often these payments lead to household debt and impoverishment (Nabi, Datta et al., 1999).

At the same time there is a growing literature on the willingness to pay for many services in order to ensure accessibility and quality of services. Several studies report that patients are willing to pay a significant proportion of the cost of services provided that quality of service is guaranteed (Routh, Hossain et al., 2000); (Khan, Quayyum et al., 2000).

A readiness to pay and need for risk pooling does not mean that people will necessarily be willing to subscribe to an insurance scheme. There are a number of

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\(^1\) Due to external factors the workshop had to be compressed from a planned two days into one day.
factors that influence demand for insurance. The first is that people must be willing to pay to an organisation outside their group of friends and relatives. Individuals have many strategies for covering the cost of health care. Borrowing from friends and relatives, using up savings or selling assets may sometimes provide sufficient resources to cover the costs of care. Since there is no administrative cost this could prove a cheaper way of generating sufficient resources than through an organised insurance scheme. The disadvantage is that the resources than can be relied upon may not be sufficient to cover unexpectedly high costs. Another potential advantage of formalised insurance is that the insurer may help to identify the correct type of service and most cost-effective provider.

A second issue is that even if a general demand exists for insurance, potential members must be convinced that a fund will deliver what it promises. Government administered insurance funds may be seen as no better than tax collectors. Conversely, community based funds may not offer sufficiently attractive benefits or not appear to manage money efficiently.

A third issue concerns the way in which household income is allocated. There is growing evidence that when women are given control over household incomes that they demand more health care not just for themselves but for the entire family (Nanda, 1999). Similar results may hold for the demand for insurance although there is currently no empirical evidence.

A final, but most important, issue is that even if a demand for insurance exists implementation is not guaranteed. Collecting insurance contributions requires accurate identification of those that pay, assessment of how much to pay and final collection of the premium. These are no small matters particularly in countries where income tax and other personal tax collection mechanisms are underdeveloped. The ease with which these three functions can be carried out depends on the population from which the contribution is collected. Compulsory contributions are mostly suited to people in stable, taxed employment belonging to large enterprises. Such arrangements minimise transaction costs of establishing and maintaining the collection mechanism.

The Development of a policy framework is based on the assumptions that a demand for health insurance exists and that appropriate and attractive packages can be developed and delivered. Even this assumption requires verification and is the subject of several research studies currently underway. Once demand has been established, the next task is to define how insurance might be extended to the disparate and unequal groups that make up the Bangladeshi population.
Health insurance in Bangladesh: gradual and piecemeal?

**Health insurance** can be defined as follows:

“Regular, non-fundable contributions into a fund in return for individual rights to specified services in the event of medical need. Rights are usually specified according to services covered subject to financial limits and certain cost-sharing principles between the fund and insured person. The fund operates on the basis of a ‘risk-pooling’ principle with the contributions of the healthy being used to pay for the treatment of those that are sick”.

The international literature suggests that there are really three main benefits of insurance (see for example (Abel-Smith, 1992); (Normand, 1999). First, to expand the revenue base either for improving quality of existing services or to extend coverage to a greater proportion of the population. Second, to provide protection against high out-of-pocket expenditures incurred for health care, especially unexpected serious ill health. Finally, to develop a capability, through the newly established insurance fund, to obtain (purchase) services in a more cost-effective way.

At the same time there are also costs involved in the initial investment of establishing the system and in the ongoing administration of a more complex system. In considering the desirability of insurance it is important to bear in mind these key benefits. It may turn out, in some or all cases, that while developing insurance is feasible in that it is managerially possible, it is not desirable because the benefits are outweighed by the new costs imposed by the scheme.

There is general acceptance that universal health insurance is not feasible at this time in Bangladesh. Yet it is also accepted that new ways must be found to finance the potentially large and usually unexpected consequences of serious ill health. These two conclusions suggest that a piecemeal strategy is required that develops separate risk pooling schemes tailored to the needs of particular population groups. In Bangladesh the formal industrial sector is relatively small while the informal sector is large and diverse accounting for a wide variety of rural and urban employment (see figure one, see (Ensor, 2000) for more details). At the same time, although schemes may develop that are quite different initially, the long term goal is for the schemes to converge and offer near to universal coverage.
I. Develop a scheme based on compulsory health insurance for civil servants that can later be extended to others in the private formal sector.

Definition of social health insurance
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 from 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 that earn high salaries pay more than those with low salaries is more or less assured through the proportionality of the system, although limits on total contributions are sometimes imposed.
Compulsory health insurance is mostly suitable only for those that work in formal employment. This group participates in large enterprises with registered permanent premises, taxable turnover and has a reasonably stable workforce and an organised payroll supported by a record keeping system. Larger firms are more likely to register one of the reasons being that it is less easy to hide from government regulation.

In Bangladesh, formal sector employment accounts for less than six percent of the population (see figure one) although this figure will rise to perhaps 10-12 per cent 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.

The seminar recommended that social health insurance is gradually introduced for the formal sector. Initially the scheme would cover the 2 per cent of the population working as public servants and then their families. Later it would be extended to cover the 4-5 per cent working in the formal sector and their families.

II. Encourage the implementation and monitoring of pilot community insurance partnerships.

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<th>Definition of voluntary community insurance</th>
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<tr>
<td>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 (micro-insurance) or may be developed by Government, NGOs or other civil society organisations.</td>
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<th>Micro-health insurance</th>
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<td>can be regarded as a special form of community insurance including the characteristics that beneficiaries are involved to some degree in the management of the scheme or setting of benefits and that it is initiated by an organisation outside the public social security system (ILO, 2000).</td>
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According to the labour force survey a total of 35 per cent of the population currently work in the private informal sector (figure one). As has been suggested, however, many of these are currently un-waged workers. Many would find insurance either unaffordable or unattractive. In the short term it is realistic to suppose that a much smaller number of these will be enrolled. In Thailand, the health card scheme achieved a coverage of around 5 per cent of the population by 1985 two years after the initial scheme but increased little over the next five years. It has taken almost 20 years to achieve today’s coverage of 11.5 per cent of the population. Other countries have similar experience (Sriratanaban, 2000).

In general countries that have attempted to impose voluntary (community) insurance from the national level down have not succeeded in extending coverage to a significant degree. In Vietnam, for example, although the principle of voluntary insurance is reported to be popular among communities, in practice the nationally imposed scheme has had little penetration (Jowett and Thompson, 1999). In the Philippines, a national social health insurance scheme managed to achieve significant coverage of the formal sector but was unable to make an significant inroads into coverage for the informal sector on a voluntary basis (Nath, Qasem et al., 2000). An exception is the scheme for school children which can be regarded as a soft-compulsory scheme with lower than average collection costs and now has upwards of
3.5 million members (Ensor, 1999). A similar pattern is reported in Egypt where more than 10 million enrollees were added over a five year period through the introduction of school health insurance (Nandakumar, Reich et al., 2000).

In Bangladesh there are already a number of notable and innovative community insurance schemes, largely run by civil society organisations such as Grameen, Gonashthaya Kendra and Shakhti (Desmet, Chowdhury et al., 1999). Most of these follow the integrated model of insurer and health provider. That is the NGO serves as both purchaser and provider of health services. In some cases, the organisation relies on government or other NGOs for secondary and tertiary level care. Some schemes, such as the Shakti scheme, are run on the back of existing women’s credit schemes. The advantage of this is that considerable social mobilisation has already been achieved prior to the implementation of insurance. In addition management capability, particularly financial management, has already been developed. In the case of Shakti payment into a health fund is a pre-condition of micro-finance membership.

In order to encourage further development Government should take active steps to encourage other schemes to develop in particular areas. In particular it would be valuable to gain experience of different types of community health insurance schemes to learn what is relevant for various groups of people. This should be in terms of the type of local group initiating insurance (community, NGO, micro-finance groups, or professional organisations and unions etc), as well as in terms of how health care is delivered (ie. are services provided directly or purchased from government or private sector?).

Already there are proposals to develop a community based system of health financing-provision developed through the Public-Private Partnership (SHAPLA) component of HPSP (NICARE/British Council, 2000b). In addition, there is growing interest in micro-insurance schemes generated through the initiative of CARE and other organisations.

From the policy point of view there is a fine balance to be trod between government taking control of such schemes with the risk, as has occurred in other countries, that such action reduces the appeal of the scheme and having no involvement or influence. Perhaps the most positive and active role is for Government to develop a enabling environment within which new schemes can develop and at the same time implement a common framework for evaluating all schemes. The next section examines the main features of an enabling policy framework for both social and community health insurance.
An enabling environment for health insurance development

The development of health insurance creates both a new source of finance and an alternative purchasing system (see figure two). In the case of social health insurance funding is derived from employee and employer contributions. In the case of community insurance from fixed contributions of members. These funds are, in theory, able to obtain services on behalf of their members through contracts with various service providers both public and private/NGO. Yet a system of contracting implied by an insurance system suggests a totally new method of financial allocation and management. It implies giving semi-autonomous funds a combination of public (taxation) and private (individual premiums) funding which is then used to finance services to members obtained from multiple providers. This is entirely different to the historic system of line budgets financed from central government revenue and allocated to public facilities for an entire geographic population.

Several dangers are inherent in the development of an insurance system. One is that because operation is so different from historic practice contracting will, in reality, go undeveloped and contributions will simply be used to finance existing parallel services. Social insurance contributions will be used as an additional source of finance for public services while community insurance is used by the insurance provider, either government or NGO, in their own facilities\(^2\). While some additional funding

\(^2\) As now occurs with existing insurance systems of civil society provided by Grameen and Gonoshataya Kendra.
will be produced, the changes in these circumstances are unlikely to effect fundamental system wide reform.

A second possibility is that the changes are implemented but are not supported by an adequate skills base. As a consequence public-private collaboration cannot achieve fundamental change and the system remains low quality and possibly unsustainable. A concurrent possibility is that all energies are devoted to developing a system of subsidised insurance for the public sector (two per cent of the population) but other risk coverage remains under-developed.

There are a number of pre-requisites that will help develop the enabling framework for the implementation of health insurance. Some of these functions are specific to the development of insurance while others have more general impact, affecting the success of other health sector reforms.

**Governance framework for health insurance**

It is vital that there be an enabling governance framework for both social and community health insurance, for example through legislation or issuing of guidelines, and regulation. An enabling governance framework will require cooperation of a variety of ministries, not just the Ministry of Health and Family Welfare, such as Establishments, Finance, Commerce and Labour.

A number of areas require support and development

I. Development of concepts, rules and legislation

Legislation will be required for the introduction of compulsory social insurance. This will cover, amongst other things:

- Who will set premiums? Premium rates should be proposed by insurance committee based on a financial analysis of likely contributors and scope of benefits.
- Who should pay premiums? – likely to be a combination of employees, employers and government,
- Scope of insured services.
- Which institutions are eligible to provide services and on what basis (scope of contract and payment methods)?

Prior to the development of legislation, a clear plan for the organisation of insurance and further definition of the pre-requisites for change will be required. This will include projections of revenue and expenditure of funds and estimate of any subsidies required to initiate the schemes.

In the case of community health insurance it would be better for government to issue guidelines for local groups on concept of health insurance and the main issues to consider when designing and implementing a scheme.
II. Rules on entry and exit of insurance organisations

Those enrolling in an insurance scheme must be confident that their money will be managed efficiently in their interest. There is a role for Government to enforce minimum standards on organisations that seek to offer insurance. One important regulation is on the level of reserves that must be carried by insurance funds in order to provide sufficient buffer against unexpectedly large pay-outs. This will depend on the numbers enrolled in the scheme and could be quite a large proportion of revenue for smaller schemes. Alternatively, funds might suggest other ways of guaranteeing benefits such as commercial reinsurance or support from a larger (parent) company.

Current regulations for establishing commercial insurance companies must be studied to see whether they provide a sufficient framework for non-profit health funds.

III. Governance of social insurance fund

Countries introducing social insurance for formal workers develop a fund organisationally separate from any one ministry but accountable to a number of relevant line ministries and relevant interest groups. One option is to establish an autonomous body governed by a board comprising representatives of line ministries, trade unions and consumer groups. A second option is to maintain the fund as a government body but directly under the Office of the Prime Minister. A third option is to develop the fund as a special department inside a line Ministry but with a Board that is representative of other ministries. This third option may make it difficult for the fund to take decisions that are independent of health providers. It might make it difficult, for example, to contract independently with private and NGO providers where appropriate.

IV. Establishing sustainable benefits.

For civil servants insurance, it would be tempting to introduce a wide package of benefits that helps to ensure staff remain in post. While benefits should be valued, it is important that the package of benefits is offered that is affordable to the economy even once cover is extended to the private sector. If an excessively generous package is offered in the beginning to civil servants the danger is that either extension to the private sector will be unaffordable or a separate scheme offering lower benefits will be offered for this group. This is the situation in Thailand where it is proving difficult to merge the separate schemes for the private sector formal employees and civil servants since the benefit package for the latter is substantially larger than for the former.

Similarly for small community based schemes, thought should be given to whether it will be possible to sustain the level of benefits offered in the future. Developing a scheme that provides extensive benefits funded through donor or government subsidy may be a good way of achieving short term expansion of the scheme. In the long term, however, as more aspire to be members of various insurance schemes it may not be affordable.

This does not mean that benefits of all schemes have to be exactly identical. Introducing a variety of packages through different schemes is one way of assessing
which benefits are attractive to individuals. But long term sustainability which bear in mind realistic future projections for economic growth, must be counted as a major factor in the development of separate schemes.

Contracting for services

An important potential advantage of health insurance is the impact a purchasing fund might have on the efficiency with which services are provided. Yet international experience suggests that any advantages are often squandered because the necessary management skills are not present and a framework for contracting is underdeveloped ((Mills and Broomberg, 1998; Ara Begum, Ensor et al., 2000)).

Developing insurance provides an excellent opportunity for involving a multiplicity of providers – public, private and NGO – to participate in the provision of health services. If developed correctly, the insurance funds should have some independence to test out alternative contracting mechanisms with service providers. There is no presumption here that public, private or NGOs are more or less efficient. Indeed it is likely that considerable variation exists in each of these categories. The aim should be to achieve maximum efficiency in service delivery through a combination of provider approaches.

In order to initiate successful public-private collaboration and contracting several things are necessary. Some of these require broader systemic changes to be implemented by government.

i) Autonomous funding and provider organisations

A fundamental problem at the moment is that it is difficult for facilities to contract with private funding agencies. Conversely it is also difficult to spend public funds in private facilities. There are exceptions to this mostly at the tertiary level. Public grants are provided to autonomous hospitals such as Sishu hospital and BSMMU and also to private (not-for profit) hospitals such as BIRDEM. Some private money is spent in public hospitals through the current system of nominal entrance charges. A key problem here is that facilities are not able to retain revenue – all must be remitted to the Treasury. This factor is an importance hinderance to insurance contracting since the principle of contributing is that the money is used to provide better services something that is rendered impossible if revenues are not retained.

ii) Provider quality assurance

To ensure that contracting with a multiplicity of providers - public and private- is successful it is important that information is available on the quality of providers. This suggests the need for a system of provider accreditation and monitoring of standards that is recognised as being accurate and sustainable.

Developing such a system would have benefits far beyond the insurance system since it would provide all consumers with a way of checking on the quality of service provided in the public and private sector.

It is likely that two new quality assurance systems will be required.
The first is to ensure the standards of registered medical practitioners and clinics, particularly in urban areas. Although it would be tempting for the Government to develop its own system of accreditation this could be a mistake. The current system for licensing private clinics, which only really monitors the standards of inputs rather than quality of outputs, has been criticised for being unable to cope with the large demands placed on the system (IEPSD, 1997). A more complicated system is even less likely to be successful. Instead the government could encourage the providers themselves to establish a system of self-regulation. Alternatively, or additionally, clinics and hospitals could be required to seek international standardisation such as ISO 9002 already used by many hospitals in countries such as Thailand (Ara_Begum, Ensor et al., 2000).

A second, and more controversial, requirement is to incorporate the many informal practitioners that are currently working particularly in rural areas. The size of this sector means that public-private collaboration in rural areas requires incorporation of this sector into the delivery network. A recent survey, for example, found that the last place of treatment attended by 63 percent of individuals was to a village doctor (NICARE/British_Council, 2000a).

iii) Management skills for contracting

Successful introduction of health insurance requires the development of a range of management and administrative skills that are not common in the system of centrally planned health care.

If they are to properly represent the population groups covered, insurance funds must become purchasers and advocates of consumer interests. They are required to develop a package of services that satisfy patient’s medical needs and demands. They must identify the best institutions and practitioners to provide for these needs and develop cost-effective contracts with these providers. Finally, they must monitor the quality of services delivered and enforce sanctions where service providers give inadequate service. These skills are required to a degree whether the insurance simply covers the most basic medicines (are the medicines appropriate, have they been stored correctly, are they given in the right quantity?) or covers sophisticated care such as major surgery or intensive care.

Much of the training, such as contracting and devolved financial management, is of a more general nature and will be useful in supporting other health sector reforms such as development of public-private partnerships and devolved management of health care institutions.

The Ministry of Health and Family Welfare might take the lead in providing or commissioning training in these areas. Training could be available both to the public sector and those in private/non-profit sector seeking to establish insurance schemes.

iv) Payment systems

It is generally acknowledged that one of the most crucial features of the financial allocation and contracting system and its impact on efficiency is the method used to
pay providers for medical services (Barnum and Kutzin, 1992). A considerable number of insurance schemes have proved excessively costly and even unsustainable as a result of the wrong payment system being chosen. This is particularly true where a fee for item of service system has been used since it gives an incentive for providers to deliver too much service. In Thailand, for instance, a fee for service system is used to reimburse services under the scheme for civil servants and the result has been accelerating costs (Tangcharoensathien, 1999). In contrast the scheme for the formal private sector uses a capitation system that has proved effective in containing the costs of services while delivering good quality care.

It may seem strange to be discussing the containment of costs in Bangladesh when expenditure is already so low. Yet the concern is not the absolute expenditure but whether the resources are used well and whether the system imposes an excessive burden on society. The current system of salary payment and normative based allocation does indeed tend to reward inactivity since the amount allocated is not directly linked to services delivered. Yet it is important not to exchange inactivity for excessive activity through an unsustainable fee based system. Many low and middle income countries have found that introducing a system that combines elements of simple case based payment with capitation can help to ensure that expenditures are contained while encouraging improved efficiency (Schieber, 1999).

Implementation of user charges

Official user charges are currently very low in public facilities and all revenue generated must be returned to the treasury. While the case for implementing large user charges has not yet been made there is considerable evidence that people are willing to pay for better quality services particularly if official charges replace the practice of taking unofficial fees. The rule that all revenue must be returned to the Treasury makes it difficult to test out the impact of user charges on quality and accessibility of services. A recent submission to the Ministry of Finance by the Ministry of Health and Family Welfare would, however, return revenue to facilities and make it possible to assess the impact of charges (Dave Sen, Karim et al., 2000).

The ability to levy and utilise user charges has important implications for insurance. One incentive for individuals to contribute into insurance schemes is if they are otherwise charged for service. In Thailand user charges were introduced in the mid-1970s at about the same time as insurance began developing. In Philippines user charges were introduced in public health facilities (with exception of first level of care) one year after the introduction of the National Health Insurance Programme. Without user charges, voluntary enrolment must rely on insurance providing improvements in the quality of services. Alternatively to rely on the absence of unofficial payments as an incentive to use services.

User charge retention also has a wider function in that it could provide some of the financial and management infrastructure to implement insurance systems. Establishing a route for returning locally collected funds to facilities can be utilised by local (community) insurance funds in their payment for services at public facilities. Without this route, insurance funds may be restricted to purchasing services from NGO or private providers and therefore miss an important opportunity for public-private collaboration. The implementation of a system for retaining charges can
therefore be seen as an important pre-requisite for the implementation of insurance funding.

**Monitoring the development of health insurance**

A common criticism of pilot health sector reforms is that they are not properly evaluated from an appropriate baseline. Also where different evaluation methodologies are used that make comparisons between schemes difficult. Several monitoring indicator sets and methodologies are already available for monitoring community based financing/insurance schemes. Baseline data are already available in Bhramanpara, the first PPP pilot site, and a system of ongoing monitoring indicators is being development to assess the impact of the community health schemes. Similarly, the STEP programme of the ILO has developed an extensive methodology for monitoring micro-insurance scheme (ILO, 2000).

An important role of the Government is to establish a framework for monitoring community insurance schemes. Evaluation should take account of the initial design, investments required, population covered, quality of services offered and sustainability of the scheme.

**Summary, key recommendations and next steps**

In the short term the government strategy for development of health insurance in the country should be to:

- Develop a scheme based on compulsory health insurance for civil servants that can be later extended to others in the private sector.
- Encourage piloting of voluntary community based health insurance schemes. This should includes pilots comprising different implementing agencies (e.g. central government, local communities, NGOs, micro-finance groups etc), financing and benefit packages, and mode of service provision (direct service delivery versus purchasing services from public, NGO, or private sectors).
- Monitor the development of multiple insurance systems and encourage the eventual convergence of benefits.

To be successful, both civil servant health insurance and community based schemes require an enabling policy framework. The discussion in the last section suggests that changes required for insurance can be divided into two categories: pre-requisites, system changes that must be in place so that the insurance systems can function effectively and development and training needs of the new systems.

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3 These schemes may lack community support and prove un-responsive to local needs. They may work where cohesive population groups can be enrolled on a soft-compulsory basis as with the school children schemes in Vietnam and Egypt.
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Pre-requisites

- **Legislative and administrative framework** for the governance and management of funds.
- **Financial projections** and assessment of sustainability of funds.
- **User charge retention** by health facilities. This provides added impetus required for encouraging people to enroll in schemes and also introduces principles of local financial management required for effective insurance contracting.
- **Greater autonomy** for public health facilities. Health facilities need authority to be able to enter into contract with insurance agencies.
- **Health facility standards** to provide information on service standards to insurance funds and consumers. Information to include standards of physical facility and staffing and also quality of services provided.

System development and training needs

Developing health insurance implies major changes in the way the system is managed. This requires investment in skills training and development of administrative systems to include:

- **Contracting and financial management training** for insurance fund managers and providers;
- **Provider payment system** that is simple to operate and encourages providers to improve quality without excessive incentive to increase costs;
- **Community participation** during design, management and implementation of community based insurance schemes
- **Marketing** strategy to ensure maximum uptake of voluntary insurance schemes;
- **Monitoring system** that permits insurance funds to assess the success of contracts and make adjustments.

Next steps

In order to develop a enabling policy framework for civil servants health insurance and community health insurance in Bangladesh the following steps are recommended:

1. Establish an inter-ministerial committee to oversee the development of health insurance in the country, including desirability and feasibility of establishing compulsory insurance for civil servants. The committee will facilitate development of legislation, systems changes and regulation for health insurance.
2. Through the Health Economics Unit of the Policy Research Unit of the Ministry of Health and Family Welfare:

- Support documentation of existing approaches and experiences with community health insurance in the country.
- Provide technical assistance for developing community health insurance pilots, including systems and capacity development.
- Support development of enabling policy for civil servant insurance and community health insurance, including legislation (where required), preparation of guidelines and facilitation for required systems changes.
- Monitor civil servant health insurance scheme as well as a series of community insurance pilots. The basis of monitoring of each pilot should be similar with baseline and ongoing indicators collected in order to analyse the financial sustainability, quality of services and size and composition of enrolment. Monitoring of the civil servant scheme should draw out lessons to inform whether coverage should be extended to others employed in the formal private sector.

Both Government and civil society organisations 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 organisations is necessary.
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