Health Microinsurance

A Comparative Study of Three Examples in Bangladesh

CGAP Working Group on Microinsurance
Good and Bad Practices
Case Study No. 13

Mosleh U Ahmed, Syed Khairul Islam, Md. Abul Quashem, and Nabil Ahmed
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Good and Bad Practices in Microinsurance

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1. A **series of case studies** to identify good and bad practices in microinsurance
2. A **synthesis document** of good and bad practices in microinsurance for practitioners based on an analysis of the case studies. The major lessons from the case studies will also be published in a series of **two-page briefing notes** for easy access by practitioners.
3. **Donor guidelines** for funding microinsurance.

The CGAP Working Group on Microinsurance

The CGAP Microinsurance Working Group includes donors, insurers and other interested parties. The Working Group coordinates donor activities as they pertain to the development and proliferation of insurance services to low-income households in developing countries. The main activities of the working group include:

1. Developing donor guidelines for supporting microinsurance
2. Document case studies of insurance products and delivery models
3. Commission research on key issues such as the regulatory environment for microinsurance
4. Supporting innovations that will expand the availability of appropriate microinsurance products
5. Publishing a quarterly newsletter on microinsurance
6. Managing the content of the Microinsurance Focus website: www.microfinancegateway.org/section/resourcecentres/microinsurance

Table of Contents

Acknowledgements iii

Acknowledgements iii

Acronyms iv

Bangla Words/Phrases v

Executive Summary vi

1. Key Issues in Offering Health Microinsurance 1

2. Health Care and Health Insurance in Bangladesh 4

2.1 Health Care 4
2.2 Health Insurance 6
2.3 Legislation and Regulation 8
2.4 The Role of the State in Social Protection 10
2.5 Overview of Microinsurance in Bangladesh 11

3. The Institutions 14

3.1 BRAC Micro Health Insurance Program 14
3.2 Grameen Kalyan 22
3.3 Society for Social Services 27

4. Results 32

5. Analysis of Issues 36

5.1 Institutional Mission 36
5.2 Institutional Capacity 38
5.3 Marketing and Client Education 41
5.4 Product Design and Controls 44
5.5 Claims Management 46
5.6 Financial Performance and Sustainability 47

6. Conclusions, Lessons Learned and Major Challenges 50

6.1 Conclusions and Lessons Learned 50
6.2 Major Challenges 54

References 56

Appendix 1. Macro Data 57

Appendix 2. ANC Package of BRAC MHIB 58

Appendix 3. BRAC Health Insurance Card 59

Appendix 4. BRAC Publicity Material 61

Tables

Table 1. Health Care Administrative Levels in Bangladesh 5
Table 2. Number of Bangladeshi Insurance Companies 6
Table 3. Insurance Industry Basics 8
Table 4. Minimum Capital and Deposit Requirements for Insurance Industry 9
Table 5. Types of Microinsurance in Bangladesh 13
Table 6. Institutional Comparison Summary 14
Table 7a. BRAC MHIB General Benefit and Ultra Poor Equity Package 18
Table 7b. BRAC MHIB Prepaid Pregnancy Related Care Package 18
Table 7c. BRAC MHIB School Health Package (Pilot Project) 19
Table 7d. BRAC MHIB Health Care Pricing and Cost Analysis (US$) 19
Table 7e. BRAC MHIB Membership Renewal Data Analysis 20
Table 8. Grameen Kalyan Product Details 24
Table 9. SSS Product Details 30
Table 10a. BRAC MHIB Basics – Trends 32
Table 10b. BRAC MHIB – Key Results 32
Table 11a. Grameen Kalyan Basics – Trends 33
Table 11b. Grameen Kalyan – Key Results 33
Table 12a. SSS Health Program - Basics Trends 34
Table 12b. SSS Health Program - Key Results 34
Table 13. Analysis of 2004 - Key Results 47

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-Natal Care
BDT	Bangladesh Taka
BRAC	Bangladesh Rural Advancement Committee
ECG	Electo-cardiogram
ENT	Ear, nose and throat
EPI	Expanded Program on Immunization
ESP	Essential Services Package
GB	Grameen Bank
GDP	Gross Domestic Product
GK	Grameen Kalyan
GSK	Gonoshashtho Kendra
HA	Health Assistant
HC	Health Centre
HFWC	Health and Family Welfare Centres
HIV	Human Immunodeficiency Virus
HMI	Health Microinsurance
HMO	Health Maintenance Organization
HPSP	Health and Population Sector Program
ILO	International Labour Organization
MFI	Microfinance Institution
MHIB	Micro Health Insurance for Poor Rural Women in Bangladesh, WEEH
MIS	Management Information Systems
NFPE	Non Formal Primary Education
NGO	Non-Government Organization
NID	National Immunization Day
NPC	National Project Coordinator
PO	Program Organiser
PPP	Purchasing Power Parity
SK	Shashtho Kormi
SS	Shashtho Shebika
SSS	Society for Social Services / SSS Health Program
STD	Sexually Transmitted Disease
STEP	Strategies and Tools against Social Exclusion and Poverty
TBA	Traditional Birth Attendants
TCO	Training and Communications Organiser
TdH	Terre des Hommes, Netherlands
TOT	Training of Trainers
UK	United Kingdom
US$	United States Dollar
VHV	Village Health Visitor
VO	Village Organization
WEDE	Women's Empowerment through Decent Employment
WEEH	Women's Empowerment through Employment and Health Project, ILO

Bangla Words/Phrases

Bangla	Language of Bangladesh/Bengali Language
Dai	Traditionally Trained Local Midwife
Dushtha	Distressed
Gono	People's
Gonoshashtho Kendra	People's Health Centre
Grameen	Rural/Village
Jiban Bima	Life Insurance
Kalyan	Welfare
Kendra	Centre
Kobiraj	Village Herbal Medicine Practitioner
Kormi	Worker
Nari	Woman
Progoti	Progress
Sadharan	General/Ordinary/Normal
Sadharan Bima	General Insurance/Non-life Insurance
Samity	Group/Organization/Association
Samogri	Family
Shakti	Power/Strength
Shashtho/Shasthya	Health
Shebikas	Carer/Nurse
Shushastho	Healthy/Good Health
Uddug	Initiative/Movement
Upazila	Sub-district
Zila	District

Executive Summary

The health care system in Bangladesh is mainly urban-based, elite-biased and curative-orientated. Even though nearly 75% of the population lives in rural areas, the public and private health care development has concentrated mainly in urban areas. The standard and the level of health care provided by the public sector is inadequate due to low investment, bureaucratic mismanagement, and the lack of equipment, facilities, and trained medical professionals. The strengthening of public sector health care by successive Bangladeshi governments has not improved the availability of health care services for the rural poor and in particular for poor women in rural areas.

With around 3,100 persons per hospital bed and 23 doctors per 100,000 people[1], only the upper and middle classes and those with political influence have access to the public health care system. The poor are unable to penetrate the bureaucracy and the deliberately biased system. Thus, they have access to public health care only in theory. These circumstances highlight the need for alternatives, including the provision of inclusive health insurance.

This comparative study looks at three health insurance schemes in Bangladesh, namely those run by BRAC, Grameen Kalyan (GK) and the Society for Social Services (SSS). All three organizations are NGOs registered with the NGO Affairs Bureau under the Foreign Donations (Voluntary Activities) Regulations Ordinance of 1978.

The BRAC Micro Health Insurance for Poor Rural Women in Bangladesh (BRAC MHIB) started as a pilot project at Madhabdi in Narshingdi District in July 2001. It was formally launched in November 2001 when a 3-year financial and technical assistance agreement was signed with the ILO's Women's Empowerment through Employment and Health (WEEH). At that time, the project was extended to also include Phulbari in Dinajpur District. The project falls under the administration of BRAC, but operates as an independent entity. Membership is open to all poor families living in its two areas of operation. The project has not yet expanded its operations outside these two areas.

Grameen Kalyan was launched in November 1996 when Grameen Trust handed over 10 of its clinics to the newly registered NGO. Membership of its health scheme is open to all Grameen Bank borrowers and their families, as well as to poor villagers living within an 8 km radius of a GK health centre. Grameen Kalyan now operates 28 clinics in eight districts in the country.

The SSS health program began in January 1996 when the organization established a 20-bed hospital in a rented two-story house in the town of Tangail with donations from SSS staff and other Bangladeshi philanthropists. Membership of its health card scheme is open to all families living in the urban and rural areas of SSS's operation. Today, SSS operates 1 urban hospital and 16 rural clinics in 6 Upazilas of Tangail Zila.

None of the organizations considers itself a health microinsurance (HMI) provider in the strict sense of the term, as each model contains a mixture of social equity, service provision

[1] UNDP Report 2001

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.

Before they began providing HMI, these organizations were engaged in development activities for years—initially savings and credit before diversifying into other spheres. Their HMI schemes grew out of their social agendas to alleviate the suffering of poor rural Bangladeshis. In line with this social agenda, they aimed to provide affordable and quality health care services to those who would otherwise have to go without.

Statistics that illustrate the relationship between the HMI schemes and poverty alleviation are not readily available; but they can be construed from the experiences of the organizations and their clients. As clients' demand for products and services are growing, the organizations are increasing their outreach and diversifying their services. Most of their clients are able to pay for the services they receive.

The target population initially had a poor understanding of HMI and, as a result, all three organizations faced difficulties in convincing them of the benefits of their services. In addition, poor people in rural Bangladesh are not willing to pay for health services until they face illness or accident, and they look at premiums as expenditures rather than payments for protection against future risks.

These organizations have deliberately overlooked the risks of adverse selection and have enrolled members without any restrictions. They accept that their organizations are the only hope for these people to receive treatment for their illnesses. Fraud is not a major problem. Their staffs frequently interact with members and get to know their families personally. The organizations feel that this works as a moral deterrent against fraud and false claims.

GK and SSS play a dual role, that of insurer and of direct service provider; BRAC MHIB provides the health care service through associated organizations. Since starting their services, all three organizations have strengthened their administration to monitor the usage of the services. This enhanced control, however, has resulted in higher administrative costs.

BRAC MHIB and SSS provide free treatment to the very poor or destitute. GK does not provide any free health care service. All three organizations provide treatment to non-members as well, but only at their own clinics/hospitals; non-members are required to pay higher charges.

All three organizations received funding from donors and/or their parent NGO to set up their initial health care facilities, and they still require ongoing support. Operational results of BRAC MHIB and SSS show that without subsidy, they are not financially viable, which is a direct consequence of prioritizing their social agendas over financial sustainability.

GK has an operating loss, but a net surplus after investment income. Grameen Kalyan received an endowment fund from its parent organization that generated a substantial investment income. The endowment fund was returned to the parent organization in 2002.

The income generated by investment of the endowment fund and reserves has strengthened the financial position of GK significantly, and has contributed to the financial viability of the program.

The managers or employees of the three organizations did not have any prior training or experience in insurance when they started their HMI schemes. There is no evidence that organizations sought any advice from insurance professionals or retained any insurance experts before or after launching their schemes. The management and staff of all three organizations are still learning through a process of trial and error.

Lessons Learned

Institutional Mission

- Ill health and the cost of health care act as major obstacles to persons trying to break out of the poverty cycle and therefore the health of the poor must be addressed before they can rid themselves of want.
- Poor people require quality health care services at an affordable price. NGOs are often the only source of health services in rural areas, and the only one trusted by the population they serve.
- Running a health microinsurance program requires different expertise and different experience than needed to operate an MFI.
- To have successful client relationship and a positive poverty impact, the organization needs to allow greater voice to the clients to influence the organizations' agendas and pricing options.
- For a variety of reasons, poverty has a women's face and therefore the prime target population for almost all microfinance programs in Bangladesh, HMIs included, are women. Making sure that the female member of a household is, whenever possible, the principal member through whom the rest of her family can access the benefits contributes to the empowerment of women.

Institutional Capacity

- Poor people choose an HMI provider if it is known to them, provides quality care, has a good reputation, is nearby and the consumer is treated appropriately.
- Existing NGOs and MFIs have advantages in terms of HMI provision as they already have the infrastructure, the manpower and the resources.
- Large membership is desirable for any HMI scheme. It brings economy of scale and covers the administrative overheads of large branch networks.

Marketing and Client Education

- Poor people do not normally have a concept of risk pooling and are sceptical of a scheme in which payments come first with no immediate return. They are normally reluctant to part with funds before a health problem arises.

- Door-to-door visitation is one of the tools that can be used by an HMI scheme to market its product cost effectively.

Product Design and Controls

- Product design must be demand-driven, decided after consultation with the end users and field staff.
- Premium collection should be simple, easy to understand and to administer.

Claims Management

- Simple claims reimbursement systems enhance customer satisfaction, keep administrative overhead expenses low, and allow clinic staff to concentrate on health care activities.

Financial Performance and Sustainability

- A direct consequence of BRAC MHIB and SSS prioritizing their social agendas over financial sustainability is that operational costs are not recovered.
- The strategy to serve the community at large, and to charge higher rates to the less poor allowing for cross-subsidisation, has some merit and should be explored in more detail. Of particular importance are effective marketing strategies to attract the non-poor.
- GK's experience shows that, with a large endowment fund for a limited period and with sound investment management, it is possible to reach financial viability. This mechanism can be applied by donors or parent NGO instead of subsidizing operational shortfall each year for an indefinite period.

1. Key Issues in Offering Health Microinsurance

Health microinsurance can be defined as a type of insurance where accessibility to essential health services is made available to individuals and families, who are unable to afford formal health insurance schemes, through affordable premiums and low prices for health services.[2]

Health risks such as illness, accident or injury, which require households to incur medical treatment costs, are some of the most common concerns to low-income households. Risk pooling over a large number of people through health insurance schemes can provide at least partial protection against these health risks at an annual cost that is within the household budget.[3] HMI schemes use the principles of insurance to fund a tangible service like health care. They must be designed with risk pooling mechanisms to harness private funds for health care financing.

The large rural informal workforce in Bangladesh makes it difficult to offer work-based social insurance and therefore health insurance provision should be incorporated within the framework of an overall national health plan and treated as a social security program. Successive Bangladeshi governments have failed to incorporate it due to misplaced priorities, poor planning and scarcity of resources. The poor cannot access the private health care system because of high costs.

Before embarking upon the provision of a complicated service like health care, HMI providers need to consider six critical areas: 1) institutional mission, 2) institutional capacity, 3) marketing and client education, 4) product design and controls, 5) claims management and 6) financial performance. Key questions around these topics are introduced in this section, and then the evidence from the three organizations will be used to answer the questions in Section 5.

Institutional Mission

NGOs in Bangladesh exist to serve the development needs of the poor. The lofty goals of poverty alleviation and empowerment of the disadvantaged are enshrined in their mission statements. The challenge, then, is to combine effective management and cost controls with a social agenda, and to maintain focus and insurance technical expertise while the organizations are involved in a whole spectra of poverty alleviation activities.

The structure for delivering health insurance often depends on the organization's mission. Typically, there are two different options: a provider model and an insurer model. In the provider model, the health care provider and the insurer are one-in-the-same, like a health maintenance organization (HMO). In the insurer model, policyholders can (usually) receive treatment from a variety of different health care providers.

The social mission also requires HMIs to take into consideration the unique characteristics of the vulnerable populations that they are seeking to serve. In Bangladesh, gender issues are a

[2] WEEH Profile.
[3] Providing Insurance to Low Income Households Part 1, Brown and Churchill 1999.

particular problem. Socio-cultural barriers that exist in society are aligned against the equal status of women and girls. That the last three Prime Ministers of Bangladesh have been women belies the fact that the majority of the females in Bangladesh, specifically those in rural areas, endure substantial deprivation. They have been, and continue to be, consistently denied many basic human rights. A well-planned health insurance scheme in Bangladesh needs to take into account the disadvantaged situation of women.

Institutional Capacity

Health microinsurance providers need access to information about the local environment, the resources, the market reality and potential. HMI service providers also need to have committed and skilled managers and staff, and a well-integrated team of other supporting players. They also need sufficient expertise to design the products, including the benefit package and the pricing—such expertise requires actuarial skills and an understanding of the target market.

Another critical capacity issue is having systems to manage the reams of data necessary to run a health insurance scheme. Unlike life insurance, where there is only one insured event, health insurance covers a range of eventualities that can occur frequently and repeatedly. To manage a health microinsurance scheme, it is therefore more complicated to keep track of results and performance.

Marketing and Client Education

The intended beneficiaries for microinsurance are a reluctant market. Low-income households are wary to part with their limited funds for a promise of future benefits that they may or may not incur. Consequently, one of the greatest challenges in microinsurance is convincing the target market that they should indeed appreciate the policy. To accomplish that, it requires salespersons who understand insurance, have the marketing tools to persuade sceptics, and are backed by an institution that can deliver its promises.

Product Design and Controls

Even though risk pooling can provide more complete compensation than individuals' capacity to pay, it cannot provide coverage against all health service requirements, and so a benefits package has to be developed with resultant costs and benefits in mind.[4] To provide microinsurance, some hard decisions need to be made about the benefit package to ensure that it is affordable.

Decisions on the part of insurers regarding the provision of HMI depend on three main factors: demand, affordability, and availability of services.[5] The high costs of health care services require the levying of premiums that may exceed the insured's ability to pay, especially in a poor country like Bangladesh. At the same time, the majority of the population may find that they are unable to bear the high costs of health care without insurance. In addition, most low-income households have irregular income flows. To make HMI schemes attractive to them, they need to be provided with premium payment schemes.

[4] Providing Insurance to Low Income Households Part 2, Brown and Churchill 2000.
[5] Regulated insurers would replace "affordability" with "profitability".

Health insurance plans the world over have inherent risks; in developing countries, the risks of adverse selection, moral hazard, over use, fraud and cost escalation are high. In Bangladesh, with its high population density, co-variant risks are also a big issue for the insurance providers.

One of the more significant challenges is fraud, especially efforts to claim treatment for individuals not covered under the scheme. Organizations need to have effective management information and identification systems to know who is and is not covered, and who is up-to-date with their premium payments.

Cost control is another challenge. One solution is to have a ceiling on the amount of benefits available, or to limit the recovery time. Such strategies may solve the HMI service providers' problems, but it merely transfers the burden to the insured and acts to make the HMI schemes less attractive to the rural poor.

Over-usage of facilities by the insured is another cost issue faced by health insurers. The insured often feel like they are not getting their money's worth unless they avail themselves of the health services provided and may, for example, insist on hospitalization for minor illnesses. There are also issues of unnecessary visits and fake illnesses. One way to control over-usage is through co-payments or deductibles.

Many health insurers control costs by requiring the insured to notify them in advance of any treatment, however such an arrangement may not make sense with microinsurance, especially in areas there communication can be difficult.

A general problem of private insurance provision, which is particularly true for the health insurance industry, is that insurers may try to limit their risks by, for example, only insuring low risk people or restricting the range of risks covered. This practice again excludes the people who need health insurance the most.

Claims Management

Claims management in health insurance is somewhat different from other types of insurance because often the claim is paid in-kind, that is through health care services. The claims management procedure will depend on the delivery model. In the provider or HMO approach, policyholders do not usually have to submit claims since they are handled internally, from one department to another. The only time policyholders would request cash reimbursements is if they had to see a specialist outside the HMO or had an emergency outside the provider's geographic area.

Sustainability and Financial Performance

From a review of the literature, it appears that there are very few success stories of health microinsurance where the schemes are viable based on the income received from policyholders and users. The question then is how to design a sustainable health care delivery model (including insurance) that serves the poor over the long term.

2. Health Care and Health Insurance in Bangladesh

2.1 Health Care

A rough estimate of the current annual worldwide health care expenditure (public and private) amounts to US$2,000 billion. On average, developed countries spend US$1,500 per person on health care, compared to US$287 in developing countries. The level of health care spending in Bangladesh – at 3.5% of its total GDP[6] or US$58 per person – is considerably lower than many developing countries; a substantial part of this spending is private, out-of-pocket expenses. A Ministry of Health and Family Welfare study concluded that only 34% of health expenditure was financed by the government, 64% by the public and 2% by NGOs.[7] Despite such a high share of expenditure by private individuals, the provision of health care is inadequate in terms of quality and access. This highlights the need for alternative financing, including the provision of more inclusive health care insurance.

The present state of health care in Bangladesh has a colonial legacy. At the time of independence in 1971, the country inherited a health system introduced during the British era and perpetuated during Pakistani rule. The system was mainly urban-based, elite-biased, and curative-orientated. The Bangladesh Government continued with the same system. Even though nearly 75% of the population still lives in rural areas, health care development is mainly urban.

Bangladesh is divided into 6 Divisions, 64 Districts, 460 Upazilas, and 4403 Unions. Each Union has on an average 3 Wards, and 4 to 5 villages constitute a ward. On an average, a Ward has a population of 7,000 people and is the lowest administrative tier of the Government.

The structure of the health service follows this administrative structure. The Ministry of Health and Family Welfare is responsible for policy, planning and decision making at the macro level. Below this are two major implementation wings: the Directorate General of Health Services and the Directorate of Family Planning. The Director General of Health Services is responsible for implementation of all health programs of the government, and provides technical guidance to the Ministry. The Directorate of Family Planning is responsible for implementing family planning programs and provides family planning related technical assistance to the Ministry.

Government health care services are provided through a five-tier system. The level and sophistication of the health service facilities go up with the rise in the level of administrative hierarchy, as shown in Table 1.

[6] WHO 2001.
[7] *A Feasibility Study of Imperial Hospital, Chittagong, Bangladesh* by International Hospital Group.

Table 1. Health Care Administrative Levels in Bangladesh[8]

	Level Of Care	Administrative Unit	Number of Facilities	Population Covered
1	Tertiary	Division	33 Teaching & Specialized Hospitals	10-15 million by all units
2	Second Referral	District	64 District Hospitals	1-2 million by each unit
3	First Referral	Upazila	553 Upazila Health Complexes	200,000-450,000 by each unit
4	First Level Facility	Union	4,068 HFWCs	21,000 by each unit
5	First Contact	Ward	Community Based Staff	7,00 by each unit
6	Informal Contact	Village	TBA (Dais) & Kobiraj	1,000-1,500

The first contact with the government health care system is at the Ward level where there are health assistants. At the Union level, the Health and Family Welfare Centres (HFWC) provides preventative and family planning services and is usually managed by a graduate doctor with some support staff. The next level of health care is the Upazila Health Complexes, which were developed during the 1970s as part of the government's strategy to develop primary health care and provide the first level referral services. Usually several graduate doctors are available in an Upazila Complex, which includes specialists and a dental surgeon. The Health Complex usually has a 30-bed in-patient department, an outpatient department, and a family planning unit that together provide preventive and limited curative services to the population.

At the District level, there is usually a hospital, with between 50 and 200 beds, which is intended to serve 1 to 2 million people. The District Hospital is under the management of the Civil Surgeon and provides more sophisticated curative, laboratory and diagnostic services.

All the tertiary level health facilities are located in the capital city and include post-graduate hospitals, medical college hospitals and specialized hospitals. These facilities provide highly specialized curative treatments, laboratory and diagnostic services and various other kinds of training and educational facilities.

The total number of hospital beds available under the Ministry of Health is approximately 28,000, of which approximately 45% are located at the Upazila level and 17% are at the District level, and the remaining 36% are either in large tertiary general hospitals or specialized hospitals at the six divisional headquarters.[9]

Statistics on the private sector in health care provision are inconsistent, and thought to be inaccurate because many doctors work in a number of public and private facilities. The Bangladesh Health Bulletin published in 1999 records approximately 485 private hospitals in the country offering approximately 15,000 beds, with over 50% of them in Dhaka division.

The standard of health care provided by the public sector continues to be poor and inadequate due to low investment, bureaucratic mismanagement, a lack of facilities and equipment, and a shortage of trained medical professionals. With around 3,100 persons per hospital bed in the country, and 23 doctors per 100,000 people, only the middle-class, rich and influential people

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[8] *A Feasibility Study of Imperial Hospital, Chittagong, Bangladesh* by International Hospital Group.
[9] Ibid.

have access to the public health care system. The poor are unable to penetrate the bureaucracy, the archaic administration and the deliberately biased system. They have access to public health care in theory only.

Two of the major limitations of the present health care system and its financing in Bangladesh are: (a) high health care costs, more than half of which is private out-of-pocket expenditure; and (b) unsatisfactory outcomes of the expenses. Most of the out-of-pocket expenses are borne by households engaged in low-income informal economic activities.

2.2 Health Insurance

Following independence in 1972, the Bangladesh Government nationalised all insurance companies in the country. The newly created Jiban Bima (Life Insurance) Corporation took over all the assets and liabilities of the life business, while the Sadharan Bima (General Insurance) Corporation did the same for the non-life business. An ordinance passed in 1984 allowed the formation of private insurance companies. As shown in Table 2, currently there are 60 Insurance Companies and Corporations in Bangladesh divided into two categories, Life and General (Non-life).

Table 2. Number of Bangladeshi Insurance Companies[10]

Bangladesh Insurance Industry	Number of Operators
Public Sector Life Insurers	1
Private Sector Life Insurers	16
Total Life Insurers	**17**
Public Sector General Insurers	1
Private Sector General Insurers	42
Total General Insurers	**43**

The Bangladeshi insurance sector remains underdeveloped compared to that of neighbouring countries. Insurance spending as a percentage of GDP in Bangladesh at 0.57% is also among the lowest in the region. Per capita insurance premiums in 2003 were US$2.1, compared to US$2.9 for Pakistan, US$14.5 for Indonesia and US$16.4 for India.

The Insurance Act in Bangladesh allows only life insurance companies and composite insurance companies to offer health insurance, and therefore the non-life insurance companies that are offering health insurance are in breach of the law.

K M Mortuza Ali conducted a survey of the life and non-life insurance companies in Bangladesh in mid-2002. Ten life insurance providers and 20 non-life insurance providers responded. Out of these, three life insurance companies had introduced limited health insurance products, one life insurance company was interested in introducing health insurance, while six others stated that they might consider health insurance as a future option.

Seven of the 20 non-life insurance companies had introduced limited health insurance products as of July 2002. Of the remainder, two stated they would not be interested in

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[10] Ali, Mortuza K M, 2002.

diversifying into health insurance because of the high risk of false claims and the lack of health care infrastructure. The remaining 11 cited a lack of demand for such products for their decision, backing up the commonly held opinion that the lack of public awareness is main reason for the underdeveloped state of health insurance in Bangladesh. All 20 insurance companies believed the government should develop a legal framework to standardize operational procedures and introduce quality assurance in health care service provision. One can conclude from Ali's results that many issues related to health insurance have to be resolved before insurance companies will be prepared to enter this market on a large scale.

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 coming years, the process of globalization will bring foreign insurers to the country. Before this can happen though, the regulatory environment pertaining to the insurance industry must be drastically improved.

There are a number of innovative community-based insurance schemes in Bangladesh, largely run by NGOs. The most notable of these are Gonoshashtho Kendra (see Box 1), Sajida Foundation, Shakti, and Dhaka Community Hospital.

Box 1. Gonoshashtho Kendra

Gonoshashtho Kendra (GSK) was the first organization to introduce HMI in Bangladesh. GSK operates a health microinsurance scheme based on the insured's ability to pay.

GSK was established in 1972 by Dr Zafarullah Chowdhury. In 1971, during the Liberation War against Pakistan, Dr. Zafarullah and a few young Bangladeshi doctors who were studying in the UK managed to raise funds from Bangladeshi doctors all over the world to assist the freedom fighters. They moved to the conflict area and set up a 480-bed field hospital for the wounded on the Indian border. After the war, in 1972, the hospital was transferred to donated land at Savar, an Upazila of Dhaka, with six tents and an outpatients' clinic under a jackfruit tree.

GSK's original aim was to provide health care appropriate to the needs of the rural poor. Over the years, it has widened its work to embrace programs that include education, nutrition, agriculture, environment, vaccine research, herbal medicinal plant research, income generation and vocational training. GSK also seeks to meet the diverse development needs of the poor and landless.

Since its inception, it has trained over 4,000 paramedics, of whom 160 are at present employed at the GSK centre in Savar and 10 sub-centres established around the country to provide health care to 180,000 low-income people. Sixty percent of the paramedics are women. They are trained in curative and primary health care programs and preventive medicine of all kinds.

In 1981, GSK set up Gono Pharmaceuticals to produce low-cost drugs. It has been a great success and now supplies 5% of all drugs consumed in Bangladesh. Its prices are about 60% below those of multinationals, which in some cases has led to lower prices as a result of competition. The factory employs 400 people. Half of its profits are earmarked for GSK's social projects.

GSK now also operates a 100-bed hospital in Dhanmondi area (an upper middle class area) of the capital, Dhaka. The main beneficiaries are slum dwellers and domestic workers in the city. Many middle-class city dwellers also use its services. The hospital has all the modern diagnostic and

treatment facilities, and a very modern cardiac unit capable of performing cardiac by-pass operations is in the planning stages.

GSK is controlled by a charitable trust, of which Dr. Zafarullah is one of the four trustees. The Trust employs some 1,500 full-time staff, with an additional 1,000 part-time staff members. About half of its budget is self-generated. An important principle is that GSK never gives away its goods and services free of charge. They have to be paid for, however cheaply.

2.3 Legislation and Regulation

The law regulating the insurance industry in Bangladesh is the Insurance Act of 1938. Introduced under the British era, it has more or less remained the same, with only a few amendments made over the ensuing decades. The only reference in the Act to health insurance is a definition. The regulatory authority in Bangladesh is staffed by bureaucrats who have limited knowledge or experience in insurance. Its presence has little impact in the insurance sector or on the quality of insurance products. As a result, insurance regulation in Bangladesh is almost non-existent.[11]

Table 3. Insurance Industry Basics[12]

Issues	Observations
Name of insurance regulatory body	The Insurance Directorate, headed by The Chief Controller of Insurance
Key responsibilities of the regulatory authority	Consumer protection, licensing, policy approval, monitoring and investigations
Key requirements for an insurance license	Life Insurance and Non-life Insurance businesses are segregated.
On-going capital requirements for an insurance company (see Table 4 below)	Maintain at least minimum capital and deposits
Other key requirements for regulatory compliance	Reporting, actuarial valuation in case of life business, auditing and separation of funds
Number of regulated private insurers (12/02)	Life = 15 Non-Life = 42 Brokers = Nil
Number of regulated foreign insurers (12/02)	Life = 1 Non-life = Nil
Number of regulated public insurers (12/02)	Life = 1, Non-Life = 1
Value of annual premiums of regulated private insurers (12/02)	Life = US$139 million Non-Life = US$77 million
Value of annual premiums of regulated public insurers (12/02)	Life = US$31 million Non-Life = US$15.5 million
Number of re-insurers (if any)	Two local, several international
Other unregulated organizations	Unknown though there are several being implemented by MFIs
Certification requirements for agents	Minor fee, generate six policyholders, pass exam, can either sell for life or non-life

[11] Ali Mortuza KM, 2002
[12] The [Bangladesh] Insurance Act, 1938 and Rules 1958, October 2001

Table 4. Minimum Capital and Deposit Requirements for Insurance Industry[13]

Issues	Minimum Capital Requirement US$ in '000	Minimum Deposit Requirement US$ in '000
Life Insurance	1,279	72
General Insurance	2,579	52
Specified Miscellaneous Insurance	258	103
Co-operative Insurance Society – Life Ins	175	175
Co-operative Insurance Society – Gen. Ins	340	340
Mutual Insurance	175	21
Provident Society – actual value	86	860

Besides the minimum capital and deposit requirements shown in Table 4**,** regulated insurance companies are required to pay 0.15% of their gross premiums as an annual licence fee to the government.

State Promotion of Insurance

The insurance industry was nationalised in 1972 by Presidential Order No. 95, known as the Bangladesh Insurance (Nationalisation) Order 1972. The law provides for insurance companies, provident societies, mutual insurance companies and co-operative insurance societies, as well as two state run insurers, Jiban Bima for Life business and Sadharan Bima Corporations for General (non-life) business.

The State holds a negative attitude towards the insurance industry and little effort is made to promote the insurance industry. The Insurance Directorate, under the Ministry of Commerce, is the regulatory body. A Chief Controller of Insurance, normally a senior civil servant, heads the Directorate. The present Chief Controller of Insurance has been in the job for just over 12 months. The position is additional to his other duties at the ministry, and therefore, is neglected. The government appoints people for this position for a short period while they await other opportunities. The office is actually run by the Deputy Chief Controller who has served at the Directorate for several years. Because the leadership of the Chief is so limited, the directorate has collected little data, compiled few reports, and undertaken little research into the insurance sector. Aggregate industry data was thus difficult to obtain. The Directorate does not have the capacity or the resources to carry out any inspection and therefore engages independent professionals to examine the books and records on its behalf.

The government is working on the development of a new insurance law. There have been several studies by insurance and regulatory experts from overseas with a view to modernizing the insurance law. Several recommendations have been made to the Chief Controller's office but no significant progress has been made in this area due to a lack of interest.

[13] The [Bangladesh] Insurance Act, 1938 and Rules 1958, October 2001. Exchange rate 1US$=BDT58.687

2.4 The Role of the State in Social Protection

Bangladesh does not have an established social security system, and the provision of social protection by public and private institutions is very limited. Government schemes are mostly focused on state employees, for whom there is an un-funded pension scheme and free health care facility at government hospitals. Free health services for the poor in urban and rural areas only exist theoretically. Only those in a position to influence, or have connections, are able to use these facilities and therefore the poor are excluded. The rich use private health care providers in the country or abroad. The majority of the population who work in the informal economy rely on traditional forms of social protection. In times of adversity, the extended family, friends and the local community provide economic and social support.

Since independence, successive governments have instituted five five-year plans to address the health care needs of its citizens. The First Plan (1973-78) recognized the need for health services to benefit the entire population, including the majority living in rural areas. Its stated priorities included the creation of a 'rural health infrastructure for providing integrated health services,' and the increased access to potable water and improved sanitation facilities. The Second Plan (1980-85) aimed to increase the coverage of health services, with particular attention to correcting the urban-rural disparities in access to such services. The Third Plan (1985-90) envisioned the provision of 'Health for All' by the year 2000, emphasizing primary health care as means to achieving the goal. The Fourth Plan (1990-95) aimed to improve the health status of Bangladeshis through consolidated and strengthened primary health care, improved nutritional status and the prevention of communicable diseases. The Fifth Plan (1995-2000), intended to ensure universal access to essential health care services for all.[14]

One component of the Government's Health and Population Sector Program (HPSP) for 1998-2003 focused on the policy and regulatory action for enhanced sustainability, accessibility, affordability and quality of services. This 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 seeks to support existing and future health microinsurance schemes operated by NGOs.[15] The HPSP does not elaborate on the operational mechanism of NGO-run schemes.

At present, less than 40% of the population has access to basic health services. Existing resource constraints are blamed for the Government's failure to provide the health care services required by the population. Even though the specific targets set out in the plans have not been achieved, there has been some improvement in the country's health indicators over the years. There has been progress in the arena of family planning, child immunization and life expectancy. Fertility rate has steadily decreased over the years and child immunization schemes have reached 70% of the population, polio eradication is almost 100% complete, and life expectancy has risen to 59, compared to 45 in 1970.[16]

Bangladesh government runs several poverty alleviation programs designed to assist the low-income, un- or self-employed. These are mostly funded by donors or through development aid and are implemented through the Ministry of Local Government and Rural Development.

[14] Ali Mortuza KM, 2002.
[15] Ibid.
[16] Ibid.

The programs include food distribution, food for work, food for training, primary education, and relief in the event of floods.

The State is involved in health programs with BRAC through joint research in developing low-cost medicines, supplements and nutrients. It is also in partnership with Gonoshashtho Kendra in its pharmaceutical business, training facilities for doctors and nurses, as well as its network of regional and local health care facilities, all specifically focused on improved access to and quality of its health care facilities.

2.5 Overview of Microinsurance in Bangladesh

Microinsurance, though gaining popularity in Bangladesh, is relatively new as a concept and data and documents are fairly scarce. Several major NGOs have some level of microinsurance provision covering health care, disability, or death. Despite the NGOs' growing role, this sector has not yet reached a level where it can make a significant impact given the scale of the problem.

For life insurance, some regulated insurers have entered the microinsurance market following the lead of Delta Life's endowment policies.[17] Life products are becoming competitive and there is an increasing variety of life insurance options available to the low-income market in Bangladesh today.

The non-governmental organizations involved in microinsurance are not registered with the Insurance Directorate and are not regulated or supervised under the Insurance Act. The NGOs are of the view that since the NGO regulations do not prohibit such a service, it is not illegal to provide health microinsurance to its members.

The Chief Controller of Insurance has the authority to regulate the provident funds, mutual and cooperative insurers, and provide a mechanism to formalize these organizations. Confusion over whether microinsurance activities of NGOs falls under the jurisdiction of the Controller's office, which is under the Ministry of Commerce, or the NGO Affairs Bureau, may become an issue in the future. There has been no attempt to regulate or facilitate microinsurance in the country.

Bangladeshi microfinance NGOs came into the health microinsurance scene in the late 1990s and early 2000s. Throughout the 1990s, the flagship organizations like Grameen Bank and BRAC were pre-occupied in their diversification programs—IT, mobile telecommunication, renewable energy, bank, university and consumer products—and very little resources were applied to the health microinsurance except for some studies and a few pilot schemes.

Important players in health microinsurance are Gonoshashtho Kendra, Sajida Foundation, Shakti, Dhaka Community Hospital, BRAC, Grameen Kalyan, Nari Uddug Kendra, Dushtha Shasthya Kendra, Integrated Development Foundation and Society for Social Development. Most call themselves 'health card systems' and employ risk pooling to cover a large number

[17] See McCord, Michael and Craig Churchill (2005), 'Delta Life, Bangladesh,' Good and Bad Practices in Microinsurance, Case Study No. 7. Geneva: International Labour Organization.

of people. Two large microfinance NGOs, ASA and Proshika, have not entered health microinsurance; they state that they do not have the resources to provide the service.

Although HMI has not been incorporated into the Government of Bangladesh's National Health Policy, the Ministry of Health and Family Welfare has shown great interest in the concept and is considering the inclusion of HMI programs as a method of extending existing government health service outreach. In the non-government sector, the provident societies, and mutual and cooperative organizations offer an important option for microinsurance. There is also a feeling among other non-NGO health service providers that a legal framework should be developed to facilitate the expansion of NGO provided health care services and introduce standardised operational procedures and maintain quality assurance.

In 2001, the ILO launched the Women's Empowerment through Employment and Health Project (WEEH), to assist poor women to access decent employment, skills, income opportunities, and to viable social protection schemes such as health insurance and quality health services. The two projects implemented under the WEEH heading were:

a) Women's Empowerment through Decent Employment (WEDE)
b) Micro Health Insurance for Poor Rural Women in Bangladesh (MHIB)

The MHIB supports community schemes working towards women's access to quality health services and health microinsurance. The project has three components:

a) The implementation of a health microinsurance scheme through Grameen Kalyan
b) The implementation of a pilot health microinsurance scheme through BRAC
c) Advocacy and knowledge development through training materials and guidelines, promotion of social protection, action research and awareness raising

MHIB as a concept and a mechanism has emerged as a way to provide health care facilities to the poor. Generally, the MHIB schemes offered are open to all, but with some variations in the service packaging and with differently applicable price schemes for members and non-members. The prices are low compared to market rates and within the affordability of the target groups. The outreach of these MHIB schemes remains very limited however, especially compared to the population covered by the flagship NGOs (Grameen and BRAC) in their savings and credit activities.

In general, the insurance packages have been designed to include basic service elements of general consultation and treatment, selected antenatal and postnatal care, simple preventative and curative care including drugs, low-cost pathology and other tests, and referral services to higher level hospitals and clinical facilities. Assisted normal deliveries and surgical deliveries are often included as well. Individual family members, mostly women, typically make premium payments for policies that cover the whole family.

Most of the NGOs under the MHIB scheme have their own community-based mini-clinics with limited laboratory facilities staffed by medical professionals and/or paramedics. Some, such as GSK and SSS, have larger clinical facilities, in some cases hospitals. Some of the NGOs have linked up with clinics or health care service providers in their area of operation to offer their schemes. The NGOs with their own facilities and referral arrangements tend to have more service options than those that depend on a third party to supply the health service.

In 2003, the ILO's WEEH project carried out an extensive study of microinsurance schemes operating in Bangladesh. The study covers nineteen organizations that provide thirty-six schemes and involve six million policyholders benefiting approximately seventeen million people in various parts of the country. A small proportion of the schemes have been in operation for more than six years while the majority have operated for three years or less.

The evolution of the microinsurance concept stems from the development and widespread implementation of micro-credit models as a development strategy for Bangladesh. As the viability of the 'credit-model' has been constrained by loan defaults, NGOs needed to complement credit with social security-type services. Today, the microinsurance model has become an important development tool to reduce the likelihood of loan defaults by addressing certain high economic costs to borrower groups and their families, for example resulting from emergency health expenditures, death of a family member, and damage to property caused by fire or natural disasters.

Most of these schemes cover loan and life insurance; health care schemes, though larger in number, have a very small membership. Two of these organizations, BRAC MHIB and Grameen Kalyan, are part of two large development NGOs that have nationwide reach. The other 17 organizations, including SSS, are small- to medium-sized, locality-based NGOs that provide primary health care, hospitalization, life insurance, loan protection and property insurance. Several commercial insurance companies run microinsurance schemes; however, their risk-coverage is limited to life insurance. The microinsurance schemes in Bangladesh fall under five categories, as shown in Table 5.

Table 5. Types of Microinsurance in Bangladesh

	Type of Scheme	No. of schemes	% Distribution
1.	Health	13	39
2.	Life	12	36
3.	Loans/Capital	8	19
4.	Livestock	2	4
5.	Disaster	1	2
	Total	**36**	**100**

The types of service offered by health microinsurance schemes in Bangladesh include preventive care, such as educational programs on cleanliness, food preparation, AIDS prevention and prenatal care; and primary care, e.g., medical exams, consultation with certified doctor, and prescription for medicines. Lab tests, such as x-rays, and major medical care level such as surgeries are also available. The organizations covered in this study provide a complete coverage of all services.

3. The Institutions

Table 6. Institutional Comparison Summary[18]

Issues	BRAC MHIB	Grameen Kalyan	SSS Health Program
Legal structure	Component of NGO BRAC	NGO	Component of NGO SSS
Start of microinsurance operations	2001	1997	1993
Target market	All families in their area of operation		
Delivery model	Insurer	Insurer/ Service Provider	Insurer/Service Provider
Reinsurance provider, type	None		
Product offerings	Preventive, Curative & Pregnancy-related Care	Preventive & Curative Care	Curative Care
Main benefits/coverage	See Table 7a, b & c	See Table 8	See Table 9
Outreach 2004: number of policyholders	12,258	58,000	45,424
Number of persons covered[19]	43,522	290,000	227,120
Premium income & Co-payments 2004	BDT 516,622 (US$8,803)	BDT 4,396,361 (US$74,912)	BDT 219,782 (US$3,745)
Claims expenses 2004[20]	US$4,911	US$5,164	-
HO & admin expenses[21]	US$34,904	US$207,462	US$92,129
Claims/premiums (%)	55.8	6.9	-
Expenses/premiums (%)	396.3	270.0	2460.0

3.1 BRAC Micro Health Insurance Program[22]

BRAC (Bangladesh Rural Advancement Committee) was set up in 1972 as a non-profit development organization to offer relief to people whose lives were dominated by extreme poverty, illiteracy and disease. Since its inception, BRAC has grown to become one of the largest NGOs in the world, working in 65,000 villages in all 64 districts of Bangladesh, employing over 35,000 regular staff and 61,750 full-time and part-time teachers. Its cumulative loan disbursement to date is US$2.8 Billion, with 98.7% recovery rate, and its deposits stand at US$136 million. BRAC's microcredit program follows the Grameen Bank group-borrowing model, delivering services through at network of 1,172 branches and 155,065 Village Organizations (VO). BRAC's microcredit program in each village is referred to as a Village Organization, and poor people who participate in the program are referred to as VO members. The current VO membership is 5.1 million.

[18] Exchange rate used 1US$= BDT58.687.
[19] Assuming 5 members per family.
[20] Only BRAC MHIB shows the full claims costs since it actually makes payments to the BRAC clinics; the claims costs for GK and SSS only include the cost of referrals.
[21] GK & SSS: includes cost of providing treatment at own clinics/hospital.
[22] Data source: BRAC at a Glance, 2005.

BRAC has a range of health and development services available to 31 million people in the country through 37 health centres. It is supported by 33,000 volunteers and treated 5.7 million rural poor in 2004.

BRAC originally introduced a health ‘insurance’ scheme in the mid 1970s as part of a project in Sulla, in the northeast of Bangladesh. The aim was to provide affordable health care to community members. In exchange for an annual ‘premium’ of one kilogram of pre-husked rice, households were eligible to receive free primary health care from BRAC paramedics. The scheme was open to all sections of the society. It was discontinued when research revealed that only landowners and established farmers were taking advantage of the scheme.

During the 1980s and early 1990s, the BRAC Health Program focused on providing free preventative health services in its areas of operation. From the mid 1990s, the program was extended to include curative services to complement their existing preventative services. The first BRAC health centre or ‘Shushastho’ was established in response to demands of BRAC’s members. User fees were introduced at the Shushasthos to ensure a financially sustainable model for the provision of clinical services to the community. Again, research showed that poorer segments of society were not able to make use of such services owing to their inability to afford the user fees. Their desire to reintroduce a health microinsurance scheme grew out of the need to include this neglected segment and address the issues of equity, affordability and accessibility to health care.

BRAC management comprehensively reviewed health microinsurance schemes at home and abroad to determine the feasibility of introducing a scheme aimed at BRAC’s target population. The intention was to implement any scheme within the context of existing program activities, so that few additional resources would be required and the scheme could be easily replicated. The scheme was designed to make use of the Shushasthos such that BRAC would play the dual role of insurer and health provider.

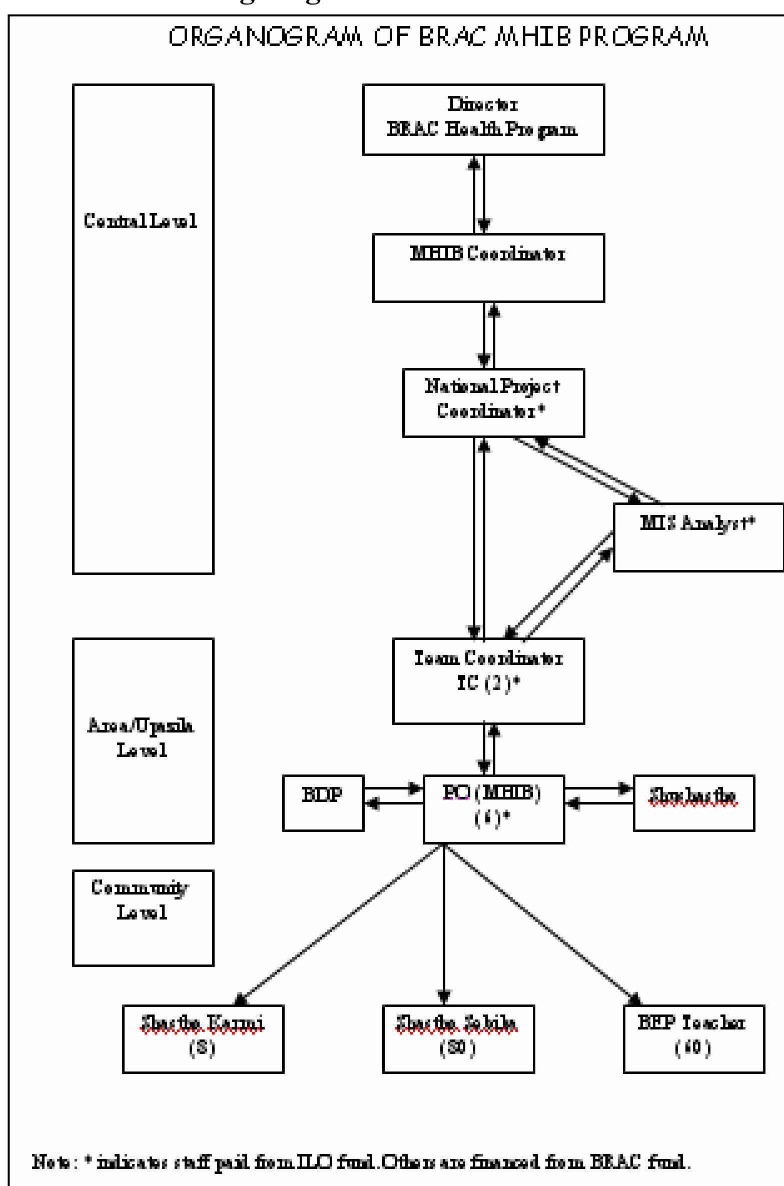
The BRAC Health Program focuses principally on the community, with a particular focus on women and children, though men are not specifically excluded, and is implemented through three tiers. The first tier is a cadre of part-time community health workers, called Shashtho Shebikas (SS), mostly women and the front-line workers of BRAC’s Health Program. They go door-to door to educate community members on critical health matters, provide treatment for basic ailments, essential health commodities, and help to create “health-empowered” communities. The second tier is a cadre of health paramedics, all women, called Shashtho Kormis (SK). A relatively new innovation of the BRAC Health Program, these paramedics oversee the work of the SS, provide pregnancy-related care, and hold health education forums where the community’s health concerns are addressed. The third tier is a network of clinical facilities, called BRAC Shushasthos. The Shushasthos provide technical and clinical backup to the SS and SK, who refer patients that they cannot treat to these centres. The Shushasthos provide treatment and diagnostic services, have comprehensive laboratory labs, outpatient facilities, and in-patient services, all supported of qualified nurses and physicians. There are 98 Shushasthos operating in 92 Upazilas in the country.

In an effort to find ways of better financing its clinics, in July 2001, BRAC initiated pilot project on health microinsurance in Madhabdi Upazila of Narshingdi District. BRAC MHIB

was formally launched in November 2001, when BRAC signed a 3-year agreement with the ILO. With this support, the project was scaled up in the initial pilot area and extended to another area, Phulbari Upazila in Dinajpur District. The project is designed to achieve three primary goals: 1) contribute to women's empowerment; 2) increase access to BRAC's existing health care initiatives for poor women and their families; and 3) increase awareness of preventative health care including HIV/AIDS and sexually transmitted diseases (STDs).

The BRAC MHIB scheme was established as a separate entity from the NGO and Shushasthos, reimbursing them for the services used by the BRAC MHIB members. The primary beneficiaries of BRAC MHIB are poor rural women who otherwise would not have access to quality health care services due to financial and cultural constraints.

Organogram 1. BRAC MHIB



The scheme offers voluntary enrolment in the General Benefits package providing subsidized essential services such as consultation, pathology testing and medicine for an annual premium and a co-payment. Family size and Village Organization (VO) membership determine the premium amount, while MHIB membership alone determines co-payment charges. BRAC MHIB has referral links with government and private sector clinics and hospitals for cases that BRAC Shushasthos are not equipped to handle. Details of the package are given in Table 7a below and in Appendix 4 & 5.

BRAC MHIB scheme is card-based; each policyholder is issued with a card, which is the evidence of the insurance coverage. The card carries the photograph of the head of the family, the cardholder's name, name of the family members covered, insurance start and end date, and a list of benefits and rules (see Appendix 3). Application forms are mostly completed by BRAC employees because of the applicants' inability to read or write. Premiums are collected annually in a single cash instalment. Individuals can register at any time at the Area Office, or at the Shushastho, or during routine visits of the BRAC MHIB staff at a village meeting. They are also authorised to collect premiums and issue receipts.

The scheme seeks to also target the very poor or destitute, referred to by BRAC as 'ultra poor.' The ultra-poor can enrol in the Equity package free of charge, and have access to the benefits of the General Benefits package. In line with BRAC's social agenda, the aim was to cross-subsidize the cost of ultra poor enrolment with the receipts from non-VO enrolment. As of October 2004, the General Benefits package had 7,816 policyholders (6,776 VO, 700 non –VO and 340 ultra poor) covering an estimated 39,080 beneficiaries.[23]

From statistics collected in 2001, BRAC MHIB observed that pregnant women visited the anti-natal clinics (ANC) on the average 3 times during the entire pregnancy. They only visited when conditions seemed desperate, as they could not afford to pay the charges. This in turn compromised their health and put their pregnancies at risk.

To counteract this practice, BRAC MHIB introduced a Prepaid Pregnancy-related Care package in January 2002 to encourage monthly checkups. The package includes services that were not widely available, such as pre-delivery complications (abortions and miscarriages), post-delivery complications, and neo-natal care. The package has increased the service-seeking behaviour of women that previously received very little. Details of the package are given in Table 7b below and in Appendix 2. At the end of October 2004, the Pregnancy-related Care package had 3,442 policyholders.

A pilot School Health package was introduced in Phulbari Upazila, Dinajpur as of January 2004. The package targets children at a particular government school and for an annual premium of US$0.17 provides them with the preventative benefits and primary health care services outlined in Table 7c. At the end of 2004, out of 1,200 students enrolled in the school, 1,000 were enrolled in the School Health package, 60% being female. BRAC MHIB is currently formulating plans to extend the School Health package to other areas.

[23] The VO pricing and enrolment for BRAC MHIB includes members of other MFIs.

Table 7a. BRAC MHIB General Benefit and Ultra Poor Equity Package

Product Details	Product Features and Policies
Microinsurance Type	Preventive & curative health care
Group or individual product	Individual
Term	Annual
Eligibility requirements	Must be living in target area
Renewal requirements	None
Rejection rate	None
Voluntary or compulsory	Voluntary
Product coverage (benefits)	50% off pathology tests; Ultra Poor 80% off 10% off medication fee; Ultra Poor 80% off US$8.52-17.04 provision for referrals Free annual check up for head of household For Ultra Poor At least 2 Post-consultation follow-up home visits Free transportation to referral hospitals and clinics
Key exclusions	No specified exclusions[24]
Pricing - premiums (in US$) for 1-5 members 6-8 members 9-12 members	1.70/4.26/0 (VO/non-VO member/Ultra poor) per year 2.56/5.12/0 (VO/non-VO member/Ultra poor) per year 3.41/5.96/0 (VO/non-VO member/Ultra poor) per year
Pricing – co-payments (in US$)	0.03/0.08/0 (VO/non-VO member/Ultra poor)
Pricing – other fees	None
Incentive to renew	25% discount on renewal if any member does not use BRAC health services in previous year

Table 7b. BRAC MHIB Prepaid Pregnancy Related Care Package

Product Details	Product Features and Policies
Microinsurance Type	Ante/Post/Neo-Natal Care
Group or individual product	Individual
Term	One Pregnancy term
Eligibility requirements	None
Voluntary or compulsory	Voluntary
Product coverage (benefits)	• ANC check-up at BRAC satellite clinic • Monthly supply of iron tablets and folic acid • Provision of Safe Delivery Kit for home delivery • Support for antenatal complications (miscarriage, bleeding) • 50% discount on normal delivery at Shushasthos • Support for postnatal complications (post-partum haemorrhage, fever) • Support in the event that newborns suffer from diarrhoea or pneumonia within 28 days of birth
Key exclusions	No specified exclusions
Pricing – premiums (US$, annual)	0.85/1.19 (VO/non-VO member)
Pricing - co-payments and deductibles	None

[24]In practice, only illnesses or accidents that can be treated at their own clinics/hospitals and referred clinics/hospitals are covered.

Table 7c. BRAC MHIB School Health Package (Pilot Project)

Product Details	Product Features and Policies
Microinsurance Type	Preventive/Partial Primary Health Care
Group or individual product	Individual
Term	Annual
Eligibility requirements	Limited to students at 1 government school in Phulbari
Voluntary or compulsory	Voluntary
Product coverage (benefits)	• 10% off pathology tests • Free biannual immunization against common intestinal worms • Free annual check up • Free supplementary iron tablets for girls
Premiums – US$	0.17
Pricing - co-payments and deductibles	None

Table 7d. BRAC MHIB Health Care Pricing and Cost Analysis (US$)[25]

VO Members[26]	Clinic Charge	Co-payment	MHIB Payment
Consultation	0.17	0.03	0.14
Medicine (50% Discount)	1.28	0.64	0.64
Pathology (10% Discount)	1.36	1.22	0.14
Child birth (50% Discount)	11.92	5.96	5.96
TOTAL			0.92 without delivery; 6.88 with delivery
Annual cost to BRAC MHIB: for a 5-member family (average 3 visits per family per year) Without Delivery: 0.92 x 3 = 2.76 - Premium 1.70) = 1.06 loss per family per year (exclusive of administrative and other costs) With Delivery: Could not be calculated as average pregnancy per family is not known			
Non VO Members	**Clinic Charge**	**Co-payment**	**MHIB Payment**
Consultation	0.34	0.085	0.26
Medicine (50% Discount)	1.28	0.64	0.64
Pathology (10% Discount)	1.36	1.22	0.14
Child birth (50% Discount)	11.92	5.96	5.96
TOTAL			1.04 without delivery; 7.00 with delivery
Annual cost to BRAC MHIB: for a 5-member family (average 3 visits per family per year) Without Delivery: 1.04 x 3 = 3.12 - Premium 4.26) = 1.14 gain per family per year (exclusive of administration and other costs) With Delivery: Could not be calculated as average pregnancy per family is not known			

Premium Calculation

BRAC MHIB premiums are not based on any actuarial calculations or feasibility study. They are based on BRAC field staff's informal discussions with community members in the Narshingdi area. During the discussions the field staff assessed the amount potential

[25] Based on a study by Dr. S Roy
[26] Includes members of other NGOs

cardholders' would be willing to pay for the proposed health care services. A study conducted by the Health Economics Department of Dhaka University, Bangladesh called *Willingness to Pay* was also consulted. All premiums and fees charged to VO members are at a subsidized rate, with the intention that premiums paid by non-VO members would cross-subsidize the VO members, as shown in Table 7d.

Other Risk-managing Financial Products

All BRAC microcredit borrowers are eligible to join a life insurance scheme operated by BRAC's parent NGO. Premium amounts to US$0.17 per year and the dependents receive US$85.20 on the death of the insured.

Membership Renewal

Despite efforts to increase membership, renewal rates remain low (see Table 7e). One of the reasons is the current policy of allowing members to renew their membership and pay for the over due premium only when medical treatment is required due to illness or injury. It must be remembered that BRAC MHIB is still in its early stage and has only been operating for a short period. As the scheme matures, popularity and membership are expected to increase.

Table 7e. BRAC MHIB Membership Renewal Data Analysis[27]

Renewal Lag	Number of Renewal	Percentage
On Time	81	27
Within 1 year	133	44
Between 1 and 2 years	65	21
Between 2 and 3 years	16	5
Over 3 years	9	3
Total Reviewed	304	100%

Structure

The MHIB scheme employs 10 salaried staff that devote 100% of their time to the scheme. Two of them are at BRAC Head Office in Dhaka, a National Project Coordinator (NPC) and a Documentation and Management Information Systems (MIS) analyst. Eight are in the field: 2 Training and Communications Organizers (TCO) and 6 Program Organizers (PO), distributed equally among the two program areas.

The remuneration of salaried staff is not linked to MHIB performance. The SS, SK and Non Formal Primary Education (NFPE) teachers are not on BRAC MHIB payroll but they render support service to the program. VO Team Leaders act as volunteers to the program. The volunteers and these support staff receive a commission for every new cardholder they enrol - US$0.07 for every expectant mother enrolled in the Pre-paid Pregnancy-related Care package, and US$0.17 for each VO member and US$0.26 for each non-VO member they enrol in the General Benefit package.

[27] Based on 304 files reviewed during a limited study by Dr. S Roy

Expertise and Training

BRAC MHIB receives technical assistance from the ILO WEEH project, which includes capacity building and monitoring, development of annual work plan, assistance in training material development, accounting and reporting, and networking with similar schemes at home and abroad. This relationship was originally for a three-year period set to end in October 2004, but as there was still un-disbursed funds remaining, ILO has agreed to extend the support until the end of September 2005.

All staff and volunteers involved with BRAC MHIB activities have been given on-the-job training by the ILO WEEH project. In March 2002, the project facilitated a three-day Training of Trainers (TOT) workshop for the BRAC MHIB and GK Health Microinsurance schemes. The purpose of the workshop was to identify the main training requirements for the organization and aid in the development of training materials for project staff. Volunteers and support staff involved in promoting the scheme such as SS, VO Leaders, and NFPE teachers are given a two-day initial training on advocating for the program. Monthly refresher courses are also held at MHIB area office.

Marketing[28]

To aid promotion, BRAC MHIB has developed Information Education and Communication, (IEC) materials in Bangla detailing the scheme's rules and benefits. A specimen of a leaflet is given in Appendix 5. Leaflets are distributed regularly among literate community members to inform them about the scheme. In addition, signboards advertising BRAC MHIB have been placed outside both Madhabdi and Phulbari Area offices, calling for people to enrol. Furthermore, BRAC MHIB has also developed flipcharts for use as a promotional aid.

In addition to BRAC MHIB full-time staff, a group of volunteers and supporting staff engaged throughout BRAC's different activities are used for marketing and promotion purposes. The SS, and to a certain extent the NFPE teachers, also play a pivotal role in promoting and educating potential cardholders and make door-to-door visits to promote the scheme.

BRAC MHIB staff members attend and organize weekly meetings at the village level to market and sell policies to potential cardholders. They act as insurance agents for the organization.

Resources and Relationships

For referral cases, the two Shushasthos have formal and informal linkages with other private and government health clinics and hospitals. In Madhabdi Upazila, MHIB has an agreement with one private clinic and in Phulbari Upazila with four private clinics to provide x-ray and ultra-sonogram services to cardholders at a 30% discount. MHIB has also negotiated to receive a 15% discount on all medicines from the program's pharmaceutical suppliers.

BRAC MHIB participates in the Expanded Immunization Program (EID), National Immunization Day (NID) and PolioPlus campaign with the State health authority. The campaign is directed towards the young and school going children to immunize them against

[28] Based on a report by Ms. Rehana Merali (Micro Health Insurance Scheme of BRAC, April 2004)

common childhood diseases and make the country polio free by the end of 2005. The vaccines are provided free of charge by the health authorities and small contributions are made to cover the cost of promoting the campaign. Such participation strengthens BRAC's own prevention program, helps keep its costs down, and enhances its image.

3.2 Grameen Kalyan

Grameen Kalyan (GK) is a member of the Grameen Samogri (Family) – the Grameen Bank group (see Box 2). Over the years, evaluations of Grameen Bank's micro-credit program revealed that ill health and the cost of health care act as major obstacles to borrowers breaking out of the poverty cycle. A study undertaken by Dr. David Gibbons and Helen Todd in 1992 found that after 10 years of Grameen borrowing, 58% of the members had lifted themselves out of poverty, compared with only 18% of non-borrowers. Of the 42% of borrowers who failed to improve their socio-economic condition, 60% had experienced a serious illness within the family that drained family resources.[29]

Box 2. Grameen Bank

Started by Dr. Mohammad Yunus in Bangladesh in 1976, the Grameen Bank is a microfinance pioneer. Dr. Yunus was touched by the problems faced by a woman in his home village in borrowing working capital to finance her small business, so he lent her less than US$25 of his own money as an experiment. This experiment has grown into an organization with a cumulative lending of over US$4.6 billion, 99% recover rate and US$346.2 million in deposits.

Grameen Bank follows the belief that the poor can be trusted with loans, that they can be financially responsible and can manage their financial affairs, and that credit for the poor creates self-employment. Grameen gives each borrower a succession of loans, without collateral, to spend on running a small business. The loan is small, usually less than US$85, for a specific purpose, for one whole year and subject to repayment performance of other borrowers of that group. The loan is repaid in small weekly instalments at group meetings held in her neighbourhood. Before 2001, the repayments were in fixed instalments, with no rescheduling option and zero tolerance for defaults, with peer pressure on defaulters by other group members.

In late 2001, Grameen II was launched, which radically changed the lending methodology. The guiding principle, that the poor always pay back their loans, is still at the centre of Grameen II. The rigidity of the earlier rules has been modified. A large variety of loan terms is now available. Borrowers now select their own loan repayment period to fit their needs and can renegotiate the loan terms in case of difficulties. An entrepreneur with a good credit record can increase her subsequent loan size. Credit life insurance has been introduced; a variety of savings schemes are now available with a personal passbook. A contractual-savings pension scheme has been introduced. To quote Dr. Yunus on the transformation: "Grameen Bank II has emerged…This second-generation microcredit institution appears much better equipped than it was in its earlier version."

Other activities in the Grameen family today include health care, education, telecommunication, Internet service, software development, garments manufacturing and renewable energy.

[29] Del Rio and Walters, 1999.

In response to the findings, GB initiated an action research project to establish a health program through Grameen Trust in May 1993. The project was intended to provide primary health care services to GB members as well as other people living within its operational areas through 10 health centres opened for this purpose. Priority was given to preventative and promotional health services with special emphasis on family planning, reproductive health, maternal and child health. The health program adopted an experimental prepaid card system. Cards carried the photograph, name and details of the cardholder as well as names of the family members covered. Each card was valid for twelve months. Card prices were US$0.88 for families with up to five members and US$1.76 for families with up to eight members. The health card had to be produced to use the services provided by ten health centres. In addition, charges for consultation, treatment and medicine were to be paid. Though the scheme was open to all villagers, virtually all members were Grameen microcredit borrowers.

The ensuing years saw a dramatic increase in the demand for health services provided by the program. In November 1996 Grameen Kalyan (GK) was registered as a 'not-for profit company' limited by guarantee and without share capital. It was also registered as an NGO with the NGO Affairs Bureau. Grameen Bank's health care services were handed over to GK. In addition to the ten clinics, GK also received a US$42.5 million Endowment Fund from its parent NGO to generate income for the scheme and meet any shortfall in the operating expenses.

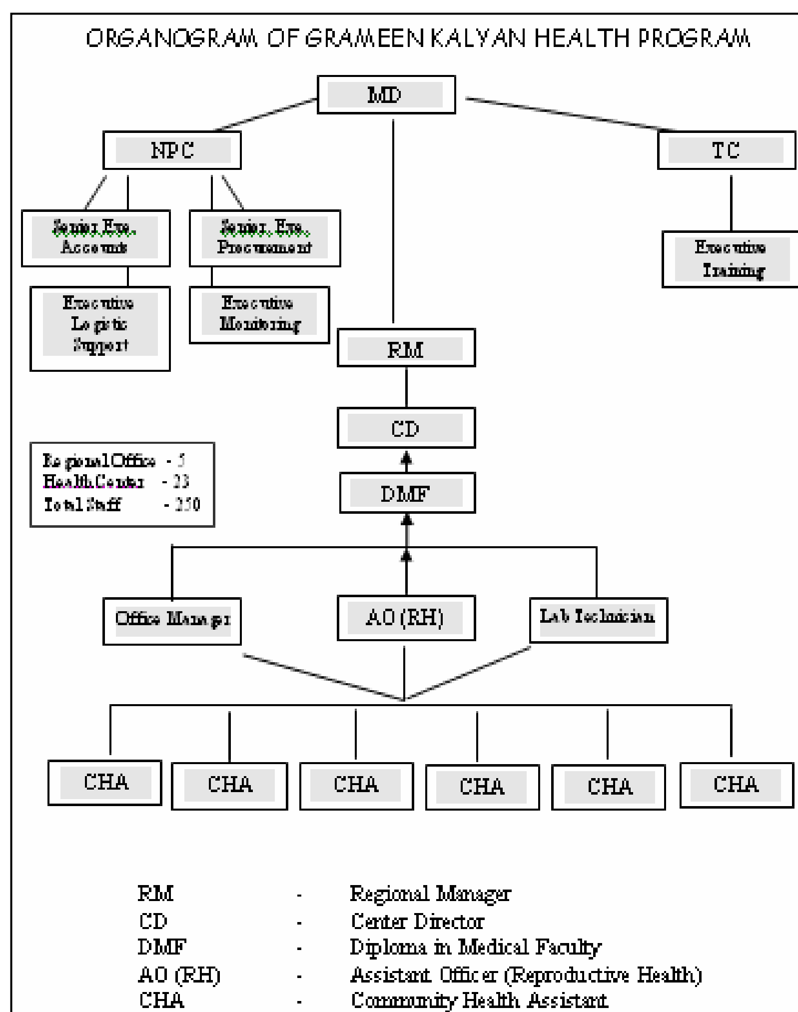
GK expanded its services and also the number of health centres in response to the increased demand. Today, GK provides curative health care through 28 clinics in 8 districts. It also provides preventive, educational, and family planning services through Health Assistants (HA) from each clinic who visit members in their homes. As an institution, GK does not give any charity as it believes this will not solve the deeply rooted problems faced by the target population. All users of GK clinics have to pay the charges. GK never refuses treatment to a patient in need. Even non-GB, non-cardholders can receive treatment, albeit, at a higher price than the cardholders.

Once GK was established in 1996, the pre-paid health card system evolved into the present GK health insurance scheme and the card still remains as part of the new scheme. The present scheme is geared towards GB borrowers and their families, as well as to eligible villagers. Eligible villages are those that are located within an 8 km radius of a GK health centre, which is generally established close to a GB branch covering roughly the same operational area. Insurance fits in with the philosophy of the organization.

A GB branch consists of about 60 to 70 centres or borrower groups, each of which includes about 40 to 45 members. About 2,000 to 2,500 GB members are enrolled as cardholders at each health centre. As of October 2004, GK had 58,000 policyholders (51,000 GB and 7,000 non-GB) covering an estimated 290,000 beneficiaries.[30]

[30] Assuming five members per family.

Organogram 2. Grameen Kalyan



Health microinsurance plays a pivotal role in GK activities. It serves the dual purpose of ensuring the participation of the target group as well as acting as a source of revenue for the program. The scheme employs a sliding scale fee structure, as shown in Table 8. Non-GB villagers pay slightly higher premiums and copayments than GB members. However, no distinction is made in terms of service and benefits once they are enrolled in the health plan.

The health plan also provides free preventive care, family planning and health education services to all, irrespective of subscription to the health insurance scheme. Each HMI plan covers up to six members of a cardholder's family. For families with more than six members, an annual fee of US$0.34 is charged for each additional member. Non-cardholders pay US$0.85 for a medical consultation and full price for medicine and pathology tests. GK attempts to cross-subsidize its members by having higher pricing structure for non-GB cardholders and non-cardholders. Receipts are issued for all cash received by the clinics.

Table 8. Grameen Kalyan Product Details

	Product Features and Policies
Microinsurance Type	Preventive and curative health care
Group or individual product	Individual
Term	Annual
Eligibility requirements	GB borrowers and their families or villagers living within 8 km of each GK health centre
Renewal requirements	None
Rejection rate	No one is rejected
Voluntary or compulsory	Voluntary
Product coverage (benefits)	• 25% off retail price of 15 essential basic medicines • 10% off retail price of other medicines • 30-50% off normal pathology tests • 50% off referred consultation fees • US$8.52 – 17.04 provision for other hospitalisation costs • Up to US$34.08 for pregnancy related costs • Free annual check-up for head of household • Free immunization against six diseases • Free house visits by female health assistant
Key exclusions	No specified exclusions[31]
Pricing – premiums	US$2.04/2.56 (GB/non-GB) per year
Pricing – co-payments and deductibles	Medical consultation fee: US$0.09/0.17/0.85 (GB/non-GB/non-cardholder)
Pricing – other fees	No other fees

Benefits

Until 1999, GK operated 11 clinics with three different schemes with separate pricing structures and benefit packages. Six health centres charged the premiums shown in Table 8 above and offered those benefits, while the remaining health centres offered significant variations. GK management soon recognized that a varied pricing structure and benefits packages were difficult to operate. Villagers were confused by the price differentials, and there were complaints from those who were paying higher premiums. In 2000, the standard premiums and benefits package was adopted in all GK clinics.

Initially, medical consultation visits for GB cardholders were free. This particular feature got a negative response from GB cardholders. One of the peculiar aspects of the psychology of rural people in Bangladesh is that most patients considered free consultation to be an indication of inferior service, and as a result, did not trust the doctors treating them. A nominal fee was introduced in 1999; this was gradually raised to US$0.09 per visit for GB cardholder, US$0.17 non-GB and US$0.85 for non-cardholder. This change also generated more revenue for the program.

[31] In practice only illnesses and accidents that can be treated at its own facilities or referred clinics/hospitals are covered. GK has a referral system under which it refers cases to other clinics and reimburses 1 claim per cardholder per year. between US$8.52 and 17.04 (BDT 500 and 1,000)

GK carries out periodic surveys of its members to assist its management to focus on priority actions. This has resulted in upgrading the health centres, expansion of services such as the safe motherhood program, cataract blindness, and linking with government programs like EPI and NID.

Premium Calculation

GK's premium rates are not based on any actuarial calculations or feasibility study; it was established through a process of trial and error and consultation. It has succeeded in its goal to provide quality health care services targeted to poor women and their families via MHI. Present GK annual premiums, as shown on Table 8, were implemented in 2000. GK maintains its data on a manual system, which is not a suitable form for a pricing study without an extensive compilation of data.

Other Risk-managing Financial Products

Besides health insurance, GB operates a number of different insurance schemes covering life, livestock, and equipment. An emergency fund is created by GB for every borrower in case of death. Initially it was 125% of the interest payable and was debited to their account at the time of taking the loan. In 1991, this was changed to US$0.085 for every US$17.04 amount of loan disbursed. In 1995, GB decided to discontinue the collection of emergency funds as US$7.16 million had already been accumulated in the fund. The interest accrued from the investment of this amount is taken to be enough to cover any death benefits to be disbursed. The death benefit was originally US$85.20 for borrowers, who died during the loan period, but it has since been changed and the amount now ranges between US$34.09 and US$85.20 depending on the loan classification of the borrower.

The livestock insurance premium is 112.5% of the interest on each loan and is debited to the borrower's account at the time of taking the loan. The benefit amounts to 50% of the outstanding loan amount at the time of death of the livestock. The equipment insurance premium amounts to 110% of the interest amount on each loan and is debited to the borrower's account at the time of taking the loan. The benefit amounts to 50% of the outstanding loan amount at the time of death of the borrower.

Structure

Each GK clinic is staffed by a qualified doctor, a manager, a paramedic, a lab technician and 4 to 5 Health Assistants (HA). HA are the main distribution channel. They provide health care at home on their door-to-door rounds promoting preventive health care and the microinsurance scheme.

The salary structure at GK is based on the distance of workplace from the capital city. The more remote the area, the higher is the salary. In remote areas, it is common to provide housing for the doctor free of cost. Staff turnover is a problem; it is difficult to retain doctors in rural areas with the low salary offered.

Expertise and Training

The expertise necessary for the smooth running of the GK HMI scheme was a result of experience learned from experimentation with different methods and pricing policies over a number of years.

GK receives technical assistance from the ILO WEEH project, which includes capacity building and monitoring, development of annual work plans, assistance in training material development, accounting and reporting, and networking with similar schemes at home and abroad. This relationship was originally for a three-year period set to end in October 2004, but as there was still un-disbursed amount left in the fund, ILO has agreed to extend the support until the end of September 2005.

All staff and volunteers involved with GK activities have been given on-the-job training by ILO WEEH project. In March 2002, the project facilitated a three-day Training of Trainers (TOT) workshop for GK Health Microinsurance schemes. The purpose of the workshop was to identify the main training requirements for the organization and aid in the development of training materials for project staff. HA involved in promoting the scheme are given a two-day initial training on building their capacity as advocators of the program.

Health centre medical staffs, such as doctors and paramedics, are sent to various institutions such as Gonoshashtho Kendra. Health Assistants are placed at health centres as trainees for a few months and then must attend formal TOT sessions.

Resources and Relationships

GK was given 10 operating clinics and a US$42.5 million Endowment Fund to start its HMI scheme. The Endowment Fund was put on deposit, generating interest income until 2002, when the fund was returned to Grameen Bank. For the past three years, GK has also received funds from the ILO.

GK's relationship with ILO/STEP has been essential to its health centre capacity building over the last three years. Because of ILO funding, GK has established 6 new health centres, and expanded or upgraded services at 14 existing health centres, 6 of which also upgraded maternity care services.

Belgian charity Stichting Gilles provides financial support for 5 GK health centres. In 1998, the Government of Bangladesh also donated a health centre to GK, which has previously been used to help rehabilitate people displaced during the construction of the Jamuna Bridge. Australian charity Fred Hollings Foundation also provided support through a one-time donation of medical equipment such as microscopes and operation theatre equipment. Like BRAC, GK also participates in the immunization programs with the State health authority.

3.3 Society for Social Services

The Society for Social Services is a non-governmental, non-profit, non-political voluntary development organization established in 1986 in the Tangail district. It is registered under the Department of Social Welfare and also with the NGO Affairs Bureau. The health program is a component of SSS NGO.

SSS was founded by a group of development workers intent on promoting the socio-economic condition of the poor through need-based provisions of microcredit, health, and education facilities. While mainly focused on microcredit, SSS is also involved in other

functional areas such as agriculture, fisheries, child development and education, child labor and an indebtedness programs in collaboration with the ILO. SSS is one of the largest NGOs in Tangail and is well regarded for the work it has done over the past 18 years. At present, SSS operates in 2,494 villages, covering a geographical area of 12 districts providing assistance to 227,120 beneficiaries.

In 1995, 16 SSS borrowers and frontline staff died of childbirth complications. Inspired by these tragedies, SSS management prioritised the health service needs of their group members and other beneficiaries, including their own staff. SSS resolved to start a health program to provide preventive and curative health services at affordable prices, focusing primarily on poor rural women. The program was to include provisions for both health awareness building and primary health care services.

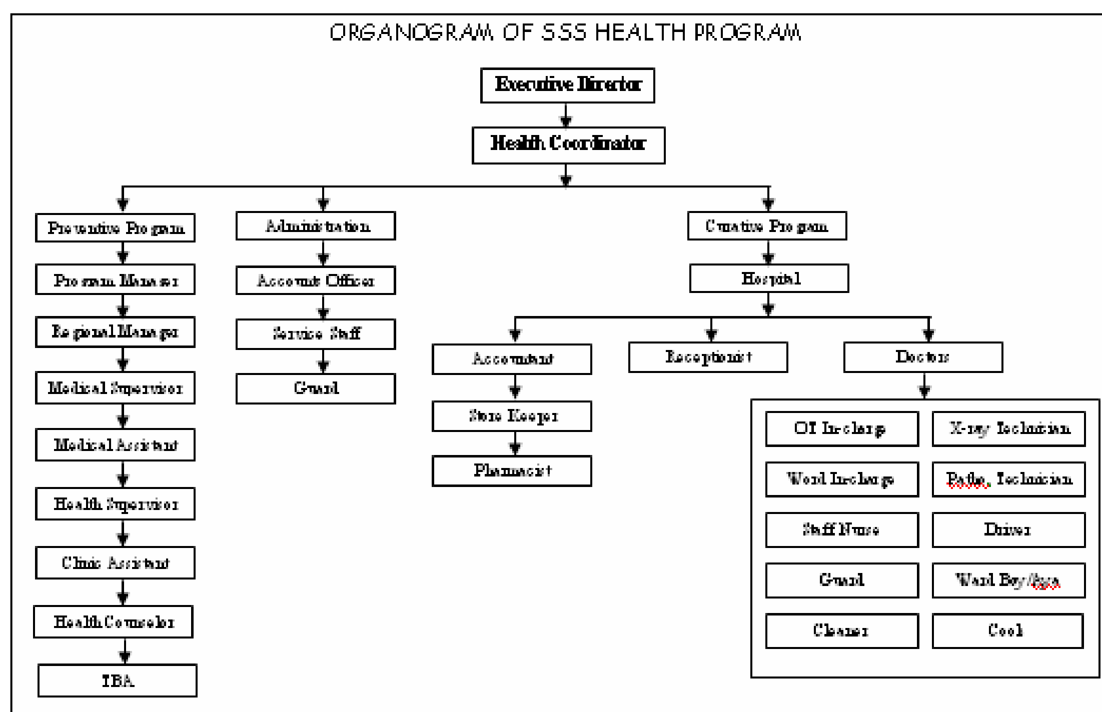
The SSS Health Program began in earnest in January 1996, and within a year, a 20-bed hospital was established in a rented two-story house in the town of Tangail. The hospital was financed through the generosity of numerous philanthropists, including SSS staff members who each donated a week's salary. In January 2004, a 52-bed hospital was opened with technical and financial assistance provided by the charity Terre des Hommes (TdH), Netherlands.

Although the main purpose of initiating a health program was to ensure safe delivery and general well-being of its microcredit borrowers and their families, the health program gradually expanded to cover the whole community. Other beneficiaries include sex workers, slum-dwellers, ethnic minorities, working children, the hard-core poor (those living in absolute poverty), and relatively well off families living in areas of SSS's operations. At present, the health program operates one urban hospital and 16 rural clinics, serving 531 villages of 83 Unions located in 6 Upazilas (sub-districts) of Tangail.

The SSS uses a health care card system that functions just like an HMI scheme in its method of operation. The health care card carries the name address and photograph of the cardholder and the names of the beneficiaries, and it has to be produced to receive treatment at the clinics. Health cards can be purchased at any SSS clinics or at the hospital at any time during the year. All payments are in cash and receipts are issued for all cash received by the clinic.

Enrolment is compulsory for all SSS borrowers living in the 6 sub-districts of Tangail in which the hospital and 16 clinics are located. They are called Samity members. Samity members are required to pay US$0.34 each year for a health card, similar to a premium under HMI programs, and are also required to pay a registration fee of US$0.51, equivalent to a co-payment, on each visit to the hospital or clinic. An SSS staff member can also join the program by purchasing a health care card at a cost of US$0.17 each year and paying the US$0.51 registration fee on each visit to the hospital or clinic.

Organogram 3. SSS Health Program



An individual, who is an SSS member but lives outside the 6 sub-districts of Tangail, is referred to as a non-Samity member. Non-Samity members cannot be a cardholder but can receive health care services at an SSS clinic or hospital by paying US$0.68 per hospital/clinic visit.

An individual, who is not member of SSS, but lives in one of the 6 sub-districts of Tangail, is referred to as a non-beneficiary. A non-beneficiary cannot be a cardholder but is allowed to use the hospital or clinics on payment of a registration fee of US$0.85 per visit.

Health service benefits are available to a cardholder's entire family, no matter how large. No one is denied treatment at an SSS clinic. In special cases where hard-core poor beneficiaries need medical attention but are unable to pay, SSS bears the full cost of the treatment. Medicines are provided free of charge to all cardholders and staff members. Others pay for their medicine at the retail price.

As of November 2004, there were 45,424 health program users, 27,071 were Samity members, 9,050 non-Samity members, 1,193 staff members, and 8,110 non-Beneficiaries. SSS attempts to cross-subsidize its cardholders by charging higher registration fees to non-cardholders.

Table 9. SSS Product Details

	Product Features and Policies
Provision Type	Curative health care
Group or individual product	Individual
Term	Annual
Eligibility requirements	None
Renewal requirements	None
Rejection rate	No one is rejected
Voluntary or compulsory	Compulsory for Samity members
Product coverage (benefits)	• Curative health care at SSS clinics • Referral to SSS hospital if required • 30% discount on SSS hospital charges
Key exclusions	No specified exclusions[32]
Pricing – premiums	US$0.34/0.17 (Samity/staff members) per year
Pricing – co-payments and deductible (registration/consultation fee)	US$0.51/0.68/0.85 (Samity & staff/non-Samity/ non-members) per visit
Pricing – other fees	No other fees

Benefits

The primary purpose of the SSS health card system is to provide curative health care services at affordable prices for program beneficiaries. Services available at the hospital and the clinics include surgery, gynaecological, paediatric, eye, ENT, dermatological, dental, heart, and diarrhoeal treatments among others. The hospital also houses facilities for pathology tests, ultra-sound, ECG and x-ray.

Premium Calculation

The health program fees were decided upon by SSS management following consultations with different sections of the community to determine fee affordability. Special priority was placed on minimizing the exclusion or 'pricing out' of potential health program beneficiaries. All premiums and fees charged are thus at a subsidized rate.

When the system was first introduced, health cards could be purchased for US$0.18 and per visit co-payments were US$0.09 and US$0.18 for Samity and non-Samity members respectively. This fee structure remained in place until 1998 when it was decided to raise fees due to the fact that such low priced health services were interpreted as a sign of low quality services. Fees were gradually raised until the current price system was put in place in 2000.

Other Risk-managing Financial Products

In 1993, SSS introduced the Group Insurance Scheme under its microcredit program to provide support for Samity members. A member up to the age of 50 years can buy death insurance coverage of US$85.20 for a single premium of US$1.70.

[32] In practice, only illnesses and accidents that can be treated at its own clinic/hospitals are covered. SSS does not have a referral system.

Structure

SSS has 16 clinics and 1 hospital, which are attached to its microcredit program. Each clinic has one non-graduate full-time paramedic called Health Assistant (HA). A HA also makes house calls to deliver both preventive and curative services and organize satellite clinics in different areas each month for patients who are not able to visit the clinics. HAs are supported by trained female Traditional Birth Assistants (TBA), locally called a Dai, at the field level. The TBAs are employed on a part-time basis. Qualified medical practitioners from SSS hospital in Tangail visit the clinics once or twice a month to treat complicated cases.

Expertise and Training

The Dutch charity Terre des Hommes (TdH) provides training, awareness education, MIS, reporting of accounts, and performance monitoring. The WEDE component of the WEEH project sponsors and coordinates health-training workshops for SSS Health Program staff.

Resources and Relationships

The main financial resources for the Health Program are surpluses generated from the parent NGOs microcredit program, which is funded by donors. SSS also receives income from certain investments earmarked for it by its parent NGO.

TdH financed the newly built hospital and 5 of the 16 clinics. SSS also receives assistance from TdH in the form of medical supplies and equipment.

Although not as intimately linked to the ILO WEEH project as GK or BRAC MHIB, the SSS is an implementing partner of the WEDE project and works to promote its Health Program along the guidelines and principles prescribed by WEEH.

The SSS Health Program negotiates discounts with suppliers on purchase of equipment and medicine for the clinics and the hospital.

4. Results

Table 10a. BRAC MHIB Basics – Trends

	2004	2003	2002
Total assets US$	No assets of their own; clinics owned by BRAC		
Annual budget US$	44,000	36,000	30,000
Total capital US$	None		
Number of branches	2	2	2
Total number of microfinance clients	4.81m	4.01m	3.50m
Total number of microinsurance policyholders[33] General Benefits Package[34] Pre-paid Pregnancy Package (from Jan 02) School Health Package (from Jan 04)	12,258 7,816 3,442 1,000	8,642 6,825 1,817 0	1,525 1,525 0 0
Total number of microinsurance beneficiaries[35]	43,522	35,942	7,625
Number of microinsurance staff	10	12	12
Staff turnover (%)	(16.7)	0	0
Number of policyholders/microinsurance staff	1225.8	720.2	127.1

Table 10b. BRAC MHIB – Key Results

	2004		2003		2002	
Income	**US$**	**% of PC**	**US$**	**% of PC**	**US$**	**% of PC**
Premiums Change in Unearned Premium Reserve (UPR) Co-payments	5,914 (237) 3,126		8,733 87 7,814		8,503 170 9,035	
Policyholders' Contribution (PC)	**8,803**		**16,634**		**17,708**	
Expenses						
Claims Expenses Claims Paid[36] Changes in claims incurred but not reported	 5,134 (223)		 4,840 118		 3,375 68	
Incurred Claims	**4,911**	**55.8**	**4,958**	**29.8**	**3,443**	**19.4**
Head Office Expenses	**3,052**	**34.7**	**5,271**	**31.7**	**2,635**	**14.9**
Field Office Expenses Field staff Travel Equipment and supplies Training, promotion and marketing Support to safety net Depreciation Other expenses	 23,803 2,252 955 2,812 - 932 1,098		 23,877 4,606 152 10,662 9,882 932 629 		 18,799 2,645 5,189 3,106 - 466 1,000	
Field Office Expenses	**31,852**	**361.8**	**50,740**	**305.0**	**31,205**	**176.2**
Total Expenditure	**39,815**	**452.3**	**60,969**	**366.5**	**37,283**	**210.5**

33 To 31st December of year concerned.
34 Number of families; includes policies not yet renewed.
35 Assuming 5 members per family.
36 Payments to BRAC clinics and referred clinics.

Net Loss	**(31,012)**		**(44,335)**		**(19,575)**	
Grants Or Subsidies	**34,903**		**43,291**		**55,503**	
Net Gain/(Loss) after Grants and Subsidies	**3,891**		**(1,044)**		**35,928**	
Growth in total premium (%)	(32.3)		2.7		Not available	
Growth in number of insured persons (%)	21.1		371.4		Not available	
Renewal rate - General Package (%)	51		25		18	
Reserves added for the period/premiums (%)	Nil		Nil		Nil	
Incurred claims cost per person insured US$	0.11		0.14		0.46	
Income from investment of premiums US$	Not available		Not available		Not available	

Table 11a. Grameen Kalyan Basics – Trends

	2004	2003	2002
Total assets US$	9.12m	8.87m	8.62m[37]
Annual budget US$	201,663	235,122	336,064
Total capital US$[38]	9.12m	8.87m	8.62m
Number of health centres	28	23	14
Total number of microfinance clients	2.5m	3.1m	3.6m
Total number of patients treated (including cataract)	243,503	146,272	133,236
Total number of microinsurance policyholders	58,000	49,166	46,902
Total number of insured beneficiaries[39]	290,000	245,830	234,510
Number of microinsurance staff	323	Not available	Not available
Staff turnover: (%) Health Centre Doctors (approximately)	Not available 50	Not available 50	Not available 50
Number of policyholders/microinsurance staff	180	Not available	Not available

Table 11b. Grameen Kalyan – Key Results

	2004		2003		2002	
Income	**US$**	**% of PC**	**US$**	**% of PC**	**US$**	**% of PC**
Premium Change in Unearned Premium Reserve Co-payment by policyholders	63,485 (4,444) 15,871		36,224 (1,449) 12,075		30,952 (1,238) 11,607	
Policyholders' Contribution (PC)	**74,912**		**46,850**		**41,321**	
Income from investment	263,093		255,593		425,989	
Total Revenue	**338,005**		**302,443**		**467,310**	
Expenses						
Claims Expenses Claims Paid – cost of referrals Changes in claims incurred but not reported	 2,983 2,181		 4,419 422		 3,312 302	
Incurred Claims	**5,164**	**6.9**	**4,841**	**10.3**	**3,614**	**8.7**
Head Office Expenses	**38,611**	**51.5**	**35,136**	**75.0**	**32,325**	**78.2**
Field Office Expenses[40] Field Staff	 115,313		 100,322		 85,274	

[37] After repayment of US$42.5 million Endowment Fund to GB during 2002
[38] Capital has been estimated at total asset value.
[39] Assuming 5 members per family; includes policies not yet renewed

	2004		2003		2002	
Travel Equipment and supplies Training, promotion and marketing	3,735 30,398 14,241		3,250 26,142 12,970		2,892 24,050 12,817	
Field Office Expenses	**163,687**	**218.5**	**142,684**	**304.6**	**125,033**	**302.6**
Total Expenditure	**207,462**	**276.9**	**182,661**	**389.9**	**160,972**	**389.5**
Net Gain	**130,543**		**119,782**		**306,338**	
Grants or Subsidies	**126,015**		**133,940**		**118,111**	
Net Gain after Grants and Subsidies	**256,558**		**253,722**		**424,449**	
Growth in total premium (%)	75.3		17.0		(12.7)	
Growth in number of policyholders (%)	17.9		4.8		37.9	
Renewal rate (GB members %)	54		50		50	
Reserves added for the period US$	250,000		250,000		250,000	
Incurred claims cost per person insured US$	0.02		0.02		0.02	
Income from investment of premiums US$	Not available		Not available		Not available	

Table 12a. SSS Health Program - Basics Trends

	2004[41]	2003	2002
Total assets SSS Health Program US$	25,971	9,706	1,521
Annual budget US$	349,289	20,705	76,906
Total capital US$	Not available	Not available	Not available
Number of branches (1 hospital + 16 clinics)	17	17	17
Total number of all SSS beneficiaries	135,193	116,392	88,411
Total number of Health Cardholders	45,424	36,982	34,576
Total number of covered lives[42]	227,120	184,910	172,880
Number of staff in hospital and 16 clinics[43]	152	53	44
Staff turnover (%)	0.1	0.1	0.1
Number of Cardholders/Staff	299	698	786

Table 12b. SSS Health Program - Key Results

	2004		2003		2002	
Income	**US$**	**% of PC**	**US$**	**% of PC**	**US$**	**% of PC**
Premium Change in Unearned Premium Reserve Co-payment by Cardholders[44]	3,031 (44) 758		1,917 95 638		4,305 (49) 864	
Policyholders' Contribution (PC)	**3,745**		**2,650**		**5,120**	
Income from investment	86,281		67,415		65,108	
Total Revenue	**90,026**		**70,065**		**70,228**	
Expenses						
Claims Expenses Claims Paid[45]	- 		-		-	

[40] Include cost of running clinics; equipment and supplies cost include cost of medicine.
[41] The big increase in 2004 was due to the new hospital that was created with funding from TdH.
[42] Assuming 5 members per family; includes policies not yet renewed.
[43] Hospital opened in January 2004.
[44] Estimated.

	2004		2003		2002	
Changes in claims incurred but not reported						
Incurred Claims	-		-		-	
Head Office Expenses	**54,314**	**1,450.3**	**50,954**	**1,922.8**	**56,075**	**1,095.2**
Field Office Expenses						
Field Staff	5,474		5,099		4,478	
Travel	550		644		1,022	
Equipment and supplies	7,058		-		2,130	
Training, promotion and marketing	446		319		1,925	
Depreciation	7,497		6,134		5,316	
Other expenses	16,790		11,915		30,447	
Field Office Expenses	**37,815**	**1,009.7**	**24,111**	**909.8**	**45,318**	**885.1**
Total Expenditure	**92,129**	**2,460.0**	**75,065**	**2,832.6**	**101,393**	**1,980.3**
Net Loss	**(2,103)**		**(5,000)**		**(31,165)**	
Grants Or Subsidies	**2,468**		**5,734**		**31,982**	
Net Gain after Grants and Subsidies	**365**		**734**		**817**	
Growth in total premium (%)	58.1		(55.5)		40.1	
Growth in number of policyholders (%)	22.8		7.0		Not available	
Renewal rate (%)	Not available		Not available		Not available	
Reserves added for the period/premiums (%)	Nil		Nil		Nil	
Incurred claims cost per person insured US$	Not applicable		Not applicable		Not applicable	
Income from investment of premiums US$	Not available		Not available		Not available	

[45] SSS does not pay any claims or refer any members or make outside referrals.

5. Analysis of Issues

This section seeks to answer the questions highlighted in Section 1 using the evidence and the experience of BRAC MHIB, Grameen Kalyan, and the SSS Health Program.

5.1 Institutional Mission

Social Agenda

BRAC, GB and SSS exist to serve the development needs of the poor in Bangladesh. The goals of poverty alleviation and empowerment of the disadvantaged are already in their mission statements. All three organizations are aware that no one solution will rid the country of poverty, and thus a multifaceted approach must be undertaken.

Ill health and the cost of health care act as major obstacles to borrowers trying to break out of the poverty cycle. A study of Grameen Bank's microcredit program revealed that of the 42% that failed to improve their socio-economic condition, 60% had experienced a serious illness within the family that drained family resources. GB initiated an action research project to establish its health program because the management was convinced that a state of good health is an issue that must be addressed before the poor can rid themselves of want.

All three organizations were aware of the direct impact of ill health on poverty when they initiated their HMI schemes. In line with their social agendas, they aimed to provide quality and affordable health care services to those who would otherwise not have access. They each hoped to cross-subsidize health service provision for those who are less well off and adopted sliding scale premium and co-payments, with higher charges for non-members and lower charges for members.

None of the organizations reject individuals in need of health care services. Also, they each overlook adverse selection as relatively higher risk individuals are allowed to enrol as policyholders. All three feel that without this policy many of the people with poor health condition and chronic illness will have to go without any medical treatment.

The SSS Health Program can be thought of as more socially conscious in terms of treatment for the hardcore poor. Though it is not publicized, discussions with SSS management revealed that they are relatively lenient with co-payments with those that cannot afford it. Grameen Kalyan and BRAC MHIB management, on the other hand, are strict in their enforcement of their co-payments and referral limits.

A direct consequence of the organizations prioritizing their social agendas over financial sustainability is that operational costs are not recovered. As illustrated in Section 4, at the end of 2004, administrative costs as a percentage of premium income for BRAC MHIB and the SSS Health Program were at the astronomically high levels of 386.1% and 2431.5% respectively. Both organizations need subsidies to meet the shortfalls.

Discussion with management and staff at the field level have revealed that because of availability of medical facilities nearby provided by the NGOs, poor village people now seek medical help whenever they have a medical problem, and in the early stages of illness. Previously, in such cases, they would either go to a Kobiraj or to an unqualified village medical practitioner or self-treat by purchasing medicine from the pharmacy, often the wrong or inappropriate medicine, or wait until the illness became more serious, and in many cases resulting in more expensive and extensive treatment, and even disability or death.

BRAC, GK and SSS programs have a focus on maternal and neonatal mortality, which are major areas of concern in Bangladesh. BRAC MHIB and GK participate in the EIP, NID and PolioPlus campaign jointly with the State health authority in Bangladesh to immunize the young and school going children against some of the common childhood diseases and make the country polio free. SSS has programs for ethnic minorities, sex-workers, and working children, and also to raise awareness about safe drinking water and sanitation.

Women's' Empowerment

BRAC MHIB, GK and SSS realize that for a variety of cultural and religious reasons, poverty in Bangladesh has a women's face. Socio-cultural barriers are aligned against the equal status of women and girls. Majority of the females in Bangladesh, specifically those in rural areas, bear the brunt of deprivation. They have been, and continue to be, consistently denied many of their basic human rights. A well-planned health insurance scheme in Bangladesh needs to take into account the disadvantaged situation of women in the country.

As a result, the prime target population for their HMI schemes are women. The empowerment of women is enhanced by making sure that female members of each household are, whenever possible, the cardholder through which the rest of her family can access their health care services. Besides this, women are the focus of many of the benefits accruing from these health packages. BRAC MHIB Prepaid Pregnancy Package and School's Package for example have a special focus on girl students and gives free supplementary iron tablets to them. 60% of the members of their school package are female. GK has a Safe Motherhood Program. The main purpose of SSS health care program was to ensure safe childbirth. SSS also has programs aimed at female sex-workers in its area of operation.

All three organizations have been instrumental in the process of contributing to empowering women. With insurance, women can now go to nearby health centres and access preventive and basic curative health on their own, and bring their children, even their husbands. When a woman or a child is sick or has pregnancy-related health problems, she does not have to depend on her husband, who would otherwise have to take a day off from work and lose a day's wages to take his wife or child to a clinic while incurring travelling and medical expenses. She can now go on her own to receive affordable health care, at a predominantly female run clinic, without her husband's assistance.

According to one community health volunteer (SS) of BRAC MHIB, "men have more appreciation and respect for their wives as they consider that they and their family members are now receiving treatment as a result of their wives' card."[46] Another SS of BRAC quotes a

[46] WEEH Report, April 2004

village man saying "because of my wife's card, we are all getting treatment. Otherwise we would have to spend more money."[47]

Not only do female cardholders feel empowered by their membership in the programs, but women involved in the distribution channels—BRAC MHIB's SS, SK and NFPE teachers, GK's health assistants and SSS TBA (Dais)—also feel empowered as a result of their involvement in the respective programs.

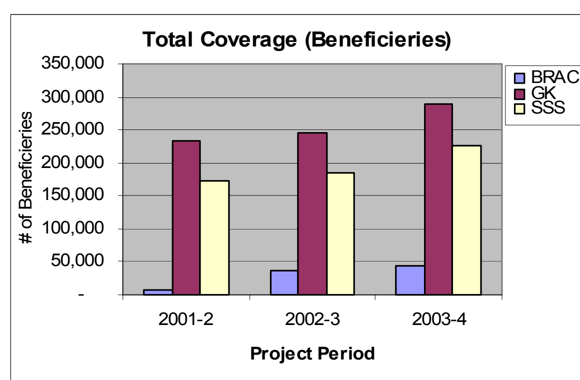
5.2 Institutional Capacity

Existing Structures

All three organizations were operating in the development field in Bangladesh long before they ventured into HMI provision. Each of them operated in several different areas, the core focus of which was their microfinance programs. Microcredit, which was the focus at the beginning, proved to be an effective method of combating poverty, and within a few years of Grameen Bank and BRAC had grown to such an extent, that their operations covered most parts of the country. SSS was intended to be a Tangail-based operation, but over the years, it expanded into 11 other districts.

Each organization had a health program prior to their involvement in health microinsurance, and was thus able to take advantage of a few years of experience before they started providing health care services through risk pooling. They were thus already at an advantage in terms of HMI provision as the infrastructure was already in place and the organizations had staff and resources in the areas in which the insurance schemes were initiated. Thus, each program has the potential to expand through future replication with very few additional resources.

Coverage and Number of Branches

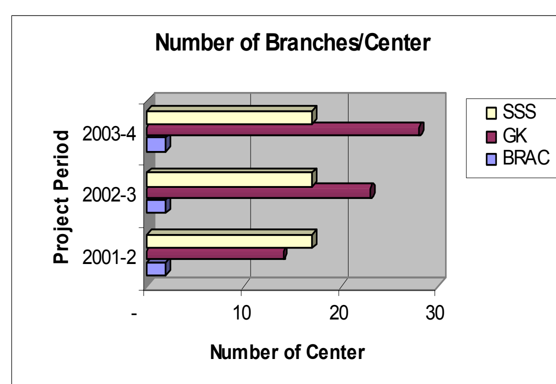


BRAC MHIB does not have any clinics of its own but uses BRAC NGO's Shushastho centres. Their operations are in two Upazilas with 7,816 policyholders in the General Benefits package covering 39,080 beneficiaries, and 3,442 policyholders in Pregnancy related package and 1,000 (60% female) policyholders in the School Health Package, for a total of 43,522 beneficiaries.

GK operates in 8 districts through 28 clinics and has 58,000 policyholders and coverers 290,000 beneficiaries, which is highest among the three organizations. The SSS Health Program operates in 6 Upazilas with one urban hospital and 16 rural clinics, 45,424 policyholders and 227,120 beneficiaries. BRAC MHIB started in 2001 and operates in two Upazilas only. It is part of a very high profile NGO and carries its image. It also had the support of ILO WEEH project, which helped it to scale up the initiative. BRAC MHIB's

[47] Ibid

parent NGO operates several other rural clinics independent of the MHIB, and therefore there is significant opportunity for future growth.



Grameen Kalyan had the advantage of starting with 10 operational clinics given to it by its parent NGO, Grameen Bank in 1993, and an Endowment Fund of US$42.5 million. Like BRAC, it is part of a high profile NGO and had the support of ILO WEEH project.

SSS started its operations in 1993 and has benefited from the compulsory membership of its HMI scheme. Its renewal rate is 80%, the highest among the three organizations. SSS operates in a large geographic area, and as such, has quite an extensive exposure in rural areas. Compared to the other two organizations, SSS has less financial resources and internal/external backing.

Expertise

Running a successful HMI requires a network of well-managed health care delivery facilities, expertise in selling of insurance, sound understanding of microinsurance operation and prudent financial management. Context and feasibility studies are required to assess financial viability; market research is required to ascertain the demand.

BRAC and GK were in health care service before they entered the HMI field and both had a well-established network of health care facilities, trained medical staff and considerable expertise in health care delivery. SSS has been able to develop quality medical facilities and well-trained medical staff after it entered the HMI field. There has been substantial capacity building in health care management and its delivery within the three organizations due to extensive training received both from outside organizations and their parent organizations. All three are therefore able to meet the health care demands and requirements of the population that they serve.

BRAC MHIB, GK and SSS use their health workers (SS, SK and HA) to sell their microinsurance by door-to-door visits. BRAC MHIB also uses volunteers and NFPE teachers, who are part-time staff in BRAC’s education program. The health workers and the teachers make their house calls mainly to provide services of their own field, so selling microinsurance is a secondary duty and often they do not pay sufficient attention to selling the products, even though BRAC’s volunteers and health workers receive commission for each member enrolled in the HMI program.

All three organisations rely on volunteers for outreach and marketing, which helps to keep their costs down. However, the volunteers and health workers do not have any knowledge of microinsurance or risk pooling and have not received any training on it. The organizations do not have in-house resources to give training on microinsurance. The field staff of all three organizations are still lacking in expertise on microinsurance and selling microinsurance products.

None of the three organizations had any experience in microinsurance; they did not consult or employ any microinsurance professionals. Context and feasibility studies were not conducted before implementing the schemes. Their premiums and co-payments were established based on ability to pay through a process of trial and error, not based on actuarial calculations or with the aim to reach sustainability. Management of all three organizations are still need to develop their microinsurance expertise.

All three organizations have adequate internal controls and there have not been any report of misappropriation of funds by its management or field staff.

MIS and Performance Monitoring

Sound financial management involves the collection of relevant and meaningful data, and systematic and timely recording, reporting and monitoring. All three organizations have manual systems, and they face difficulties in timely analysis and monitoring of statistics and financial data. Separate cost compilation or cost-benefit analyses are not prepared. BRAC MHIB and GK do have systems for budgetary control, but there is no evidence of this at SSS.

BRAC MHIB currently holds fortnightly progress review meetings at the Upazila level, as well as monthly and quarterly meetings at the Head Office, to review and analyze data, compare performance over time and across Upazilas, identify shortcomings and take measures to solve problems. In the future, a biannual budget review will be prepared to monitor the use and allocation of resources and, if necessary, alter the financial projections.

At its inception, BRAC MHIB decided upon sales targets to track enrolment performance during the initial three years of operation. The goal by the third year was the enrolment of at least 10,000 poor rural women and their families. In October 2004, 11,064 women were enrolled in MHIB packages, representing 111% of the third year target.

At Grameen Kalyan, each health centre sends a paper-based consolidated monthly revenue and expense report to the Head Office through the Regional Manager, which also identifies challenges faced and recommendations. Grameen Kalyan monitors client satisfaction through the meetings of an Implementation Committee made up of mid-level GB and GK staff and program volunteers to discuss problems, complaints from clients, and review procedures and policies. The committee meets every two months and makes recommendations to management at the head office.

At SSS, client satisfaction is monitored through the interaction of staff members with cardholders. There is also a complaint box at the SSS Hospital in which one can place complaints regarding the Health Program. SSS is also undertaking a comprehensive survey based on questionnaires completed by cardholders concerning their level of satisfaction with the Health Program. The most common complaint is the distances cardholders have to travel to different clinics to receive treatment. This is also a common complaint heard by staff and volunteers at both GK and BRAC MHIB.

5.3 Marketing and Client Education

Marketing

The poor people will choose an HMI provider if it is known, provides quality health care, has a good reputation, and is nearby. The parent organizations of BRAC MHIB, GK and SSS are known in their respective areas, they have good reputations and client loyalty.

BRAC MHIB and GK both use a number of similar marketing and promotional techniques. Their staff and managers inform potential cardholders of the benefits of enrolling in their health microinsurance scheme through regular visits to weekly meetings of the microcredit borrower groups. It is mandatory for microcredit clients to attend these meetings, so they are essentially a captive audience. Furthermore, GK and MHIB staffs have noticed that the microcredit members, who are the main target for the insurance schemes, feel a sense of obligation to join the scheme.

The frontline field staffs for BRAC MHIB and GK raise awareness through their door-to-door community visits. Health centre staffs of both programs encourage non-cardholder patients to enrol in the scheme. Both schemes also use information, education and communication (IEC) materials such as promotional brochures, leaflets and posters to promote their schemes (See Appendix 5).

Grameen Kalyan uses the maternal, child health services and free check-ups provided to each household by the roving health assistants as promotional tools. BRAC's non-formal teachers also serve to promote the scheme to parents of their students. In addition, BRAC MHIB has developed an illustrated flipchart based on a cartoon illustration of the Mutual Health Insurance schemes present in West Africa, which proved to be an extremely effective method of promotion in Senegal.

BRAC has also pioneered the use of popular theatre to educate target groups on the benefits of health microinsurance. Since 1998, BRAC's Social Development Program has produced plays to highlight certain unjust, illicit and exploitative practices of society while preserving Bangladesh's rich tradition of local drama and folk songs. Participants are selected from VO members and are provided with 10 days of intensive training in rural theatre. During the last 3 days of training, participants are sent to different villages to collect real life stories reflecting critical social issues. Such methods promote the MHIB by portraying the benefits if struck by a health tragedy.

BRAC MHIB has a large force of SS and NFPE Teachers and uses them for marketing extensively. Although BRAC MHIB has a commission-based incentive system in place for marketing, neither GK nor BRAC MHIB rewards salaried employees for increasing enrolment. Both organizations monitor and periodically evaluate the performance of salaried staff involved in insurance activities and base subsequent promotions on such factors.

SSS has the advantage of requiring its microcredit clients in the respective areas to enrol, but it still relies on the front line field workers of SSS HMI scheme—the health assistants and the traditional birth attendants—to market its services to non-Samity members. They promote the health insurance scheme when they make house calls and hold satellite clinics in different areas of Tangail each month.

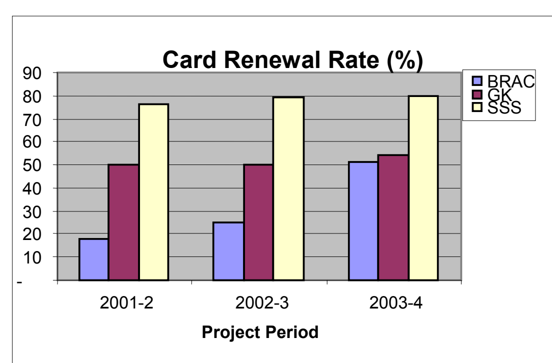
In 2004, BRAC MHIB spent 47.5% of its premium income on training, promotion and marketing, including commission for enrolling new members, GK spent 22.4% and SSS spent 14.7%.

Client Education and Retention

All three organizations faced initial problems in selling health insurance policies to persons who had no prior concept of risk pooling. Villagers were sceptical of a scheme in which premiums would drain their resources with no immediate advantage conferred to them in return. They were reluctant to part with funds before a health problem had arisen and expense had been incurred. Therefore HMI programs require not just proper management, but more importantly, behaviour change for the user group through client education.

All three organizations overcame this problem by explaining the various benefits and services provided under the schemes through real life and hypothetical situations of illnesses they could experience with particular attention to the elimination or reduction of such risks as a result of enrolment. An important issue in this regard that applies to all three organizations is the trust engendered among Bangladeshis and their outstanding reputation. Each organization has benefited from the goodwill associated with their names.

Staff and volunteers of the organizations try their utmost to make sure all cardholders have knowledge of the benefits to which their families are entitled. On questioning the cardholders during field visits, it was revealed that even though each cardholder might not be able to name all the benefits, the information was easily available to them through staff, volunteers and neighbours. Similarly, the close ties between residents of each village also serve client education purposes through word-of-mouth promotion.



Renewal rates were 51%, 54% and 80% for BRAC MHIB, GK and SSS respectively. The SSS figure may seem respectable, but it is actually quite low considering enrolment in the scheme is compulsory for most cardholders. Field visits revealed that the main reason cardholders did not renew their coverage was that they were unwilling to incur premium costs before they incurred a health expense. Cardholders tend to renew their policies once an accident or injury occurs or a health service is required. Another common reason for not renewing is the distances and associated transport costs some cardholders encounter in travelling to and from the hospitals and clinics. As a result, all three organizations face problems of delayed renewals and low renewal rates.

Low renewal is not only a reflection on the quality of service or dissatisfaction of the policyholders. Most policyholders drop out due to financial constraints and due to their ignorance of the benefits of HMI. There has been steady growth in the renewal rates of BRAC MHIB and GK, whereas SSS growth rate appears to have peaked.

To enhance renewals, GK automatically increases the maximum referral benefit to repeat cardholders to US$34.08 as an incentive for renewal. BRAC MHIB offers the incentive of a 25% discount on premiums upon renewal if cardholders did not avail themselves of any health services during the previous year. This incentive seems particularly appropriate because not only are they lower risks, but those who do not receive benefits are much more likely to drop out of the scheme. Renewal rates among MHIB's ultra poor cardholders remains low mainly due to a lack of education and awareness of the risk pooling concept and misunderstanding of program's policy.

Prevention Services

Preventative care is valuable to the insured because of the health benefits conferred, but also to the insurer as it reduces more significant, costlier health risks, thereby reducing the overall amount paid out in claims. Both BRAC MHIB and GK provide incentives for preventive health care through free annual checkups for policyholders.

One of the goals of BRAC MHIB is to promote preventive health care to its target population. The organization holds various forums for all community members, which are used to deliver preventative information and health education while promote the insurance scheme. At VO meetings, MHIB staff use pictorial flipcharts to disseminate information on topics such as family planning, antenatal care, puberty, gender differences, tuberculosis, HIV/AIDS and STDs. Community health volunteers discuss basic health and hygiene information with households during their door-to-door visits and conduct monthly health information sessions in each village. BRAC's Ante Natal Satellite Clinics also provide health education to pregnant women, both cardholders and non-cardholders.

In October 2002, BRAC MHIB launched an HIV/AIDS/STD Awareness Pilot Program in MHIB areas to raise awareness. The project includes discussions at VO meetings, one to one sessions with couples, information sessions for adolescents, and meetings with truck drivers and rickshaw pullers.

BRAC MHIB and GK participate in the government's immunization campaign directed towards the young and school going children. The vaccines are provided free of charge by the health authorities and small contributions are made to cover the cost of promoting the campaign. Such participation strengthens their own prevention program, enhances their image, and adds to their own efforts in marketing and publicity.

SSS HMI holds lectures/meetings on maternal care, family planning, hygiene, safe drinking water and sanitation. It also provides ante/post natal checkups by trained TBAs. The HAs and TBAs discuss the prevention of communicable diseases during house calls and satellite clinics held in different areas of Tangail each month. This service also extended to sex workers, slum-dwellers, ethnic minorities and working children – the other beneficiaries of SSS's main program.

SSS provides free child health care service that includes the promotion of breast-feeding, education, nutrition of newborns, immunization against six common childhood diseases, and de-worming. It also distributes free vitamins and nutrition supplements to the cardholders.

5.4 Product Design and Controls

Benefits

BRAC MHIB has three voluntary HMI packages: the General Benefit and Ultra Poor Package, Pregnancy Related Care Package and School Health Package. BRAC MHIB's first insurance scheme, the General Benefit and Ultra Poor package, provides medical consultations at BRAC Shushastho at reduced rates, discounts on pathology tests and medicines. The ultra poor gets 2 post consultation home visits, and the head of the household gets a free annual check-up. In case of referral to other clinics or hospitals, the scheme reimburses between US$8.52 and US$17.04. The benefits were adopted after consulting the community's disease profile and extensive consultation with target group members.

The Pregnancy Related Package, which was introduced in 2002, covers the cardholder against a number of pregnancy related complication through all stages of one pregnancy. It also covers newborns against diarrhoea and pneumonia. Free iron tablets, folic acid and Safe Delivery Kit are also supplied all pregnant women covered by this scheme. The package was designed through consultation with BRAC field staffs and target group members to cover the most the frequent pregnancy problems faced by the rural Bangladesh women.

Introduced in 2004, the School Health Package provides a free annual check-up, half-yearly immunization against intestinal worms, and discounts on pathology tests. Girls are supplied with free supplementary iron tablets. The package was designed through consultation with BRAC field staff, parents of school going children and school authorities. It is pilot project in one centre, but BRAC is now in the process of implementing the same in other areas.

GK has one voluntary package. Benefits include medical consultation at GK clinics at reduced rates, free immunization against 6 common illnesses, free home visits by female health assistants, free annual check-up for the head of the household, discount on pathology tests and medicines. In case of referral to other clinics or hospitals, cardholder is reimbursed US$8.52 and US$17.04 hospitalisation costs and up to US$34.08 pregnancy related costs. The current GK benefits package was adopted as a standard package for all GK clinics in 2000 after GK experimented with several benefit options. Initially there was no consultancy fee, but a co-payment was introduced to enhance the image of the services.

SSS has one standard package for all its clinics and hospital. Enrolment is compulsory for all SSS borrowers resident in the 6 sub-districts of Tangail in which the hospital and 16 clinics are located. Members are entitled to curative health care at SSS clinics and are referred to tertiary level SSS hospital in Tangail if required. Members get 30% discount on SSS hospital charges. SSS does not refer patients to any outside clinics or hospitals. SSS benefits are available to a cardholder's entire family, no matter how large. Medicines are provided free of charge to all cardholders and staff members. Others pay for their medicine at the retail price.

Premium Collection

BRAC MHIB premiums are collected annually in one instalment in cash. Individuals can register at any time at the Area Office, or at the Shushastho, or during routine visits of the BRAC MHIB staff at village meetings.

BRAC MHIB tried instalment system with a group of cardholders as an experiment, but the cardholders complained that the weekly insurance premiums was an added burden to their weekly savings and loan repayments as they that did not have sufficient weekly cash flow to service all three payments. BRAC MHIB also experienced that cardholders in activities like agriculture, fisheries and poultry, etc. that generate cash flow quarterly or half-yearly preferred a longer payment interval to coincide with their cash flow. BRAC MHIB then decided to continue with their annual premium collection system.

Grameen Kalyan premium is collected on issue of a new card with a new number each year. Issuing of a new card number at each renewal makes monitoring difficult and time consuming. Premiums from Grameen Bank members are collected by transfer from the GB group account to the GK account in the same branch. The member's written consent is obtained. Non-GB members are required to pay premiums and renewals in cash in one instalment. HA are allowed to collect premiums during home visits or at the health centre. Receipts are issued for all premiums collected.

SSS members are required to buy their health card from the SSS clinic nearest to them, and pay by a single instalment in cash.

Controlling Risks and Costs

In its first year of operation, BRAC MHIB encountered a few cases of fraud or misuse. Individuals who were not covered under the scheme tried to receive discounted services by using members' cards. In these cases, the cardholders' policies were cancelled. Since then, fraud has not been an issue as the community health volunteers get to know each member on a personal level. As such, they know what is going on in the community and could detect cases of fraud or misuse of its services.

Similarly, fraud or misuse is not an issue for GK. It is the job of the health assistants attached to each health centre to know everyone in the villages they have been assigned to cover. At SSS also, most cardholders are known to the clinic staff and other SSS staff members, and therefore constant monitoring and surveillance of the cardholders takes place. As a result, SSS also has not experienced any large-scale fraud or misuse of its services.

All three organizations are not particularly effective at controlling adverse selection since they are willing to provide health care and insurance to anyone who wants it. The notion of controlling adverse selection runs counter to their mission. None of the organizations introduced a waiting period as they felt that this would cause hardship to those who were already ill or had a chronic illness when enrolling. Their policy of enrolling the whole family to some extent mitigates adverse selection, although their primary purpose for doing so stems from their inclusive social agendas.

Over-usage of facilities by the insured is another cost issue faced by health insurers. The insured often feel like they are not getting their money's worth unless they take advantage of the services. To control over-usage, all three schemes require co-payments. To control costs, GK and BRAC MHIB have a limit on the fees that they will pay for referrals. Such a strategy may solve the HMI service providers' problems, but it merely transfers the burden to the insured and acts to make the HMI schemes less attractive to their members.

Many health insurers control costs by requiring the insured to notify them in advance of any treatment. In a country like Bangladesh, with high poverty, low literacy and limited communication, this requirement cannot be applied easily or equitably.

5.5 Claims Management

In a typical health insurance scheme using outside service provider, claims are normally settled using one of the two following methods:

a) A patient makes the co-payment directly to the service provider and the balance of the cost of treatment is settled between the service provider and the insurer following their agreed procedures.

b) A patient makes full payment for the treatment direct to the service provider and then submits the bills to the insurer for reimbursement. The insurer reimburses the cost of treatment to the patient after deducting the co-payment.

BRAC Shushasthos, on average, treat over 99% of their cardholders and refer less than one percent of the cardholders to other health facilities. The cardholders pay the Shushastho charges direct to them at the discounted rate while receiving the treatment. No further claims and reimbursements are involved.

For the small number of cardholders referred, the Medical Officer makes a note on the patient's prescription stating which centre they should visit. Patients are required to pay the total cost of treatment to the referred centre at their prescribed rate. To claim reimbursement, the cardholder is required to submit the prescription, medicine bills and the treatment bill to BRAC Shushastho. The claim is examined by the MHIB claim committee consisting of the Area Coordinator, the Medical Officer, and the TCO. The committee decides on the amount (between US$8.52 and US$17.04) to be reimbursed based on the cost of treatment and the severity of the illness. The claims process takes about a week. The claim is settled in cash. For VO cardholders, the claim is paid at the next VO meeting in front of the other members, as this serves to promote the scheme and its benefits to other members.

Similarly, at Grameen Kalyan, the health centre and the staff provide 99% of insured cardholders' health care needs. The cardholders pay the GK clinic charges direct to them at the discounted rate while receiving the treatment. No further claims and reimbursements are involved.

For the one percent that requires referrals, cardholders must take a sheet signed by a GK doctor to the referred clinic. In case of emergencies, such a sheet is not required. Cardholders get a 50% discount on referred consultation charges and pay direct to the referral treatment centre. GK reimburses up to US$34.08 for hospitalisation due to maternity complications, and up to US$17.04 for hospitalisation due to other complications. Depending on the severity of the illness, patients may receive an advance towards hospitalisation bills.

The signed sheet from GK clinic, prescription and the bills are required to be submitted while claiming reimbursement. The local GB Branch Manager and GK Centre Director make the decision about claims payments. If the patient is non-GB member, the health assistant for the

area and the GK Centre Director make the decision. Proof of hospitalisation from referred hospital is required. Claims are paid in cash and usually take a week to process.

SSS provides treatment at it own clinics. For complicated cases, clinic personnel refer patients to the program's well-staffed and adequately equipped hospital, which can provide most of the health care requirements of the cardholder. Cardholders pay their charges direct to the clinic or hospital at the time getting treatment. No claims or reimbursement are involved.

Where illnesses cannot be treated by SSS medical staff, they bring in medical specialists from different public and private sector clinics to examine and treat the patients. The SSS Health Program does not normally reimburse the expenses for treatment outside its own facilities; only in special cases, part or whole of the treatment cost of the ultra-poor cardholders are reimbursed.

5.6 Financial Performance and Sustainability

The analysis of key figures for 2004 in Table 13, and earlier in Tables 10b, 11b and 12b show that the three organizations have not yet broken even. This result is partly a consequence of the organizations' prioritizing their social agendas over financial sustainability. In addition, all three programs have been running for a relatively short period and their memberships have not reached a level that can generate sufficient revenue to achieve operational self-sufficiency. Currently, they are subsidized by outside donors and/or by their parent organizations. In addition, GK and the SSS Health Program were given funds for investment by their parent organizations, which generate substantial investment income. Funds were invested in government bonds and securities, and in bank fixed deposits; all are secured and give a reasonable return. The stock market is very volatile and therefore and therefore is not safe for investment of NGO funds.

Table 13. Analysis of 2004 - Key Results

	BRAC MHIB		GK		SSS	
	US$	% of PC	US$	% of PC	US$	% of PC
Premiums and Co-payments	**8,803**		**74,912**		**3,745**	
Less:						
Incurred Claims	4,911	55.8	5,164	6.9	-	-
Head Office Expenses	3,052	34.7	38,611	51.5	54,314	1,450.3
Field Office Expenses	31,852	361.8	163,687	218.5	37,815	1,009.7
Total Expenditure	**39,815**	**452.3**	**207,462**	**276.9**	**92,129**	**2,460.0**
Operating Loss	**(31,012)**		**(132,550)**		**(88,384)**	
Investment Income	-		263,093		86,281	
Net Gain/(Loss)	**(31,012)**		**130,543**		**(2,103)**	
Grants Or Subsidies	34,903		126,015		2,468	
Net Gain after Grants and Subsidies	**3,891**		**256,558**		**365**	

All three organizations entered the HMI field to make affordable health care available to their members and to the other rural poor in their areas of operation. Their initial emphases have been on covering a large geographical area, making a wide range of health care services

available, and keeping their charges low. The premium and the co-payments were set at an affordable level, well below commercial rates, in consultation with their members, with several revisions, some times downwards. There were no actuarial calculations, projections or feasibility studies. None of the organizations have set up an insurance fund.

The organizations do not have any reinsurance relationship, nor are they in a legal position to have a reinsurance treaty. They draw comfort from the fact that their parent organizations have large financial resources and will come to their rescue if they get into any difficulties. All three organizations also feel that entering in a reinsurance contract with a formal insurance company may not be in the best interest of the poor people that they serve. Reinsurance may require rigid controls and they would loose the flexibility they now have in responding to the requirements or problems of the population that they serve. They now enjoy the freedom of revising the premiums, benefits and products whenever required.

BRAC had discussions in the past with Delta Life and Green Delta General Insurance to explore the possibilities of co-operating in microinsurance activities, both of whom are joint-venture partners with BRAC in Delta BRAC Housing – a finance company specializing in housing loans for the upper middle class. Both Delta Life and Green Delta are in health insurance, and Delta Life has a substantial microinsurance business. The discussions did not materialize in any association as BRAC management felt that any partnership with a commercial organization will not be in the best interest of its members.

BRAC MHIB

During the three years under review, BRAC MHIB had an operating loss of US$94,922. During this period, it received US$133,697 from the ILO as subsidies. BRAC MHIB does not have any investment fund or investment income. The ILO subsidy is due to end this year and MHIB management is concerned about the future of the program. A study was carried out in May 2005 to find the possible ways of making the program sustainable. The report recommended the following, which the BRAC MHIB management has decided to implement:

- Reduce head office staff from two to one
- Reduce field staff to two per field location
- Increase outreach and premiums
- Introduce late renewal penalty
- Introduce no-usage renewal discount
- Increase monitoring of pathology services
- Experiment with more innovative concepts

BRAC MHIB management realizes that even after implementing the above, it will take several years before the program can become sustainable. It has therefore requested the ILO for continued financial support until such time. Neither the report nor MHIB management has given any indication of a timetable for the implementation of the above or for achieving sustainability. The ILO has not yet taken a decision on the continuation of this subsidy. BRAC MHIB does not have any capital, nor does it have any reserves or assets of its own. It will not be possible for BRAC MHIB to continue its operations without financial support from a donor or its parent organization.

Grameen Kalyan

Grameen Kalyan received an endowment fund of US$42.5 million from its parent organization that generated a substantial investment income. The endowment fund was returned to the parent organization in 2002. GK's operating loss for the three years amounted to US$388,012, but with income received from investment of US$944,675, it showed a net gain of US$556,663. It received US$378,066 from the ILO as a grant and transferred a total of US$750,000 to reserves during the three years period.

The income generated by investment of the endowment fund and the funds transferred to reserves each year has strengthened the financial position of GK significantly, and has contributed to the financial viability of the program. GK has been able to meet its operating expenses fully from the revenue from cardholders and investments for the past three years.

GK's experience shows that with an injection of a large endowment fund for a limited period, and with sound investment management, it is possible to reach financial viability. This is a mechanism that can be applied by donors or parent NGO instead of subsidizing operational shortfall each year for an indefinite period.

Society for Social Services

SSS's operating loss during the 3 years amounted to US$257,072. The income from investment during this period was US$218,804, which reduced this loss to US$38,268. The subsidy received from its parent organization during the period amounted to US$40,184. Head office expenses amount to US$161,343, which is approximately 60% of its operating costs. SSS does not receive any financial subsidy from any other organization.

SSS has kept its charges quite low as part of its policy to make their health card system affordable. This has resulted in low income generated from its policyholders relative to the size of its membership. The outreach is good and the rate of growth in membership is satisfactory. The parent NGO considers the Health Program as an extension of its service to the members and looks at the subsidy as a cost for achieving it. As of now, there is no plan to discontinue the subsidy, which is needed by SSS Health Program for its continued operation. SSS Health Program has the potential to reach financial viability by revising its charges, improving the renewal rates and rationalizing some of its head office expenses.

6. Conclusions, Lessons Learned and Major Challenges

6.1 Conclusions and Lessons Learned

Institutional Mission

- Ill health and the cost of health care act as major obstacles to borrowers trying to break out of the poverty cycle and therefore the health of the poor must be addressed before they can rid themselves of want.
- Poor people require quality health care services at an affordable price. Adverse selection has to be overlooked to accommodate poor people with existing or chronic illness, otherwise these people would not be able to get any health care. Though a majority of the poor people can pay for health care services, a section of them would still require further assistance like free treatment and medicine. NGOs are often the only source of health service rural areas, and the only trusted one for the population they serve.
- The prioritizing of the social agenda over financial self-sufficiency can lead to an adverse financial position. For financial sustainability, a HMI scheme must have a large client base, low administrative cost and sound financial management. Cross-subsidy by adopting a sliding scale premium and co-payments is one of the models that can be used for meeting part of the operational shortfall.
- With all their resources, experience and expertise, the world's two largest NGOs went into health microinsurance after many years of study and experiment. They did not get it right the first time and needed many trials and errors, and even now they are not yet perfect. Running a health microinsurance program requires specialized expertise and experience.
- To have successful clients' relationship and a positive poverty impact, the organization needs to allow greater voice to the clients to influence the organizations' agenda and pricing structure. While this may encourage poor people to enrol in the program, and eventually increase the premium income on the long run, in the initial period, low pricing structure normally results in operating losses.
- HMI schemes have the geographical coverage and the infrastructure with which they can successfully participate in many national health campaigns in the country and improve health condition of the general public. One example is immunization of children against common childhood diseases. Others are safe drinking water and sanitation.
- For a variety of reasons, poverty has a women's face. Therefore, the prime target for almost all microfinance programs, HMI included, are women. Making sure that the female member of a household is, whenever possible, the principal member through whom the rest of her family can access the benefits contributes to the empowerment of women. Though this puts the burden of family health care financing on the female member, her involvement in a major financial commitment enhances her stature and image within the family.
- Traditionally, microfinance programs, HMI included, engage female staff for their activities and thereby strengthen their policy of empowerment of women even further.

Institutional Capacity

- Consumers choose an HMI provider if it is known to them, provides quality care, has a good reputation, is nearby and treats the consumer appropriately.
- Existing NGOs and MFIs have advantages in terms of HMI provision as the infrastructure is already in place and the organizations have the work force and resources in the geographical areas in which the insurance schemes are initiated. Thus, they have the potential to expand through future replication with very few additional resources.
- Running a successful HMI requires a network of well-managed health care delivery facilities, expertise in selling of insurance, sound understanding of microinsurance operation, and prudent financial management.
- Large membership is necessary for any HMI scheme to be successful. A large membership brings economies of scale and can cover the administrative overheads of a large branch network if the premiums are priced correctly. The three HMO schemes are part of well-established and reputable NGOs; despite their major efforts, the membership remains low. HMI is fairly new in Bangladesh and the schemes have not been operating for very long. Given time, the membership will grow and the HMIs will break even.
- Field staff need to have a sound knowledge of HMI products and marketing, periodic training, motivation and incentives. They are in the best position to explain the concept and benefits of HMI schemes to the target population.
- Prior experience in microinsurance is desirable for the management of an HMI scheme, and if not there, outside microinsurance professionals should be employed or consulted. Learning through a process of trial and error can be expensive and can have serious implication on the financial viability and reputation of an HMI provider.
- The experience and orientation of volunteers and health workers are normally towards the delivery of NGO services, and they do not normally possess knowledge of microinsurance or risk pooling. Unless trained in this area, they may hamper the drive for new members in the scheme. The field staff of BRAC MHIB, GK and SSS lack expertise on microinsurance and selling of microinsurance products, and therefore in spite of considerable efforts by them, the membership growth is slow.
- MIS and performance monitoring are key elements for ensuring proper delivery of health care services, efficiency in the system, reduction of wastage, client satisfaction and value for money to the members.
- For MIS to be effective, data has be analysed quickly and conveyed to the users in a simple report. If the reports are not timely, they are not useful. Microinsurance providers should carefully consider automating their management information systems.

Marketing

- Microcredit members of NGOs or MFIs, who are the main targets for HMI schemes, show a sense of obligation to join the parent NGO's program.
- Door-to-door visits can be used by an HMI scheme to market its product. Field staff of an NGO that routinely visit villagers in connection with their other services can assess the health care needs of the households that they visit and are in a position to earn their confidence and encourage non-cardholder patients to enrol in the scheme.

- Potential HMI members do not normally have an understanding of risk pooling and are sceptical of a scheme in which payments come first with no immediate return. They are normally reluctant to part with funds before a health problem arises. Therefore, HMI programs need to change the behaviour of the target market through client education. This is one of the major hurdles that these HMI schemes have not been able to overcome.
- Such problems can be overcome by explaining the various benefits and services provided under the schemes through real life and hypothetical situations, with particular attention to the elimination or reduction of such risks as a result of enrolment.
- Low renewal is not necessarily a reflection on the quality of service by the organizations or dissatisfaction of the policyholders. Many policyholders drop out due to financial constraints and due to their ignorance of the benefits of HMI.
- It is essential for an HMI scheme to ensure all members understand the benefits to which they and their families are entitled. This information can be made available to them through staff, volunteers and neighbours. Close ties between residents of each village also serve client education purposes through word-of-mouth promotion.
- Promotional brochures, leaflets and posters are essential tools in client education and marketing and can be used successfully in increasing membership.
- Distances and associated transport costs in travelling to and from the hospitals and clinics can be an issue and a reason for low renewal rates. Location of health care facilities is therefore an important issue and requires attention.
- Preventative care is not only valuable to the insured because of the health benefits conferred, but also to the insurer as it reduces more significant, costlier health risks, thereby reducing the overall amount paid out in claims.
- The HMIs can deliver preventive care information and health education on topics such as family planning, antenatal care, puberty, gender differences, tuberculosis, HIV/AIDS and STDs while promoting the insurance scheme through door-to-door visits, forums and community meetings.
- HMIs and their parent NGOs can strengthen their preventive care program, enhance their image in the eyes of own their members and potential members, and supplement their own efforts in marketing and publicity by joining in state sponsored health programs. In the immunization programs, for example, the vaccine is provided free of charge by the state health authority and a small contribution is made towards publicizing the events, therefore an HMI's own cost of preventive care is also reduced.
- For VO cardholders, BRAC MHIB makes its claim settlements at VO meetings in front of the other members. This serves to promote the scheme and its benefits to the members
- Financial incentives such as 'no claims discount' and maximum referral benefits can enhance membership renewals. Such incentives are appropriate because not only 'no claims' members are lower risks, but those who do not receive benefits are much more likely to drop out of the scheme. However, HMI schemes need to monitor such incentives and carry out a cost benefit study.

Product Design

- It is important to have simple, easy to understand and standard charges and benefits packages throughout the organization. Different charges and benefits can confuse the target group and can develop discontent among the members.
- Benefit packages should be designed through consultation with field staff and potential members and reviewed periodically.
- Premium collection should be simple, easy to understand and to administer. A single annual instalment in cash is popular, but can be burdensome on the members. BRAC HMIB tried a weekly instalment system on an experimental basis, but this was not popular.
- Accepting premiums in the field is convenient for the members, but consideration must be given to security of the cash and also the staff carrying the cash to the office. Though there have not yet been any reported cases of misappropriation by a staff member, such possibilities exist.
- Collection of premiums by transfer from a member's savings account with the NGO to the HMI scheme, like in GB, is a convenient way of collecting premiums. It reduces administrative work and safeguards the security of cash.
- Numbered health cards with photograph and details of beneficiaries can be used for controlling the collection of premiums, but health card numbers should be used in a planned way so that confusion and complication are avoided in future while recording and monitoring. Such cards also offer effective controls against fraudulent use of services by non-members.
- Sophisticated control systems are not cost effective in an organization dealing with a large number of people at the grass root level, and therefore moral hazard problems always exist. In villages, the community health volunteers get to know people on a personal level. As such, they know what is going on in the community and can detect cases of fraud or misuse of its services just by being vigilant. Strict disciplinary measure taken against detected cases of fraud and misuse acts as moral deterrent and is effective.
- The notion of controlling adverse selection runs counter to the mission and social agenda of a NGO. BRAC MHIB, GK and SSS scheme are willing to provide health care and insurance to anyone that wants it. They also will not introduce a waiting period, as this would cause hardship to those who were already ill. The policy of enrolling the whole family to some extent mitigates adverse selection, although the primary purpose for doing so stems from the inclusive social agendas of the three schemes.
- Over-usage of facilities by the insured is another cost issue faced by HMI schemes. The insured often feel like they are not getting their money's worth unless they take advantage of the services. Co-payments and limitation on the reimbursement of referral fees are used to control this risk. Such a strategy may solve the HMI service providers' problems, but it merely transfers the burden to the insured.

Claims Management

- BRAC MHIB, GK and SSS all have simple claims mechanism since nearly all treatments are given within their own organization/group. As a result, claims management is easy and claims rejections are unknown.
- Cardholders pay their charges directly to the clinic; as a result, there is no paper work to be dealt with between the insurers and the clinics providing the treatment.
- Simple procedures help to keep administrative overhead expenses low and allow clinic staff to concentrate more on health care activities.
- Reimbursement of claims by BRAC MHIB at VO meetings allows it to promote its products without any expenses and generates confidence about the scheme in the mind of cardholders and potential cardholders.

Financial Performance and Sustainability

- All three organizations entered the HMI field with financial support from donors, parent NGOs or charitable donations. Their initial emphases have been on covering a large geographical area, making a wide range of health care services available, and keeping their charges low. The premium and the co-payments were set well below commercial rates.
- A direct consequence of the organizations prioritizing their social agendas over financial sustainability is that operational costs are not recovered.
- The strategy to serve the community at large, and to charge higher rates to the less poor allowing for cross-subsidisation, has some merit and should be explored in more detail. Of particular importance are effective marketing strategies to attract the non-poor.
- The ILO subsidy to BRAC MHIB and GK is due to end this year and MHIB management is concerned about the future of the program. BRAC MHIB does not have any capital, nor does it have any reserves or assets of its own; it will require financial support from a donor or its parent organization to continue its operation.
- Grameen Kalyan's endowment fund generated a substantial investment income and resulted in a surplus each year. GK's experience shows that, with an injection of a large endowment fund for a limited period and with sound investment management, it is possible to reach financial viability. This mechanism can be applied by donors or parent NGO instead of subsidizing operational shortfall each year for an indefinite period.

6.2 Major Challenges

The major challenge faced by the three HMI schemes today is their financial viability. With all their resources, experience and expertise, the world's two largest NGOs, Grameen Bank and BRAC require donors continuing support for their HMIs. SSS also requires outside support to continue its HMI scheme. Even with continued financial support, none of the three organizations can meet their operational expenses from premiums and fees.

To be sustainable the three HMIs need to reassess their premium rates to reflect reality, increase renewal rates and encourage timely renewal, and reduce their overhead through

efficient management. Parent organizations may continue funding HMI operations because it is part of their social agenda, but it is unlikely that donors will continue funding an HMI indefinitely. In addition, by funding a non-viable HMI scheme, a parent NGO is diverting its financial resources from its other activities.

Poor villagers do not normally have an understanding of risk pooling and are sceptical of a scheme in which payments come first with no immediate return. They are normally reluctant to part with funds before a health problem arises. Therefore, HMI programs require not just proper management, but more importantly, behaviour change for the user group through client education. This behaviour change is one of the major hurdles that the three HMI schemes have not yet overcome.

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Appendix 1. Macro Data

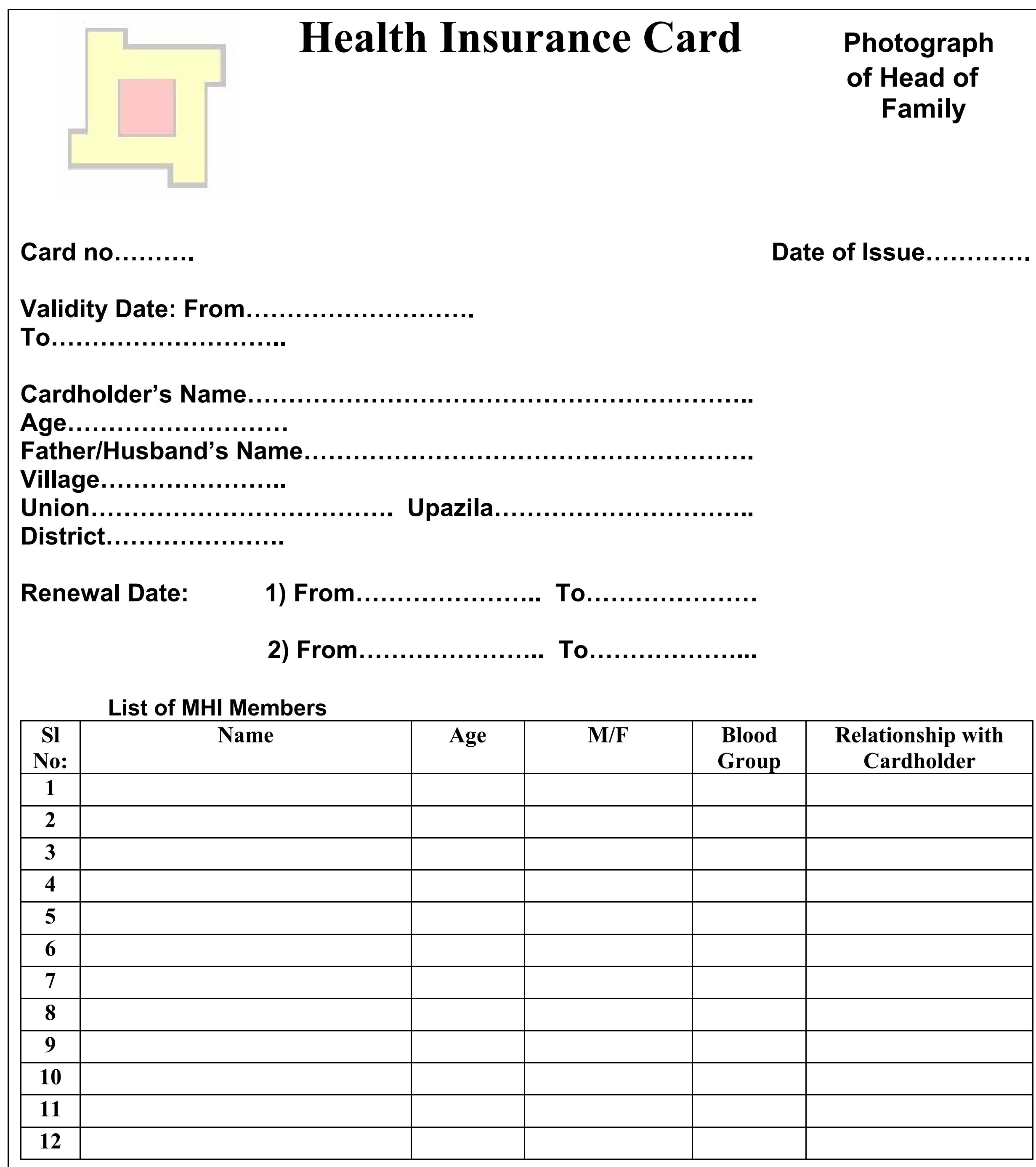
GDP (US$ Billions)	47.3	2002	WB
Population (millions)	135.7	2002	WB
Population density per km2	1024	2001	WB
Percentage urban / rural population (%)	25.5/74.5	2001	UNDP
GDP/Capita (US$)	350	2001	UNDP
GDP Growth Rate (%)	4.4	2002	WB
Average Annual Change in CPI (%)	5.1	1990-2002	WB
Exchange Rate (current, X Currency per US$1)48	58.687	31.01.05	OANDA.COM
PPP GDP per Capita	1,610	2001	UNDP
Infant Mortality (per 1000 live births)	51	2001	UNDP
Under Five Mortality (per thousand)	71 M/7773 F	2002	WHO
Maternal Mortality (per 100,000 live births)	400	2001	UNDP
Access to safe water (% of population)	97	2000	UNDP
Health Expenditure as % of GDP (public/private/total)	1.5/2.0//3.5	2001	WHO
Health Expenditure per capita (PPP US$)	58	2001	WHO
Physicians per 100,000 people (1990-2003)	23	2001	UNDP
Total number of hospital beds	43,440	2001	UNDP
Number of persons per hospital bed (Total)	3,123.6	2001	UNDP
Adult Literacy rate - ages 15 and above (%)	40.6	2001	UNDP

[48] This exchange rate will be used in all calculations of current figures in this paper.

Appendix 2. ANC Package of BRAC MHIB

	SERVICE DELIVERY POINTS		
	Shastho Shebika (Community Health Volunteer)	Ante-Natal Care Centre (Satellite Centre)	Shushastho (BRAC health centre)
Service	The Shebika provides motivational, moral and referral support. She acts as a link between the community and the other service delivery points at the initial level of reference. She is also responsible for disseminating information and following up on TB, childhood diseases, family planning, STDs, HIV/AIDS pregnancy related care, safe delivery practices, sanitation, etc… She also has the authority to supply 10 essential drugs and health commodities to the community.	Already established ANC services include family planning promotion, breast-feeding information, infant care and nutrition, and immunization. The women will receive the following ANC services if they enroll in the optional ANC package: Per visit for the duration of their pregnancy: • Mother's height (one time upon registration) • Fundal height • Weight • Urine sugar and albumin • Blood Pressure • Foetal heart sound examination • Check for jaundice and edema • Check for Anaemia *As required:* • 60 iron tablets (monthly) • TT immunization (from the Gov't EPI centres) *In the last month:* • Delivery Kit box (if they want to deliver at home) • Discount 50% delivery cost at BRAC health centre	The Shushasthos offer outpatient counselling and consultation, treatment for common diseases, first aid, and family planning. In-patient treatments include deliveries, MR, pathology, emergency services and selective surgeries for all. The mothers-to-be will be eligible for normal delivery at the Shushastho. Should complications arise, Emergency Obstetric Care (EOC) procedures can be carried out at the upgraded Shushasthos.
Referral	The Shebika receives remuneration for referring cases to the Shushastho and for each health insurance enrolment that she has secured. For each ANC check up referral, she receives a fee.	Duration of referral for neonatal care is up to birth and 28 days thereafter for the child and 42 days thereafter for the mothers. Postnatal care services include home visits for the mother and newborn. The insurance will subsidize treatment (up to a ceiling amount) for complicated pregnancies including abortion, miscarriage, transport, and neonatal complications (diarrhoea, pneumonia) irrespective of membership status.	If the need arises, the case can be referred to a higher referral centre.

Appendix 3. BRAC Health Insurance Card



Health Insurance Card

Photograph of Head of Family

Card no………. Date of Issue…………

Validity Date: From………………………
To………………………..

Cardholder's Name……………………………………………………..
Age………………………
Father/Husband's Name……………………………………………….
Village…………………..
Union………………………………. Upazila…………………………..
District…………………

Renewal Date: 1) From………………….. To…………………

2) From………………….. To………………...

List of MHI Members

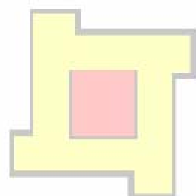
Sl No:	Name	Age	M/F	Blood Group	Relationship with Cardholder
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Signature of Issuing Officer……………………………..

Name……………………………………………………...

Date……………………………………………………….

(Translated from card in Bangla)



Benefits and Rules of MHI Card

1. Premium for members of BRAC VOs and other NGOs: Taka 100 (Family members 1 – 5), Taka 150 (Family member 6 – 8), Taka 200 (Family member 9 – 12); for non-VO/non NGO members: Taka 250 (Family members 1 – 5), Taka 300 (Family members 6 – 8), Taka 350 (Family members 9 – 12).
2. Consultation fee for MHI Cardholders of BRAC VOs or other NGOs with the doctors of *Shushastho* is Taka 2 per visit; for other cardholders Taka 5 per visit.
3. MHI members are entitled to 25% discount on medicines purchased from *Shushasthos.*
4. MHI cardholders are entitled to 50% discount on *Shushastho* Pathology charges.
5. If a MHI cardholder or a family member requires treatment at a referred hospital, the cardholder will be paid Taka 500 – 1000 depending on the illness and its severity. A cardholder can make only one claim a year.
6. Head of the cardholder's household is entitled to one free health check each year.
7. If a cardholder or her/his family members do not use any services of *Shushastho* in any year, she/he is entitled to 25% discount on next year's premium.
8. Enrolment of MHI is open at any time of the year.
9. The Health card must be produced at the time receiving service by the MHI cardholder or her/his family members.
10. MHI cardholder or family members are entitled to 50% discount on charges for a normal delivery at a *Shushastho.*

Above rules are printed on the back of Health Insurance Cards

Appendix 4. BRAC Publicity Material

Translated from BRAC leaflet in Bangla

BRAC HEALTH INSURANCE PROJECT

HAVE YOU JOINED THE BRAC HEALTH INSURANCE PROJECT? IF YOU HAVE NOT, CONTACT YOUR NEAREST BRAC OFFICE AND GET THE BENEFITS.

HEALTH INSURANCE BENEFITS AND RULES

- **This card can be purchased by members of BRAC VOs and other NGOs for Taka 100 (Family members 1 – 5), Taka 150 (Family member 6 – 8), Taka 200 (Family member 9 – 12); for non-VO/non NGO members Taka 250 (Family members 1 – 5), Taka 300 (Family members 6 – 8), Taka 350 (Family members 9 – 12).**
- **Cardholders with VO membership and other NGO membership will pay Taka 2 per visit and non-VO and non-NGO cardholders will pay Taka 5 per visit for Consultation with the doctors at *Shushastho*.**
- **MHI cardholders are entitled to 10% discount on medicines purchased from a *Shushastho.***
- **MHI cardholders are entitled to 50% discount on Pathology charges at a *Shushastho*.**
- **If a MHI cardholder or her/his family member requires treatment at a referred hospital, the cardholder will be paid Taka 500 – 1000 depending on the illness and its severity. A cardholder can make only one claim a year.**
- **Head of the cardholder's household is entitled to one free health check each year at a *Shushastho*.**
- **If a cardholder or a family member does not use any services of *Shushastho* in any year, the cardholder is entitled to 25% discount on the following year's renewal premium.**
- **Enrolment of MHI is open at any time of the year.**
- **The Health Card must be produced at the time receiving service by the cardholder or a family member.**
- **A cardholder or a family member is entitled to 50% discount on charges for a normal delivery at a *Shushastho.***

SPECIALITIES OF SHUSHASTHOS

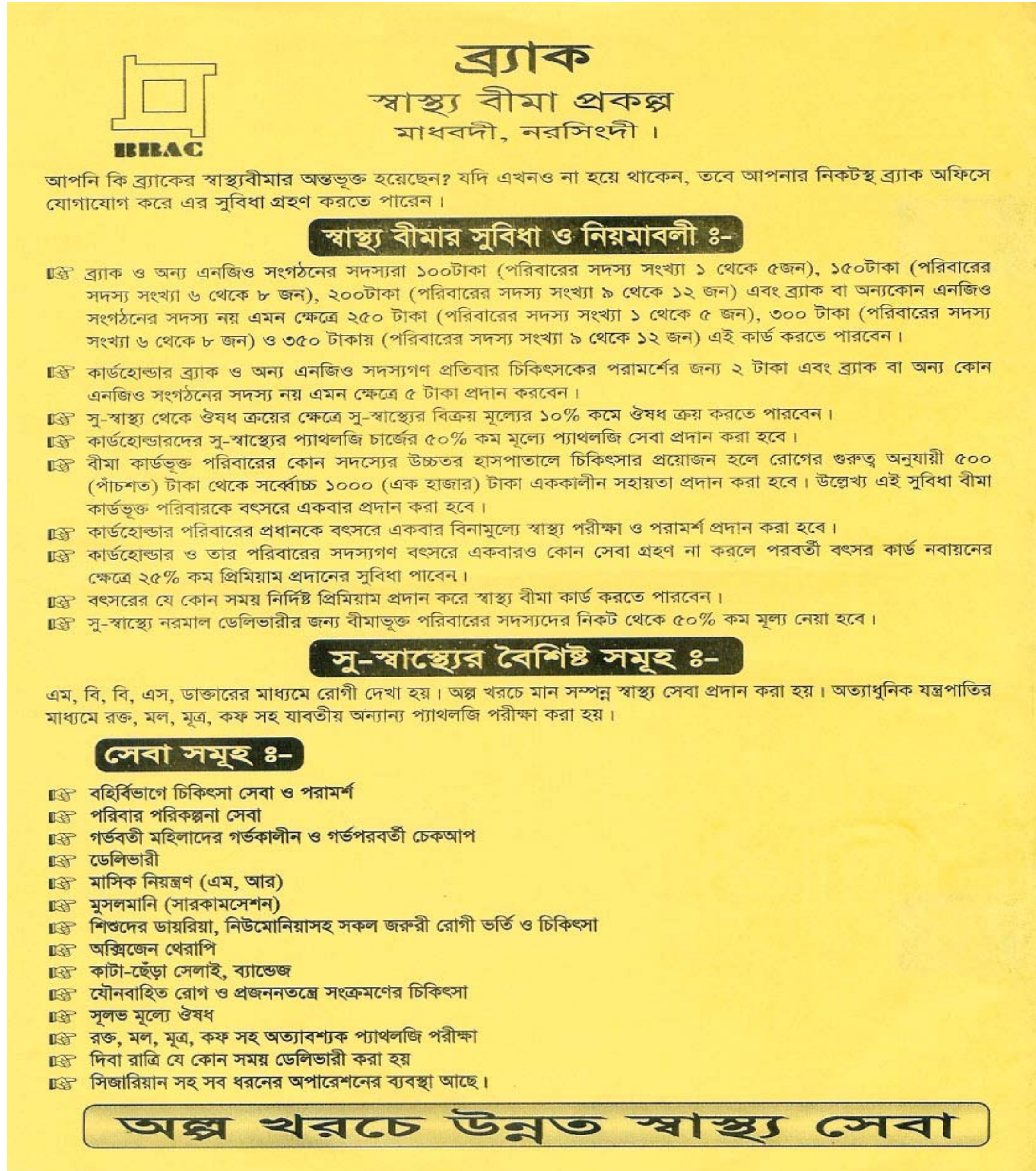
Patients are examined by MBBS doctors. Quality health care service provided at a low cost. All pathology tests including blood, stool, urine, cough etc are carried out using the latest equipments.

SERVICES

- **Out-patient service**
- **Family planning service**
- **Ante-natal and post-natal clinic**
- **Child birth**
- **Menstrual complications**
- **Circumcisions**
- **Emergency treatment and admission for children with diarrhoea and pneumonia**
- **Oxygen therapy**

- **Incisions, stitches and dressing**
- **Clinic for STD and its prevention**
- **Medicines at low cost**
- **Urgent pathology test for blood, stool, urine and cough**
- **Child birth service at any time of day or night**
- **Arrangements for Caesarean section and all other surgical operations**

QUALITY HEALTH CARE AT LOW COST



BRAC

ব্র্যাক

স্বাস্থ্য বীমা প্রকল্প

মাধবদী, নরসিংদী।

আপনি কি ব্র্যাকের স্বাস্থ্যবীমার অন্তভূক্ত হয়েছেন? যদি এখনও না হয়ে থাকেন, তবে আপনার নিকটস্থ ব্র্যাক অফিসে যোগাযোগ করে এর সুবিধা গ্রহণ করতে পারেন।

স্বাস্থ্য বীমার সুবিধা ও নিয়মাবলী ঃ-

- ব্র্যাক ও অন্য এনজিও সংগঠনের সদস্যরা ১০০টাকা (পরিবারের সদস্য সংখ্যা ১ থেকে ৫জন), ১৫০টাকা (পরিবারের সদস্য সংখ্যা ৬ থেকে ৮ জন), ২০০টাকা (পরিবারের সদস্য সংখ্যা ৯ থেকে ১২ জন) এবং ব্র্যাক বা অন্যকোন এনজিও সংগঠনের সদস্য নয় এমন ক্ষেত্রে ২৫০ টাকা (পরিবারের সদস্য সংখ্যা ১ থেকে ৫ জন), ৩০০ টাকা (পরিবারের সদস্য সংখ্যা ৬ থেকে ৮ জন) ও ৩৫০ টাকায় (পরিবারের সদস্য সংখ্যা ৯ থেকে ১২ জন) এই কার্ড করতে পারবেন।
- কার্ডহোল্ডার ব্র্যাক ও অন্য এনজিও সদস্যগণ প্রতিবার চিকিৎসকের পরামর্শের জন্য ২ টাকা এবং ব্র্যাক বা অন্য কোন এনজিও সংগঠনের সদস্য নয় এমন ক্ষেত্রে ৫ টাকা প্রদান করবেন।
- সু-স্বাস্থ্য থেকে ঔষধ ক্রয়ের ক্ষেত্রে সু-স্বাস্থ্যের বিক্রয় মূল্যের ১০% কমে ঔষধ ক্রয় করতে পারবেন।
- কার্ডহোল্ডারদের সু-স্বাস্থ্যের প্যাথলজি চার্জের ৫০% কম মূল্যে প্যাথলজি সেবা প্রদান করা হবে।
- বীমা কার্ডভূক্ত পরিবারের কোন সদস্যের উচ্চতর হাসপাতালে চিকিৎসার প্রয়োজন হলে রোগের গুরুত্ব অনুযায়ী ৫০০ (পাঁচশত) টাকা থেকে সর্ব্বোচ্চ ১০০০ (এক হাজার) টাকা এককালীন সহায়তা প্রদান করা হবে। উল্লেখ্য এই সুবিধা বীমা কার্ডভূক্ত পরিবারকে বৎসরে একবার প্রদান করা হবে।
- কার্ডহোল্ডার পরিবারের প্রধানকে বৎসরে একবার বিনামুল্যে স্বাস্থ্য পরীক্ষা ও পরামর্শ প্রদান করা হবে।
- কার্ডহোল্ডার ও তার পরিবারের সদস্যগণ বৎসরে একবারও কোন সেবা গ্রহণ না করলে পরবর্তী বৎসর কার্ড নবায়নের ক্ষেত্রে ২৫% কম প্রিমিয়াম প্রদানের সুবিধা পাবেন।
- বৎসরের যে কোন সময় নির্দিষ্ট প্রিমিয়াম প্রদান করে স্বাস্থ্য বীমা কার্ড করতে পারবেন।
- সু-স্বাস্থ্যে নরমাল ডেলিভারীর জন্য বীমাভূক্ত পরিবারের সদস্যদের নিকট থেকে ৫০% কম মূল্য নেয়া হবে।

সু-স্বাস্থ্যের বৈশিষ্ট সমূহ ঃ-

এম, বি, বি, এস, ডাক্তারের মাধ্যমে রোগী দেখা হয়। অল্প খরচে মান সম্পন্ন স্বাস্থ্য সেবা প্রদান করা হয়। অত্যাধুনিক যন্ত্রপাতির মাধ্যমে রক্ত, মল, মূত্র, কফ সহ যাবতীয় অন্যান্য প্যাথলজি পরীক্ষা করা হয়।

সেবা সমূহ ঃ-

- বহির্বিভাগে চিকিৎসা সেবা ও পরামর্শ
- পরিবার পরিকল্পনা সেবা
- গর্ভবতী মহিলাদের গর্ভকালীন ও গর্ভপরবর্তী চেকআপ
- ডেলিভারী
- মাসিক নিয়ন্ত্রণ (এম, আর)
- মুসলমানি (সারকামসেশন)
- শিশুদের ডায়রিয়া, নিউমোনিয়াসহ সকল জরুরী রোগী ভর্তি ও চিকিৎসা
- অক্সিজেন থেরাপি
- কাটা-ছেঁড়া সেলাই, ব্যান্ডেজ
- যৌনবাহিত রোগ ও প্রজননতন্ত্রে সংক্রমণের চিকিৎসা
- সূলভ মূল্যে ঔষধ
- রক্ত, মল, মূত্র, কফ সহ অত্যাবশ্যক প্যাথলজি পরীক্ষা
- দিবা রাত্রি যে কোন সময় ডেলিভারী করা হয়
- সিজারিয়ান সহ সব ধরনের অপারেশনের ব্যবস্থা আছে।

অল্প খরচে উন্নত স্বাস্থ্য সেবা

(Team's comment: Some of the information on this leaflet is out of date and may not agree with data used elsewhere in the Comparative Study)