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LANDSCAPE OF PREPAID HEALTH SCHEMES IN BANGLADESH

May 2016
This publication was produced for review by the United States Agency for International Development.
It was prepared by Hamid, Syed Abdul for the Health Finance and Governance Project.

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May 2016

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Recommended Citation: Hamid, Syed Abdul. May 2016. *Landscape of Prepaid Health Schemes in Bangladesh,* Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

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LANDSCAPE OF PREPAID HEALTH SCHEMES IN BANGLADESH

STUDY I OF THE FEASIBILITY ANALYSIS OF NGO PROVIDER-BASED PREPAYMENT SCHEMES IN BANGLADESH

CONTENTS

Acronyms ..... **iii**

Executive Summary ..... **v**

1. Background **1**

2. Objective of the Feasibility Study **2**

3. Activities **3**

4. Introduction **4**

5. Methods **5**

6. Provider driven model **6**

6.1 Gonoshasthaya Kendra (GK) 6
6.2 Dhaka Community Hospital (DCH) Trust 9
6.3 Diabetic Association of Bangladesh (BADAS) 10

7. Microfinance Institutions (MFIs) initiated schemes **11**

7.1 Grameen Kalyan 11
7.2 Sajida Foundation (SAJIDA) 12

8. Other initiatives **15**

8.1 Niramoy 15
8.2 Amader Shasthya 17
8.3 BRAC Health Security Programme (bHSP) 18
8.4 Developing Inclusive Insurance Sector Project (DIISP) 18
8.5 Ayesha Abed Foundation Health Security Scheme (AAF-HSS) 19
8.6 Shasthyo Surokhsha Karmasuchi (SSK) 20

9. Summary and Conclusion **21**

Annex A **27**

Annex B: Bibliography **33**

List of Tables

Table 1: GK Social Class Based Health Insurance (HI): Premium for Individual and Family of 5 members for urban areas 7
Table 2: GK Social Class Based Health Insurance (HI): Premium for Individual and Family of 5 members for rural areas 7
Table 3: Co-payment structure of some services of GK 8
Table 4: Salient features of the industrial health program of DCH Trust 9
Table 5: Benefits offered to the micro insurance card holders by Grameen Kalyan 12
Table 6: Health benefit of Sajida's Health Insurance Scheme 13
Table 7: Benefits, co-payments and premium structure of Niramoy MHI scheme 16
Table 8: Level of premium for different groups of households 18
Table 9: Piloting status of Hospital Cash benefit Insurance (HCB) (January 2014 to December 2014) 19
Table 10: Summary of the prepaid health schemes in Bangladesh 24
Table 10: Summary of the prepaid health schemes in Bangladesh/Cont. 25
Table A1: Copayment and Benefits Provided: GK Social Class Based Health Insurance (HI) [Taka 80 = US Dollar 1] 27
Table A2: GK Social Class Based Health Insurance (HI) Co-payment and Benefits Provided (in BDT) 27
Table A3: GK Social Class Based Health Insurance (HI), Co-payment and Benefits Provided: Diagnostic Services 29
Table A4: GK Social Class Based Health Insurance (HI), Co-payment and Benefits Provided: Specialized Investigations of Essential Medicines, Blood Transfusion & Alternative care 30
Table A5: GK Social Class Based Health Insurance (HI), Copayment and Benefits Provided: Clinical Service 31
Table A6: Impact evaluation of the prepaid health schemes 32

ACRONYMS

ADB	Asian Development Bank
ANC	Ante Natal Care
BADAS	Diabetic Association of Bangladesh
BDT	Bangladeshi Taka
BMA	Bangladesh Medical Association
BPL	Below Poverty Line
CBMCB	Community Based Medical College, Bangladesh
DCH	Dhaka Community Hospital
DIISP	Developing Inclusive Insurance Sector Project
DRG	Diagnostic Related Group
FFS	Fee-for-services
GK	Gonoshasthaya Kendra
GP	General Physician
GDIC	Green Delta Insurance Company
HI	Health Insurance
ICDDR, B	International Centre for Diarrheal Diseases Research Centre, Bangladesh
JFPR	Japan Fund for Poverty Reduction
NAG	New Asia Group
NGO	Non-government Organization
MFI	Microfinance Institutions
MHI	Micro Health Insurance
PKSF	Palli Karma-Sahayak Foundation
PNC	Post Natal Care
SAJIDA	Sajida Foundation
SSK	Shasthyo Surokhsha Karmasuchi
SME	Small and Medium Enterprises
UIC	United Insurance Company
UK	United Kingdom
UHC	Upazila Health Complex
USD	US Dollar

EXECUTIVE SUMMARY

This landscape study is part of a series of studies and analysis, please seen Annex X for complete list, undertaken by HFG on behalf of the USAID mission in Bangladesh to determine the feasibility of NGO provider-based prepayment schemes.

This paper describes, based on available documents, published and gray literature, and key informant and expert interviews, the landscape of prepaid health schemes in Bangladesh giving particular focus on provider based prepayment schemes. Bangladesh has extensive networks of NGO providers, some such as the Smiling Sun NGO networks have been supported through external funding. This paper reviews existing or recently completed prepaid schemes as a first step to determine the feasibility of provider-based prepaid schemes to increase the NGO providers' sustainability.

Micro health insurance (MHI) is an innovative health financing mechanism for increasing access and lessening financial burden of health care. The schemes often target the informal sector and the poor. MHI can be depicted as four delivery models: provider driven, partner-agent, full service and community based. In Bangladesh, historically mainly two motivations worked behind the introduction of MHI : (i) health care providers driven initiatives for providing health care to the unprivileged at affordable costs and (ii) Micro Finance Institutions (MFI) driven initiatives for protecting the borrowers from income/productivity loss due to illnesses and the huge burden of treatment costs.

Gonoshasthaya Kendra (GK) and Dhaka Community Hospital are the examples of provider driven model in Bangladesh. Gonoshasthaya Kendra offers a voluntary and social class based health insurance where premium and benefits vary across the six social classes (i.e., destitute and ultra poor, poor, lower middle class, middle class, upper middle class and rich) of the catchment populations. GK serves about 1.2 million individuals in its catchment areas. The insured are entitled to receive health care from GK owned health centres and hospitals. The copayments for the services are progressive across the social class and the upper three tiers of the social class face large co-payment which is above 70% for most of the services. The major challenges faced by GK are low enrolment of the rich and overall low renewal rate. Costs recovery is also low at 35% of the recurrent costs. Thus the scheme is highly cross-subsidized by the other entities of GK including a pharmaceutical company, a private medical college and a private university.

Dhaka Community hospital (DCH) operates a scheme to serve the garments workers. Under this scheme DCH provides a doctor and an assistance who visit once a week to an industry for a full day as long as patients are available; the employer manages the prescribed medicines for the patients; and pays to DCH an agreed amount per month for doctor's services. Although services on site are free, there are also very high copayments (90%) for the inpatient care and referral services provided by DCH. Currently, about 8000 workers are being served. The current cost recovery for this program is reported to be 100 per cent.

Of the two provider-driven schemes, one charges progressive premiums and copayments and faces difficulty in attracting the higher paying clients and is heavily subsided, and the other only offers limited discount on hospital care, but breaks even. The main objective of prepaid health scheme or MHI is to increase access to health care and reducing out-of-pocket payments significantly at the point of receiving health care.

Sajida Foundation's Nirapotta is an example of MFIs initiated scheme. This scheme is mandatory for SAJIDA's microfinance and Small and Medium Enterprise (SME) members and the premiums are paid at the time of loan receipt. The premium ranges from BDT 250 to BDT 1,050, depending on the amount and tenure of loan. There is an additional premium of BDT 100 for each supplementary loan. SAJIDA reimburses some cash benefit which is up to BDT 4,000. SAJIDA also runs two hospitals.

The insured in hospital catchment areas have the opportunity to seek health care from these hospitals. However, the coverage, given the price of health care in the market, is not adequate and hence the insured pays a large amount of the medical expenses.[1] It is well recognised that 'reimbursement system' is not a form of prepayment as the insured first must pay. Cashless or low co-payments are preferred. SAJIDA has achieved the break even in the recent years (with part of operation subsidized by microfinance surplus).

Grameen Kalyan's health scheme is a MFI initiated voluntary scheme. The scheme is currently serving about 3 million individuals. The insured receive primary care from the health centres operated by Grameen Kalyan itself. There is also some hospitalization benefit which is BDT 2000 (or USD 25) per household. There are also high co-payments which are more than 50%. Low renewal rate and lack of continuum of care are the major challenges. There was 65-70 percent costs recovery in the recent years. Nonetheless, the scheme has been expanded recently.

Whatever the delivery models and/or motives the prevailing schemes in Bangladesh commonly face the following challenges: (i) non-existent of independent micro health insurance regulatory authority that would enable the recognition of micro health insurance as an independent sector; (ii) complexities of designing micro health insurance products appropriate for the low income market; (iii) lack of reliable health service providers and thus micro health insurance providers need to take the responsibility of providing health care (iv) lack of skilled resources in micro health insurance; and (v) more importantly a limited and negative perception of insurance in the country as a whole. For the provider-based models, the limited provider networks limits extension of the coverage.

As in many countries, voluntary schemes face low demand (i.e., low enrolment and low renewal) in Bangladesh. Evidence shows that enrollment figures are also low for many voluntary schemes worldwide (Matul et al., 2013). In terms of the number of schemes, population coverage and growth micro health insurance is very limited in Bangladesh. It should be noted that health insurance, present through private insurance schemes, has a low coverage in Bangladesh. Although included in the government's health care financing strategy, there is to this date no social health insurance scheme and government employees are given an amount each month to cover their health care needs. This to note that worldwide micro health insurance has close alignment with microfinance. Though an unquestioned pioneer of microfinance initiatives, Bangladesh has not had expected success with prepaid health schemes. Voluntary health insurance has also not been popular in the formal sector. For example, the contribution of voluntary health insurance in total health financing is only 0.1 percent (BNHA4 1999- 2012). There is no compulsory health insurance scheme.

Presumably demand side factors such as lack of confidence/trust on prepayment mode, lack of awareness about the benefit of prepayment scheme, lack of affordability to pay premium and giving more weight to the present consumption plays an important role for the low development of health insurance sector. Some supply side factors such as low level of benefit, high copayment charged, committing fraud, complex procedures of claim submission, delay in claim settlement and rejecting the claim are equally responsible. Lack of trust as well as insurance culture may also be responsible for the underdevelopment of insurance market as a whole in the country.

All these challenges and limitations along with limited coverage and high co-payments restrict the scaling up and replication of the prepaid health schemes. The provider based schemes also face the challenge of limited facilities.

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

1. BACKGROUND

Bangladesh's Health Care Financing Strategy (HCFS) identifies three target populations: the poor (below the poverty line – BPL); the informal sector; and the formal sector. These three type populations are to be covered using different approaches. For the BPL, a government scheme known as Shasthyo Shuroksha Karmasuchi (SSK) has achieved much progress to begin its operation. For the formal sector, a government employee contributive scheme is being designed, and several initiatives are being implemented in the garment industry. The HCFS calls for community-based health insurance, micro health insurance, and other innovative initiatives for the informal sector. Global practice and knowledge identifies the informal sector population as the most difficult to reach with health protection coverage; these individuals are not classified as BPL and therefore do not qualify for government support, nor can they be easily reached through formal employment-based mechanisms.

In the fall of 2013, USAID Bangladesh asked the Health Finance and Governance project (HFG) to design and facilitate a one-day workshop focusing on Health Micro Insurance (including Community Based Health Insurance (CBHI), micro health insurance, and other insurance mechanisms) to cover/reach the informal sector. The workshop concluded that the most promising area was Micro Health Insurance (insurance associated with micro lending), followed by provider based insurance. Considering USAID's support for the Smiling Sun NGO network, USAID Bangladesh asked HFG to explore how provider-based prepayment schemes[2] could further the cost recovery/sustainability goals of the Smiling Sun NGOs. HFG proposed a feasibility study.

Thus, HFG proposed, and USAID Bangladesh approved, the project to conduct a feasibility study (and thereafter, if feasibility is determined to be positive, design an NGO provider-based pre-payment scheme).

2. The February workshop highlighted the fact that each segment (CBHI, Micro Health Insurance, Provider Based Schemes) fell under a different legal framework -each with its own challenges. Therefore, prepayment is used instead of insurance, as NGOs do not fall under insurance regulations.

2. OBJECTIVE OF THE FEASIBILITY STUDY

The objective of the activity is to determine the feasibility of a Smiling Sun NGO based prepayment scheme.

The study should identify under what conditions a scheme would be feasible, if these conditions exist, what could be done to address any gaps, and if doing so would be recommended considering the costs, resources, and other identified issues.

The implementation of the feasibility study should be designed as to provide important information/data to the partner NGO, NHSDP, and USAID Bangladesh. The feasibility study should directly benefit the partner NGO and strive to minimize the burden of participation.

3. ACTIVITIES

In order to determine the feasibility of provider based prepayment schemes in Bangladesh, HFG, in close collaboration with the NGO Health Service Delivery project (NHSDP), executed the following steps: 1) Selected a Smiling Sun NGO network on a competitive basis; 2) Conducted an analysis of Bangladesh prepayment schemes landscape; 3) Executed a costing of services provided, compared the costs to the prices charged for these services to paying clients; 4) Compared the prices charged at selected CFWD clinics to competitors; 5) Developed two prepaid services packages, and finally, 6) HFG partner, the Centre of Excellence for Universal Health Coverage icddr,b at James P Grant School of Public Health, BRAC University, designed and implemented a study to gage existing clients' interest/demand for these packages.

This paper is the result of step 2 above. This landscape study and four other document, please see feasibility analysis content page for complete list, inform the feasibility analysis

4. INTRODUCTION

Poor people are more vulnerable to various idiosyncratic (e.g., illness, accident, injury, death, loss of livelihoods) and covariant (e.g., endemic, natural calamities) shocks. Illness, as found in the literature, is the most burdensome shock of the low income people (Ahsan et al., 2014). Micro health insurance has emerged as an innovative health financing targeting the informal sector (especially for poor and low income people) in many low income countries to increase access to health care as well reducing out-of-pocket outlays.[3] The initiatives of micro health insurance worldwide are taken by the different stakeholders, such as (i) health care provider (e.g., hospital/group of doctors); (ii) insurance company with some microfinance institutions (MFIs), (iii) microfinance institution, and community based organization or social organization itself, and (iv) community people. Globally there are, thus, mainly four kinds of delivery channel of offering micro health insurance: the provider driven model, the partner-agent model, the full-service model, and the community-based model.

Historically there were two motivations of developing prepaid health scheme in Bangladesh. Microfinance institutions (MFIs), such as Grameen Bank and Sajida Foundation, initiated micro health insurance scheme aiming at primarily protecting their borrowers from financial loss resulting from illness or injuries and thus their ability to repay the loans. These initiatives are sometime opened to the general public. Some health care providers such as Gonoshasthaya Kendra, Dhaka Community Hospital started prepaid health scheme aiming at providing health care for low-income underprivileged people at an affordable cost in both the urban and rural areas of Bangladesh. The objective of the latter type of schemes seems to be more broad and altruistic.

Conducting country-specific critical analyses of prepaid health scenario focusing on provider driven schemes is important for policy context. Ahsan et al (2013a) conducted a detailed review of microinsurance sector (which covers credit insurance, micro life insurance, micro health insurance, cattle insurance, etc.) in Bangladesh. Although Micro health insurance was also covered in the study it was not the focus. Thus, for policy discussions, there is lack of information focusing on prepaid health insurance scheme in Bangladesh. This study will provide information for a feasibility study of NGO provider based prepayment schemes in Bangladesh.

This study was conducted on the bases of available documents, published and gray literature and key informant interviews.

The paper is organized as follows: after this introductory section, Section 2 explains the methods; Section 3 reviews the provider driven initiatives of prepaid health scheme; Section 4 depicts MFIs initiated schemes; Section 5 illustrates other initiatives; and Section 6 provides discussions and conclusions.

[3] For the purpose of this paper, prepaid health scheme refers to micro health insurance; we have used these terms interchangeably thought the texts.

5. METHODS

The paper analyzes both quantitative and qualitative data available in the secondary sources. The paper also analyzes some primary data based on key informant interviews and consultation with relevant experts. We conducted an initial review of the relevant documents (e.g., program manual, annual report, leaflet, assessment report) available at online, and made a list of prepayment health schemes in Bangladesh. In the next stage we conducted a thorough review of all the relevant secondary sources of information. In the third stage we conducted key informant interviews and consultation with experts. The data was presented in the cross-tabular format.

6. PROVIDER DRIVEN MODEL

Under provider driven model health-service providers (i.e. hospitals, clinics, or groups of doctors) take all the responsibilities including product designing, marketing, providing health and carrying the risk. In true sense, this delivery channel, outside of the United States where it is well developed[4], is rare in the global context and in Bangladesh.[5] Gonoshasthaya Kendra (GK) is an example of provider driven model in Bangladesh. Dhaka Community Hospital (DCH) also provides some discounted health services based on prepaid card. [6] The health insurance scheme recently been piloted for garments workers by Diabetic Association of Bangladesh (BADAS) is an example of a different form of provider based model in Bangladesh. Each of these health schemes is critically described here.

6.1 Gonoshasthaya Kendra (GK)

Gonoshasthaya Kendra (GK), a non-government organization, was established by a group of doctors led by Dr Zafrullah Chowdhury after the liberation war of 1971. In addition to Dhaka City and Savar area of Dhaka district GK's health journey has expanded in rural and remote communities of Chittagong Hill Tracts (CHT), riverine chars of Gaibandha and Kurigram and offshore islands of Kutubdia, Moheskhali and Charfashon. GK has established 40 Health Clinics in 25 Upazila and 5 secondary care hospitals at Savar, Dhaka City, Sreepur (Gazipur District), Kashinathpur (Pabna) and Gaibandha.

Gonoshasthaya Kendra operates its socio-economic based health insurance scheme in urban areas (Dhaka city, Savar, Tongi, Galachipa Pourshova, Sreepur, Cox`s Bazar, Char Fasson, Monohordee etc.), rural areas (Shibganj, Sirajganj, Parbatipur, Sonagaji, Kashinathpur, Daulutdia, Delduar etc.) and char areas of Gaibandha and Kurigram in order to provide sustainable health care services to 1.2 million population in the catchment areas. About 43 percent of the population in the catchment areas hold insurance card. Among the poor 58 percent have insurance card where 100 percent ultra poor hold insurance card. This is to note that 52 percent populations in the catchment areas are poor.

4 The largest Kaiser Permanente is the third largest health insurer in the US with a 10% share of commercial insurance and the first in California with a 40% share (source LA Times, January 29, 2013).
5 Yeshasvini health insurance (initiated by Dr. Devi Shetty, chairman of Narayana Health, in 2002 for rural farmers at the Karnataka state in India) is a prominent example of provider based prepaid scheme in the third world country context. Yeshasvini health insurance provides low probability high-cost medical events only. The scheme allows preexisting conditions and offers hospitalization care with the ceiling of Rs. 200,000 per year and Rs. 100,000 per surgery. This is a cashless scheme where patients can seek treatment from any designated hospital (which may be public, private or charitable) by showing their Yeshasvini identity cards, an electronic card containing all the attributes of the individual. As a true public-private partnership, this scheme has built partnership with state government, non-for-profit and private sectors where state government Cooperation Department plays a vital role by mobilizing members, collecting revenue and overseeing the activities. Farmer co-operative society also plays a crucial role by helping the government for identifying and enrolling members and explaining the program's benefits to potential beneficiaries. A Third Party Administrator (TPA), an essential part of insurance operation, handles claims and preapprovals. Although the state government provides subsidies and administrative support an autonomous trust (where government representatives are also members) governs the scheme independently from the government.
6 Ad-din Welfare Centre also runs a hospital based discounted health scheme, which offers 10% discount for purchasing medicine from Ad-din and 50% discount for other services. These services are offered at free of cost to the ultra poor.

Insured persons are divided into six groups according to their socio-economic status: destitute and ultra poor, poor, lower middle class, middle class, upper middle class and rich. Each group is further classified into smoker and non-smoker. There are also options for individual enrolment and family enrolment. The premium is determined progressively across the socioeconomic classes (see Tables 1-2). Another distinct feature is that premium for each class is bit higher for smoker than the non-smoker. There is also variation in premium between the urban and the rural areas. There is also differential premium between the capital city and other urban areas where the scheme is in functional.

Table 1: GK Social Class Based Health Insurance (HI): Premium for Individual and Family of 5 Members for Urban Areas

Social Classes	Annual Premium (in BDT*)							
	Dhaka City				Savar/Tongi/Galachipa/ Pourshova/Sreepur/ Cox`s Bazar /Char Fasson/ Monohordee etc.			
	Individual HI		Family HI Yearly Premium		Family HI Half-yearly Premium		Family HI Yearly Premium	
	Non-smoker	Smoker	Non-smoker	Smoker	Non-smoker	Smoker	Non-smoker	Smoker
Destitute & Ultra poor	70	80	140	150	50	60	90	100
Poor	100	120	240	250	110	120	200	210
Lower Middle class	200	225	550	600	160	170	300	320
Middle class	500	525	1100	1200	240	250	400	450
Upper middle class	900	1000	2700	3000	350	400	600	700
Rich	1200	1300	3200	3500	400	450	800	900

Source: Key informant interview and official data of GK, 2015

* BDT 80 = 1 USD

Table 2: GK Social Class Based Health Insurance (HI): Premium for Individual and Family of 5 Members for Rural Areas

Social Classes	Annual Premium (in BDT*)					
	Rural Areas (Shibganj, Sirajganj, Parbatipur, Sonagaji, Kashinathpur, Daulutdia, Delduar etc.)				Char Areas of Gaibandha & Kurigram	
	Individual HI		Family HI		Family HI	
	Non-smoker	Smoker	Non-smoker	Smoker	Non-smoker	Smoker
Destitute & Ultra poor	40	50	80	90	50	60
Poor	60	70	150	160	90	100
Lower Middle class	90	100	200	210	140	150
Middle class	120	150	300	320	190	200
Upper middle class	200	220	400	450	280	300
Rich	250	270	500	550	350	400

Source: Key informant interview and official data of GK, 2015

* BDT 80 = 1 USD

Benefits include both preventive and curative care (consultation, diagnostic, hospital bed, and medicine). Preventive care, paramedic and GPs services are free for all the insured. However, there are differential copayments among the social classes for other services (see Tables A1-A5 in the Appendix).

The closer look of the benefits provided by the this scheme shows that other than paramedic and GP's consultation services and some preventive care, GK charges for almost every service including junior and specialized consultants' services, laboratory services and surgical procedures. Although this charge may be bit lower than the market price (i.e., the price charged for the non-insured as seen Tables A1-A5 in the Appendix) the beneficiaries need to pay substantial co-payment (especially for middle class and above) for various services (Table 3). As a social class based scheme the copayment progressively varies across the different social classes.

Table 3: Co-payment Structure of Some Services of GK

Social Classes	Co-payment (at %) charges for various services							
	Junior Consultants	Specialized Consultants	Ultrasound	Cabin Charge	Major General Surgery Gynae/ Obstetrics	Normal Institutional Delivery	C-Section Delivery Package	
Destitute & Ultra poor	0	NA	8	Not admissible*	5	NA	3	
Poor	0	NA	25	Not admissible*		25	23	27
Lower Middle class	33	25	50	Not Admissible*		45	33	47
Middle class	42	37.5	67	75		6	67	60
Upper middle class	67	50	75	75		75	67	73
Rich	75	62.5	83	75		85	67	87

Note: The copayment has been calculated comparing the price charged for the insured and the non-insured for each category of service.

* Destitute, ultra poor, poor and lower middle class are entitled to general bed at free of charge.

The major challenge of the scheme, as per the views of the key informant, is low renewal rate. After more than four decades of its operation the renewal rate does not reach 50 percent. Presumably due to the level of premiums and high copayment, the scheme also could not attract the rich class. Moreover, the scheme has not achieved expected geographical coverage. The cost recovery rate is 35% and thus the scheme is highly cross-subsidized by the other entities of GK (e.g., medical college, pharmaceutical company, university). This is to note that GK owns a medical college, a pharmaceutical company and a private university. Thus a major finding is that one cannot replicate this scheme without the cross subsidy.

6.2 Dhaka Community Hospital (DCH) Trust

Dhaka Community Hospital (DCH) Trust started its journey in 1988 aiming at providing health care for low-income underprivileged people at an affordable cost in both the urban and rural areas of Bangladesh. Currently the trust has a fully equipped hospital with 500 beds and other institutes including a Medical College. DCH Trust also serves the community people through its Industrial Health Program and Rural Health Program.[7]

Industrial Health Program provides free to the workers preventive and curative health care to the garment workers paid by the employers. The satellite teams (doctors and paramedics) visit the industries at a regular weekly interval. The team provides health education session, ante natal care (ANC), post-natal care (PNC) including breast feeding, motivation for accepting family planning method, child care, education, environmental hygiene, reproductive health care, safe drinking water and food. Cardholders also receive thorough yearly medical check-up and referral service at DCH where they benefit from 10% discount on fees. Presently, 24 factories are covered and on average 350 workers/employees are being served every week. The current cost recovery for this program is reported to be 100 per cent. The salient features of the program are presented in Table 4.

Table 4: Salient Features of the Industrial Health Program of DCH Trust

Services	Services cost/fee	Period of services
• DCH provides a doctor and an assistance who visit once a week to an industry for a full day as long as patients are available. • Industry manages the prescribed medicines for the patients. • DCH provides indoor service, pathology service, operation and emergency service to industrial worker by the 10% discount on general service rates at Dhaka Community Hospital. • DCH makes necessary arrangements for providing the age certificate to industrial worker whenever needed by industrial organization. Industry pays for it. • DCH provides PHC training to two workers to become Doctor's Assistants. • Industry provides a place for Doctor and his Assistant to examine the patients. • Industry Cardholders also receive thorough yearly medical check-up and referral service at 10% discount at DCH. Presently, 24 factories are covered and on average 350 workers/employees are being served every week. The current cost recovery for this program is reported to be 100 per cent.	• Industry pays to DCH an agreed amount per month for Doctor's services • Industry pays the cost of PHC training for two workers for doctor's assistance • Industry pays the printing cost of health card	• Agreement is effective for one year. It may be renewed on mutual discussion • Termination of agreement will depend on mutual consent. 30 days notice is required from either side • Doctor's visiting day and time are fixed by mutual discussion

Source: Key informant interview and official website of DCH

[7] In addition, DCH Trust runs a school health program. This is a subsidized program and has been implemented in collaboration with NGO schools, in Dhaka City and Pabna. Each child is provided with a "Health Card" (BDT 20 on average, borne usually by the NGO School or DCH). DCH doctors visit the schools once a week and provide care services to the students. Currently, a total of 16 schools (on average 80 children in each) are covered. The focus here is on general pediatric care, but targeted areas include vision, hearing (ENT), dental, immunization, etc. Funding of this program is mainly through DCH subsidies and fixed amounts of token money collected from the NGO school authorities. Estimated 'cost recovery' for this program is less than 30 per cent.

The rural health program is offered in collaboration with partner organizations (e.g., MFIs, CBOs/SBOs), operating in a large number of districts. Over and above primary health services, both preventive care and curative procedures are made available to the cardholders. Typically, in each rural health centre doctors are available 8 hours a day and paramedic service can be accessed 24 hours a day. Doctor and paramedic services are free. There is also some provision of referral services at 10% discount at DCH. DCH serves 100,000 people under this program, via approximately 20,000 cardholder households. A nominal premium (BDT 10-20) is annually charged for a household. This program is financed with support from Oxfam and DCH subsidies.

This program, as depicted above, mainly provides some primary care. There is a 10% discount on the referral services provided by DCH. This means that this scheme offers little protection at secondary care level.

6.3 Diabetic Association of Bangladesh (BADAS)

Diabetic Association of Bangladesh (BADAS) with the financial assistance of Swiss Agency for Development and Cooperation (SDC) and technical assistance of a Swiss Institute has been piloting a health insurance scheme for the garment workers since April 2014. The scheme aims at increasing health service coverage with improved disease prevention, immediate access to health information, and efficient cost control, through a health financing plan by testing the economic viability of a health insurance for industry workers. The key players of the scheme are: Diabetic Association of Bangladesh (BADAS), National Health Network (NHN), New Asia Group (NAG), and United Insurance Company (UIC). The hospitals under NHN are the health care providers, NAG is the employer of the garments workers insured under the scheme and UIC is the risk carrier. Ideally this is a proper model of health insurance as an insurance company is taking part in carrying the risk. However, the initiative was started by BADAS. Moreover, BADAS plays the main role in the piloting process. Thus, this also may be broadly treated as provider driven model.

This is a group health insurance scheme of 800 workers belonging to the lowest salary groups of 7 garment factories of NAG. The scheme provides both inpatient and outpatient benefits to the insured individuals. The annual maximum coverage is BDT 15,000 and annual premium is BDT 487. The premium is paid by the employer. UIC and NAG equally share benefits and loss. There are some innovations of this scheme:

- Introducing telemedicine through establishing a medical call centre for giving immediate access to health information which also plays gate keeping role.
- Introducing health promotion program to raise awareness on nutrition, hygiene, communicable and non communicable diseases, reproductive & child health, occupational health and financial literacy.

The 12-months long piloting has been ended recently. The available information shows that the use of call centre is not satisfactory; overall claim rate is high, some claims have exceeded the maximum limit. In addition, the scheme has incurred some loss. The preliminary findings of an evaluation study shows that the insured were 1.62 times more likely to utilize health care than the non-insured control group; health care use increased by 5.1%; sickness absenteeism was significantly reduced by 1 day (from 4.2 to 3.2); OOP expenditure did not significantly decrease; and there is ambiguity in willingness to pay (Roth and Gyr, 2015).

7. MICROFINANCE INSTITUTIONS (MFIS) INITIATED SCHEMES

A number Microfinance Institutions (MFIs) including Grameen Bank (through Grameen Kalyan), Sajida Foundation, BRAC and Society for Social Services (SSS) initiated micro health insurance primarily in late 1990 and early 2000 for protecting their borrowers from financial loss occurred due to income/productivity loss and treatment costs. However, after few years of operation, most of these organizations did not continue the schemes presumably due to not achieving expected performance or financial costs. The Bangladesh wing of International Network of Alternative Financial Institutions (INAFI) also piloted a micro health scheme. However, the scheme was not continued after piloting phase. Grameen Kalyan and Sajida Foundation are more prominent among the schemes currently offering micro health insurance in Bangladesh.

7.1 Grameen Kalyan

Grameen Kalyan, a sister concern of Grameen Bank (GB), introduced its version of MHI in 1996 and covered several hundred thousand individuals at its peak in 2008. MHI is central among its activities serving the dual purpose of ensuring the participation of the target group as well as acting as a source of revenue for the program. Grameen Kalyan attempts to cross subsidize its members by having higher pricing structure for non-Grameen Bank cardholders and non-cardholders.

Under Grameen Kalyan Micro health insurance scheme by paying only BDT 200 (USD 2.5) for GB borrowers and BDT 300 (USD 3.75) for Non-GB households can subscribe an annual health insurance policy. Each health insurance policy covers 6 members in the family. Till the end of 2014 Grameen Kalyan had 15,868 micro insurance policy holders. This is to note that there was a sharp fall in insurance policy holders in 2010 when Prof Yunus left Grameen Bank as the Managing Director. This is because Grameen Bank ended its cooperation with Grameen Kalayan although this belongs to the Grameen Family. Previously branch offices of Grameen Bank supported the scheme by enrolling the new members, renewal and premium collection.

The poor households in the community are allowed to pay micro health insurance premium through quarterly/half yearly installments. The main benefits include reduced medical consultation fees (50% of the fee to non-cardholders), discounts on drugs and pathological tests (10% and 30% respectively), hospitalization benefits (BDT 2,000 or USD 25), and free annual health checks and immunization (Table 5).

Table 5: Benefits Offered to the Micro Insurance Card Holders by Grameen Kalyan

Type of Benefit	Magnitude of Benefit	Magnitude of Co-Payments/Co-Insurance
Consultation	50% discount on consultation/advice/ prescription fees	BDT 50
Pathological tests	30% discount on pathological tests available in Grameen Kalyan Health Center; and 70% discount on monthly blood sugar tests for diabetic patients	70% on pathological tests
Medication	10% discount on medicine available in the pharmacy in Health Center	90% on medicine
Medical check up	Quarterly free health check-up at home for 6 family members at free of charge	None
Hospitalization	Compensation up to BDT 2,000 (USD 25) for hospitalization	BDT 6000 (USD 77)* or 75%

Source: Key informant interview and official website of Grameen Kalyan

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

Grameen Kalyan provides a wide range of primary health care services including maternal care. The health services provided by the centers are operated by Grameen Kalyan itself. Each centre covers about 36-42 squared kilometer area with approximately 30,000-40,000 population. Each centre has a pharmacy with essential medicine and a mini-pathological laboratory. A center was initially headed by a MBBS doctor. However, due to severe drop out of MBBS doctors and their negligence to work in the rural areas most centers are run by Medical Assistant.[8] The other staffs in each health centre commonly are: an office manager, a female paramedic, a laboratory technician, six community health assistants and some Trained Traditional Birth Attendants. The centre is open for both the insured and the noninsured for 8 hours a day and 6 days a week.

There was a sharp increase in the number of clinics in the recent past. The total number of clinics has increased to 76 in 2015 from 59 in 2013. Grameen Kalyan has also added some new services including blood grouping and diabetic tests. The recovery of recurrent costs varies between 65-70 percent during last three years (2013-2015). Low level of renewal rate is a major concern of the scheme. The low renewal rate is caused mainly due to large copayment, lack of continuum of care and lack of significant difference in benefits between the insurance card holders and the non-insured (Hamid et al., 2011a). The Grameen Kalyan Management believes that the current level of referral benefits is not sufficient to ensure the secondary and tertiary level of care. Thus, Grameen Kalyan has decided to establish some tertiary level hospitals.

7.2 Sajida Foundation (SAJIDA)

Originally started as a private family-run charity, by 1993 SAJIDA evolved into a formal institution offering micro-credit to poor urban women. It became involved in the health field in 1999 in response to demand from its microfinance members. In 2006 SAJIDA established a comprehensive micro insurance program called HELP, later renamed as Nirapotta (Safety net), with the aim of providing social protection and security to its members and their families. This is a comprehensive package inclusive of health, education, life/loan, legal and disaster coverage. Nirapotta is applicable for both microfinance members and SME members of SAJIDA. Nirapotta is currently being provided in all the 10 operating districts (including Dhaka, Narayangonj, Chittagong, Feni, Comillah, Munshigonj, Jamalpur, Narshindi) of SAJIDA. The number of Nirapotta members in July 2015 was 130,000.

[8] About 7 centers are still run by MBBS doctors.

This is SAJIDA's priority program and mandatory for its microfinance members. The premium charged for Nirapotta ranges from BDT 250 to BDT 1,050, depending on the amount and tenure of loan. Additional premium of BDT 100 is charged for each supplementary loan borrowed by Nirapotta members.

Health insurance is the major component of SAJIDA's micro insurance program. The insurance holder can receive monetary support up to BDT 4,000 for most major hospital services as outlined in the policy. The detailed list of benefit is depicted in Table 6. However the scheme works on a reimbursement system which is less than optimum as the insured need to pay all medical expenditures from out-of-pocket at the point of service delivery.

The scheme has achieved the break even and even some surplus in the recent years. However, some of the operation costs are subsidized by the surplus of microfinance. The key success of this scheme is attributed to its integration with microfinance and its compulsory nature. However, there are some limitations. As micro insurance is operated within microfinance the program is regulated by Microfinance Regulatory Authority (MRA) which does not address the growth/scaling up of micro insurance as a stand-alone product. Hence, the expansion of micro insurance is entirely dependent on the expansion of the microfinance portfolio since the product is only being offered to SAJIDA members.

SAJIDA also faced some challenges including dissemination of incorrect information to the policy holders, errors in claim settlement and delay in claim settlement for operating both microfinance and micro insurance with the same set of staff. SJIDA has learned some important lessons that may be beneficial for the sector: (i) operational costs are low if integrated with other programs, hence keeping premium low; and (ii) a package product rather than single products like health, life, credit insurance etc. allows providing expanded benefit.

Table 6: Health Benefit of Sajida's Health Insurance Scheme

Description	Benefit Amount (BDT)	Description	Benefit Amount (BDT)
General Surgery		Other Surgery	4000
Appendectomy	2500	**Hospitalization**	
Cholecystectomy	4000	Normal vaginal delivery	2000
Fistula/Fissure/Abscess	2500	Brain injury	3000
Haemorrhoidectomy	2500	Burn/Scalding	1500
Hernia operation	2000	Neonatal (within 28 days age) hospitalization	2000
Obstetrical & Gynecology		Diarrhea	1500
Caesarean Section	3000	Fever	1000
Hysterectomy	4000	5-day hospitalization (if other illness)	3000
D&C Dilation and Curettage	1000	**ANC support (can be claimed times a year) with the following danger signals:** • **Bleeding (moderate to profuse)** • **High blood pressure with severe** • **Headache and blurred vision** • **Odema/ positive urine albumin** • **Convulsion** • **High temperature**	500
Ophthalmic Surgery			
Cataract operation (SAJIDA Hospital)	Free		
Cataract operation (other hospital)	1200		
Pterygium	1200		
Chalazion	1000		

Description	Benefit Amount (BDT)	Description	Benefit Amount (BDT)
Fracture			
Simple fracture and dislocation	1500	**Asthma adult** (can be claimed two times a year)	750
Compound fracture and dislocation	3000	**Cashless Benefit** Normal delivery (including medication) is free at Sajida hospitals for members Cataract operation (including medication) is free at Sajida hospitals for members	
Verbal dislocation/Prolapsed	3000		
Accident	800		
ENT			
Tonsillectomy	2500		
Nasal I septoplosty	2500		
Polypectomy	2500		

Source: Sajida Foundation's Annual Report 2014

Another program, which is SAJIDA's Health Program (HEALTH), is open to all and used as a marketing strategy to promote SAJIDA's two urban-based hospitals in Keraniganj (100-bed) and Narayanganj (70-bed). The HEALTH program is targeted at the non-poor who live in the catchment area of the hospitals, and have to pay annually BDT 150 per person in order to be eligible for coverage. Once a cardholder, they receive some discount (up to 30%) on price, but no cash claims. Only those purchasing coverage are eligible, there being no family membership here. The benefits are only available at the two hospitals as there is no referral system. Currently there are only few hundred members in this scheme.

8. OTHER INITIATIVES

There are some initiatives, in addition to provider and MFIs driven initiatives, taken some research organizations, government, employers, etc. Most of these initiatives are experimental.

8.1 Niramoy

The Niramoy micro health insurance scheme was piloted jointly by Institute of microfinance and Green Delta insurance Company Ltd. with some local MFIs and Community Based Medical College, Bangladesh (CBMCB) in Mymensingh.

The scheme was designed by Ahsan et al (2013b) for keeping in view the goals of adequate risk protection, inclusivity of access and affordability.[9] The benefit package, encompassing outpatient care (consultation, diagnostics), maternity and inpatient care with most common surgeries and medication, is the most comprehensive that is ever known of in Bangladesh.

Niramoy encompassed many more players, i.e., partners, than is standard, namely, the microfinance institutions (MFIs), the hospital, drug companies (probably the first of its kind), the insurance company, and, above all, the beneficiaries. In the overall design, each of these players took on some risks. MFIs run the risk of excessive operating costs that is not reimbursed by anyone, the providers offer discounts in the expectation of potential growth of business which may not materialise, while the insurer of course takes on the greatest of risk.

The provider hospital, Community Based Medical College Hospital (CBMCH), was the mainstay of this pilot project; its state-of-the-art facilities and rural location are major attributes prompting its selection. Three participating MFIs (ASPADA, POPI and SSS), all active in the vicinity of the provider hospital (i.e., within a 5-7 kilometre radius), form another indispensable partner as their clients are the eligible beneficiaries of the scheme. The induction of a leading commercial risk carrier, Green Delta Insurance Company (GDIC) shouldering a large responsibility, is a milestone for the micro health insurance sector in Bangladesh. Several pharmaceutical companies (including General Pharmaceuticals, Sanofi Aventis, and Delta Pharma) provide drugs at discounted prices.

The benefit package was designed on the basis of the local need. Over the 12-month period, a maximum of five outpatient visits were set for a household of four and five members, three visits for a household of two or three members, six visits for a household of six or seven members, seven for a household of eight or nine members and eight visits for a household of more than nine members (Table 7).

[9] 'NIRAMOY' is a Bengali word, which refers to the recovery chiefly from illness, but may also refer to overcoming a crisis.

Each eligible household is entitled to receive one complete maternal care including four ANCs, delivery (normal or Caesarean Section), two PNCs and neonatal care. Note however that a household is considered eligible for the maternity component of the package if the pregnancy develops after enrolment in the MHI scheme by a mother who is at least 18 years old and does not have more than two children. In addition, each household is entitled to receive up to two episodes of inpatient care (surgical or non-surgical) available at CBMCH. However, if a household avails the maternal care, this household would be entitled to receive only one additional hospitalization benefit. Low co-payments were set on drugs and injectable.

Table 7: Benefits, Co-payments and Premium Structure of Niramoy MHI Scheme

No. of Total Insured Persons in the Household (HH)	Eligible No. of Total Outpatient Care Visits Per HH	Eligible No. of Total Inpatient Stays Per HH	Eligible No. of Maternity Cases Per HH	Co-Payment on Drugs and Injectable*	Total Premium per HH (380 x No. of Members)
2	3	2	1	20%	760
3	3	2	1	20%	1,140
4	5	2	1	20%	1,520
5	**5**	**2**	**1**	20%	1,900
6	6	2	1	20%	2,280
7	6	2	1	20%	2,660
8	7	2	1	20%	3,040
9	7	2	1	20%	3,420
10	8	2	1	20%	3,800

Source: Compiled from Ahsan et al (2013b)

Despite all the innovations the enrolment was very low (about 1% of the target households) mainly, due to, negative perception of insurance and lack of awareness about insurance.[10] This was very difficult to convince them to pay for health before onset of their illnesses. Although the scheme kept provision of some incentives there was also lack of proper efforts of the staff of MFIs to enroll their members in the insurance scheme as this was not their priority program. The scheme also faced difficulties in containing costs from the hospital side as it was not possible to introduce diagnostic related group (DRG) or any other innovative payment mechanisms other than fee-for-services (FFS). Presumably the FFS leads to provider moral hazards. Given the FFS educating the provider about the norms of health insurance for convincing them to rational prescription of drugs and laboratory tests many reduce the moral hazard to some extent. Thus, insurance education is vital for both the potential beneficiaries and the health care providers.

After first year of piloting Green Delta Insurance Company (GDIC) has taken over the charge of continuing the field operation, and GDIC has made slight changes in the premium structure and benefit package. GDIC is preparing ground to start this as a regular program in the piloting location and elsewhere.

[10] This misperception has been generally arisen due to committing frauds of some life insurance companies, unusual delay in claim settlement and requiring many documents to submit the claims.

8.2 Amader Shasthya

The icddr,b, b has been piloting a project on community health insurance in Chakaria, a remote rural area in Cox's Bazaar district of Chittagong division, since 2012. This project is locally known as "Amader Shasthya," meaning "our health." Amader Shasthya believes that "a burden shared is a burden halved" and thereby encourages solidarity among villagers.

The scheme runs two packages: Indoor and outdoor. The premium for the outdoor package is set at BDT 500 per household per year, which entitles each household member to free consultation with paramedics, doctors, access to medicine, and diagnostic services at a discounted price.

This package has a special rate for the poor, which is set at BDT 200 and provides the same set of services. The maximum benefit under this package is fixed at BDT 5,000 per individual per year, and BDT 30,000 per household per year.

The indoor package, on the other hand, charges BDT 1,200 per household per year as a premium and provides services including consultation with paramedics, doctors, hospital admission, diagnostic services, medicine, and operation costs. The maximum benefit each household can claim is set at BDT 54,000 for this package, and for an individual, this amount is set at BDT 9,000 per year. As of July 2015, nearly 30% of the households (which is around 2700) in their area of operation have been enrolled in the scheme and the benefit received by the clients is worth BDT 7 million to date. The total number of enrolment for last three years is 6500 and annual renewal rate is about 30 percent. The current costs (without the costs of clinical and marketing team) recovery for inpatient is 65 percent and outpatient is 100 percent. The scheme started with financial assistance of Rockefeller Foundation. Now Government of Bangladesh (GOB) is providing annually one hundred thousand US Dollar for continuing the scheme.

As per the narration of the key informant out-of-pocket payment of the insured for inpatient and outpatient have reduced to 66 and 50 percent respectively. The lessons learned (e.g., establishing partnership with local hospital, and referral linkages with partner hospitals) by the scheme may be useful for the sector.

Confident relationship with local people and community participation in planning and implementation are the major strengths of the scheme. The main challenges of the scheme are low enrolment, low level of renewal, low cost recovery, donor dependent, tackling of fraud practiced by the pharmacies; and tacking the conflict of interest of the other pharmacies which are currently outside this scheme. Not covering the pre-existing illnesses and lack of establishing formal referral chain with government hospitals are the major weakness of the scheme.

8.3 BRAC Health Security Programme (bHSP)

BRAC, aiming at weighing the effectiveness of a pre-paid health financing scheme with differential premiums, has started to experiment an inclusive and innovative health financing model entitled as "BRAC Health Security Programme" (bHSP) targeted to cover 5000 urban households at Gazipur district in August 2014. This experiment will continue for three years. Based on the monthly income, the population was classified into 4 different groups as seen in Table 8. Different groups of households have differentiated annual premium: BDT 600, BDT 1500, BDT 1800 and BDT 2400 respectively for the poor, low income, middle income and higher income households.

Table 8: Level of Premium for Different Groups of Households

Grade	Criteria	Yearly premium *(Taka)
Grade 1	i. Monthly income <7,000 taka (Manoshi grade 1)	600
Grade 2	i. Monthly income 7,001-12,000 taka) (Manoshi grade 2) ii. Micro finance loan size <50,000 taka iii. House rent <3000 taka	1500
Grade 3	i. Monthly income more than 12,000 taka (Manoshi grade 3) ii. Micro finance loan size 50,000-200,000 iii. House rent 3000-5000 taka	1800
Grade 4	i. Micro finance loan size >200,000 taka ii. House rent is more than 5000 taka or live in own house	2400

Note: USD 1= BDT 78

This scheme provides both outpatient and surgical and non-surgical inpatient supports to the beneficiaries. All household-members are entitled to receive three outpatient consultations (with some discount on drugs and diagnostics) and two episodes of hospitalization. The maximum annual benefit of a household for a surgical hospitalization is BDT 5000 and non-surgical hospitalization is BDT 1500. The package also includes maternal care worth of BDT 1000 for normal delivery and BDT 3000 for C-Section. The health care is provided by some empanelled hospitals (e.g., BRAC Clinic, Tairunnessa Memorial Medical College Hospital, and Desh Hospital). The patients are referred to Gazipur Medical College Hospital, and Dhaka Medical College Hospital. A referral program organizer is employed to manage the referral patients in each referral hospital.

A total of about 1000 households of different economic groups have been enrolled in the scheme of which 30 percent from the poor, 38 percent from the low income, 19 percent from the middle income and 13 percent from the higher income households. The average claim amount is BDT 1200 while average premium is BDT 1400 and, hence, the scheme may attend at the break even if sufficient number of household is enrolled.

8.4 Developing Inclusive Insurance Sector Project (DIISP)

Palli Karma-Sahayak Foundation (PKSF) piloted a microinsurance project titled 'Developing Inclusive Insurance Sector Project (DIISP)' with the financial grant support of the Japan Fund for Poverty Reduction (JFPR) under the cooperation of the Asian Development Bank (ADB). The objective of the pilot project was to protect the livelihoods of poor households, especially women, from risks such as accidents, illness or natural disasters to secure their welfare and assets through the development of low-cost microinsurance services. Key innovative aspects of the project were addressing the needs of the poor through reducing vulnerability, building protection against shocks by developing affordable insurance services and expanding insurance service outreach through the network of MFIs in a sustainable approach.

Health package was the more prominent component of DIISP. The other components were life, loan and livestock. Some 80 branches were selected from 40 MFIs (2 branches from each MFI) for the field level pilot testing of health program under DIISP. Members of 80 branches were eligible to buy hospital cash benefit (HCB) policy for them and their family. The policy holder and his/her insured family members were entitled to receive hospital cash benefit if any insured person is hospitalized for more than 24 hours. In that case BDT 200 to BDT 400 per day is given as cash benefit for a maximum of 30 days, excluding the first day. This is note that the project kept the provision to seek inpatient services from the empanelled hospitals. In addition, policy holders are entitled to receive free services from the paramedics employed by the MFIs under the project. The claim settlement was executed by the respective MFI itself. The project provided a financial grant to the respective MFI for claim settlement of HCB services.

A policy holder member needs to pay BDT 250 as premium for one year to obtain a HCB policy. The HCB policy is *optional* for the members and yearly renewable. Although project started in January 2010 the field experiment lasted in one year (during January-December 2014).

Table 9 shows the Piloting status of Hospital Cash benefit Insurance (HCB). The data shows that annual claim ratio is about 5 percent and loss ratio is 27 percent.[11] Both figures are very sound for practicing health insurance in the country. The surplus generated by the MFIs has been retained as a seed fund while introducing this as a regular scheme. This is to note that, as per the report of the key informant, the scheme is being continued by 8 MFIs out of 40 after the piloting phase.

Table 9: Piloting status of Hospital Cash benefit Insurance (HCB) (January 2014 to December 2014)

Total Number of HCB policy issued	Total amount of collected premium (in BDT)	Total numbers of claims paid	Total amount of claims paid (In BDT)
33,771	97,93,298	1,657	27,40,590

Source: Key informant interview and official website of PKSF

8.5 Ayesha Abed Foundation Health Security Scheme (AAF-HSS)

Ayesha Abed Foundation (AAF), a BRAC Social Enterprise, have taken a unique initiative of financial risk protection, which is an employer sponsored "health-security scheme" in 637 sub-centers for their contractual workers around 13 districts of Bangladesh. Each sub-center employs 20 to 25 female workers (called Artisans) to work on small-scale handicraft production primarily involving stitching. Ayesha Abed Foundation is supporting more than 60,000 Artisans of which 85% are women from low income communities. The unique business model helps develop the skills of Artisans and empowers them to make informed decisions and take shared control over production and assets through their involvement in quality control, financial management and microfinance loans. For accessing health security Fund an artisan have to give BDT 25 monthly and AAF will add the same amount into the pooled fund.

HSS will cover 13 districts around Bangladesh. The project intends to cover all the regular artisans working in the foundation across 15 districts of Bangladesh. The pilot for the Health Security Scheme (HSS) started in Manikgonj and Nilphamari in February 2015.

[11] A loss ratio is an insurance term that refers to the amount of money paid out in claims divided by the amount of money taken in for premiums. Insurance is profitable if the magnitude of this ratio is less than one and vice versa.

All listed household-members will receive monetary benefits for hospitalization for two incidents each year while seeking treatment and/before starting the treatment/surgical procedures. If artisan or the listed family members use health care facilities using this scheme they will receive BDT 1,000 as initial payment for all cases (emergency, normal delivery, surgical or medical) while seeking care. Other two benefits are of BDT 6,000 and 10,000 for minor surgeries including Caesarean Section and major surgeries respectively before starting the surgical procedures. They will receive maximum of BDT 3,000 for nonsurgical treatments. Three-five public and private facilities will be selected in every district for providing health care.

8.6 Shasthyo Surokhsha Karmasuchi (SSK)

As part of the governments' implementation of the Health Care Financing Strategy, the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MoHFW) is in the progress of piloting Shasthyo Surokhsha Karmasuchi, a social health protection scheme designed for Below-poverty-Line (BPL) population, in three Upazilas of Tangail District. As per the current design government will pay the full premium on behalf of BPL population. BPL population also will not have to pay any copayment at the point of service delivery. Health card will be provided to every BPL household.

A list of reimbursable benefits will be basic in the beginning and will evolve over time. It will be regularly updated. Ultimately, the benefit package will include: in-patient care which is manageable mostly at Upazila and partly at District level (upon limited referral). The benefits include the following: free physician's consultation in UHCs; free drugs and diagnostic facilities in UHCs; structured referral to the secondary level hospitals; and hospitalized SSK members will be treated according to defined medical treatment guidelines.

9. SUMMARY AND CONCLUSION

This paper depicts the landscape of prepaid health schemes in Bangladesh giving particular focus on provider based prepayment schemes for its implications and lacks thereof. Prepaid health insurance or micro health insurance is an innovative health financing mechanism for protecting the health of the poor. This mechanism has become popular in many corners of the developing countries as there are lot potential benefits. Worldwide there are four delivery models of offering prepaid health scheme or micro health insurance: provider driven, partner-agent, full service and community based. Historically mainly two motivations worked behind the introduction of micro health insurance in Bangladesh: (i) MFIs driven initiatives for protecting the borrowers from income/productivity loss due to illnesses and the huge burden of treatment costs; (ii) health care providers driven initiatives for providing health care to the unprivileged at affordable costs.

Table 10 illustrates a summary of various prepaid health scheme in Bangladesh. Gonoshasthaya Kendra and Dhaka Community Hospital are the examples of provider driven model in Bangladesh. Gonoshasthaya Kendra (GK) offers a voluntary and social class based health insurance where premium and benefits vary across the six social classes (i.e., destitute and ultra poor, poor, lower middle class, middle class, upper middle class and rich) of the catchment population. GK serves about 1.2 million populations in its catchment areas. The insured are entitled to receive health care from GK owned health centres and hospitals. The copayments for the services are progressive across the social class and the upper three tiers of the social class face huge copayment which is above 70% for most of the services (see Table 3). The major challenges faced by GK are low enrolment of the rich and overall low renewal rate. The costs recovery is also low, 35% of the recurrent costs. The scheme is highly cross-subsidized by the other entities of GK including a pharmaceutical company, a private medical college and a private university. This presumably restricts the replication of the scheme. There is some evidence that the scheme has created significant impact on increasing the utilization of ANC (Islam et al., 2012) Dhaka Community hospital (DCH) operates a scheme to serve the garments workers. Under this scheme DCH provides a doctor and an assistance who visit once a week to an industry for a full day as long as patients are available; industry manages the prescribed medicines for the patients; and industry pays to DCH an agreed amount per month for doctor's services. There is a small discount, 10%, for the inpatient care and referral services provided by DCH. Currently, about 8,000 workers are being served every week. The current cost recovery for this program is reported to be 100 per cent.

Sajida Foundation's Nirapotta is an example of MFIs initiated scheme. This scheme is mandatory for SAJIDA's microfinance and SME members and the premium is paid while disbursing the loan. The premium ranges from BDT 250 to BDT 1,050, depending on the amount and tenure of loan. There is an additional premium of BDT 100 for each supplementary loan. SAJIDA reimburses some cash benefit which is up to BDT 4,000. SAJID also runs two hospitals. The insured in hospital catchment areas have the opportunity to seek health care from these hospitals. However, the coverage, given the price of health care in the market, is not adequate and hence needs a high co-payment. It is well recognised that 'reimbursement system' is not the best one as the insured need to pay whole amount of medical expenditure from out of pocket at the point of service delivery under reimbursement system. SAJIDA has achieved the break even in the recent years.

Grameen Kalyan's health scheme is a MFI initiated voluntary scheme. The scheme is currently serving about 3 million individuals. The insured receive primary care from the health centres operated by Grameen Kalyan itself. There is also some hospitalization benefit which is BDT 2000 (or USD 25) per household. There is also high copayment which more than 50% or above. Low renewal rate and lack of continuum of care are the major challenges. There was 65-70 percent costs recovery in the recent years. Nonetheless, the scheme has been expanded recently. Although the scheme has created some impact to increase access to primary health care, this has not have any mentionable impact on health outcomes (i.e. improving health status) and economic outcomes (i.e., reducing poverty) due to high co-payments (Hamid et al, 2011a; 2011b).

This is to note that there are some partial evaluation of some of the scheme, such as Gonoshasthaya Kendra and Grameen Kalyan. However, there is lack of scientific evidence on the impact of most of the schemes (See Table A6). There is also no plan to conduct any impact evaluation of some of the schemes in future.

Whatever the delivery models the prevailing scheme in Bangladesh commonly face a number of challenges and shortcomings, as depicted in the literature (e.g., Ahsan et al., 2011), in addition to moral hazard and adverse selection, the standard reasons for failure of insurance market in general.

The limited extent of risk shifting in most programs cited above implies that the insured have to pay upfront a significant copayment for any diagnostic test, medication and surgery or any inpatient episode. Although co-insurance or copayment is generally a desirable feature of any insurance arrangement primarily to reduce moral hazard, the major portion of the risk should be borne by the insurer, not by the insured. The necessity of payment in cash up-front in meeting various fees and copayments in each of these programs is another substantial drawback. The flow of cash in the poor rural households is typically irregular as most are involved in informal activities. This is a real conundrum while credit-link would appear necessary to overcome the liquidity issue for spending any bulk amount, this create the risk of greater indebtedness. There is also lack of provision of external referral services. These may lead to the low demand of the voluntary schemes. It also seems that the rural poor fully do not grasp the value of an advance payment for 'the right to buy protection against a future contingency'.

The other notable constraints and challenges are: (i) non-existent of independent microinsurance regulatory authority that would enable the recognition of microinsurance as an independent sector; (ii) complexities of designing microinsurance product appropriate for the low income market; (iii) lack of reliable health service providers and thus microinsurance providers need to take the responsibility of providing health care (iv) lack of skilled resources in microinsurance; and (v) more importantly a limited and negative perception of insurance in the country as a whole.

All the voluntary schemes face low demand (i.e., low enrolment and low renewal) in Bangladesh. Enrollment figures are also low for many voluntary schemes worldwide (Matul et al., 2013). In a systematic review on the enrollment of voluntary and community-based health insurance programs, Panda et al. (2013) find that enrollment decisions are associated with both supply side and demand side factors, while for renewal decisions, supply side factors (e.g., quality of healthcare) are more important.

The development of micro health insurance sector is low in all aspects including numbers, coverage and growth in Bangladesh. This to note that worldwide micro health insurance has closed alignment with microfinance. Though an unquestioned pioneer of microfinance initiatives, Bangladesh has not had expected success with prepaid health schemes. Voluntary health insurance has also not been popular in the formal sector. The overall development of voluntary health insurance sector is also not satisfactory. For example, the contribution of voluntary health insurance in total health financing is only 0.1 percent (BNHA4 1999- 2012). There is also no compulsory health insurance scheme.

Presumably demand side factors such as lack of confidence/trust on prepayment mode, lack of awareness about the benefit of prepayment scheme, previous bitter experience, lack of affordability to pay premium and giving more weight to the present consumption plays an important role for the low development of health insurance sector. Some supply side factors such as low level of benefit, high copayment charged, committing fraud, complex procedures of claim submission, delay in claim settlement and rejecting the claim are equally responsible. Lack of trust as well as insurance culture may also be responsible for the underdevelopment of insurance market as a whole in the country.

All these challenges and limitations along with limited coverage and high co-payments restrict the scaling up and replication of the prepaid health schemes, especially provider driven initiatives and hence the growth of the sector

Table 10: Summary of the prepaid health schemes in Bangladesh

Name of the Scheme and/ Organization	Delivery Model	Name of Insurance Product	Target Population	Enrolment Criteria	Annual Premium (BDT)*		Benefit Package (BDT)*	Costs Recovery (%)	Health Care Providers	Population and Geographical Coverage	Major Challenges and Criticisms
Dhaka Community Hospital (DCH)	Provider driven	Industrial Health Program	Garment workers	Compulsory, but free, for all workers in the selected garment factories	Lump sum payment by employers based on capitation method		(i) Preventive care (ii) Free consultation services (iii) Free medical checkup once a year (iv) 10% discount referral and/or inpatient care	100	DCH	About 8000 employees in 24 factories	Very high copayments for inpatient and referral services
Gonoshasthaya Kendra	Provider driven	Social Class Based Health Insurance	Destitute & Ultra poor	Voluntary	Individual (BDT)*	Family (BDT)*	(i) No charges for paramedic and GP services (ii) No charges for consultation of expert physicians	35%	GK health centers and hospitals	Target population: 1.2 Million population in 10 districts No. of card holders: about 50,000	Low enrolment of the rich and overall low renewal rate
					70	140					
			Poor	Voluntary	100	240	(i) No charges for paramedic and GP services (ii) No charges for consultation of expert physicians				
			Lower Middle class	Voluntary	200	550	(i) No charges for paramedic and GP services (ii) considerable discount on consultation of expert physicians				
			Middle class	Voluntary	500	1100	(i) No charges for paramedic and GP services (ii) Fair discount consultation of expert physicians				
			Upper middle class	Voluntary	900	2700	(i) No charges for paramedic and GP services (ii) Some discount on consultation of expert physicians				
			Rich	Voluntary	1200	3200	(i) No charges for paramedic and GP services (ii) Some discount on consultation of expert physicians				

Note: * USD 1 = BDT

Table 10: Summary of the prepaid health schemes in Bangladesh/Cont.

Name of the Scheme and/ Organization	Delivery Model	Name of Insurance Product	Target Population	Enrolment Criteria	Annual Premium (BDT)*	Benefit Package (BDT)*	Costs Recovery (%)	Health Care Providers	Population and Geographical Coverage	Major Challenges and Criticisms
BADAS	Provider driven	Outpatient and Inpatient	The lowest salary groups of some selected garment factories	Compulsory	487 per worker which is paid by the employer	Maximum annual 15000 per worker	Below breakeven	National Health Network	8000 workers of seven garment factories of New Asia Group	High claim rate and potential loss
Sajida Foundation	MFI initiated	Nirapotta	Sajida's microfinance borrowers and SME borrowers	Compulsory	250 - 1050 based on amount of loan	Reimbursement : 500-4000 per episode	Break even	Hospital of Sajida Foundation and any other hospitals	130,000 in 10 districts	Errors in claim settlement and delay in claim settlement for operating both microfinance and microinsurance with the same set of staff
Grameen Kalyan	MFI initiated	Basic primary care	Rural people	Voluntary	(i) 200 for Grameen microcredit member (ii) 300 for other	10-70% discount on various services Referral benefit: 2000 annually		Grameen Kalyan's own health centres	Card holders: 15,868	Low renewal and lack of continuum of care
Amader Shasthya (ICDDR,B)	Community based	Outpatient	Rural people	Voluntary	500 per household	Maximum annual 30,000 per household	-	Outpatient care by community run health centre with assistance of icddr,b; referral and inpatient by empanelled local hospitals	10,000	Low renewal rate
		Inpatient			1200 per household	Maximum annual 54000 per household				

Name of the Scheme and/ Organization	Delivery Model	Name of Insurance Product	Target Population	Enrolment Criteria	Annual Premium (BDT)*	Benefit Package (BDT)*	Costs Recovery (%)	Health Care Providers	Population and Geographical Coverage	Major Challenges and Criticisms
DIISP	MFI initiated	Inpatient	Rural people	Voluntary	250	200 to 400 per day is given as cash benefit for a maximum of 30 days, excluding the first day	Generated surplus	Paramedic services by MFIs and inpatient care by empanelled hospitals	33,771 members of 40 MFIs	Low enrolment
Niramoy (Institute of Microfinance and Green Delta Insurance Company Ltd)	Joint initiative of MFIs and Insurance company with the assistance of some resear-chers	Outpatient, inpatient and maternity	Microfinance members	Voluntary	380 per individual	No charges excluding medicine and injectable. There is 20% copayment on medicine and injectable.	Loss incurred	Community Based Medical College Hospital, Mymensing	Target: 3000 households or 15000 people Card holders: 200 household or 1000 people	Low enrolment

ANNEX A

Table A1: Copayment and Benefits Provided: GK Social Class Based Health Insurance (HI)
[Taka 80 = US Dollar 1]

Social Classes	Consultation with									Preventive Services		Recreation Services	
	Para-medic	General Practitioner (GP) / Dental Surgeon /Junior Physio-therapist	Registrar /Junior Consultant	Consultants of				Physician Home visit		Blood pressure check, Nail cutting, Foot care etc.	Immunization	Dental Checkup / Eye Sight Checkup	Annual Cultural Event & Sports for elderly
				Physio-therapy	Ayur-vedh	Medicine /Surgery /Cardiology /Eye/ ENT / Gynae / Obs. / Urology etc.							
						Dhaka City	Other Areas	Dhaka City	Other Areas				
Destitute & Ultra poor	Free	Free	Free	Free	50	Free	N/A	N/A	N/A	Free	Free	Free	Free
Poor	Free	Free	Free	Free	100	100 ($1.25)	N/A	N/A	N/A	Free	Free	Free	Free
Lower Middle Class	Free	Free	100 ($1.25)	100	150	150 ($1.88)	100 ($1.25)	N/A	N/A	Free	Free	Free	Free
Middle Class	Free	Free	125 ($1.62)	300	300	200 ($2.50)	150 ($1.88)	2000	1000	Free	Free	Free	Free
Upper Middle Class	Free	Free	200 ($2.50)	400	400	250 ($3.13)	200 ($2.50)	2000	1000	Free	Free	Free	Free
Rich	Free	Free	225 ($2.73)	500	500	300 ($3.75)	250 ($3.13)	2000	1000	Free	Free	Free	Free
Non Insured	20 ($0.25)	100 ($1.25)	300 ($3.75)	600	700	500 ($6.25)	400 ($5.00)	3000	2000	50 ($0.63)	Free	200 ($2.50)	200 ($2.50)

Source: Official data of GK, 2015, Note: NA= Not Available

Table A2: GK Social Class Based Health Insurance (HI) Co-payment and Benefits Provided (in BDT)

Social Classes	Reproductive Health Services											
	Oral / Injectable FP/ Vaginal FP	Vasectomy	Tubectomy	Pregnancy Consultation& Testing	Menstrual Regulation (Early Abortion)		Ante Natal Care (ANC) & Post Natal Care (PNC)	Safe Home Birth Support		Institutional Normal Delivery		Caesarian Delivery package **
					Rural	Dhaka city & Savar		Rural	Dhaka city & Savar	Rural	Dhaka city & Savar	
Destitute & Ultra poor	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free	Free	500
Poor	Free	Free	Free	Free	200	300	Free	Free	300	500	700	4,000
Lower Middle Class	At Cost Price	Free	200	100	500	800	Free	Free	800	800	1,000	7,000
Middle Class	At Cost Price	Free	300	200	700	1000	Free	500	1,500	1,000	2,000	9,000
Upper Middle Class	At Cost Price	Free	500	200	700	1,500	Free	500	1,500	1,000	2,000	11,000
Rich	At Cost Price	Free	500	200	700	1,500	Free	500	1,500	1,000	2,000	13,000
Non Insured	At Cost Price	Free	500	300	1,000	2,000	200	1000	2,000	1,500	3,000	15,000

Source: Official data of GK, 2015

**Hospital admission, seat rent, medicines, investigation, anesthesia operation charges etc. included in package

Table A3: GK Social Class Based Health Insurance (HI), Co-payment and Benefits Provided: Diagnostic Services

Social Classes	Pathological Services							Diagnostic Radiology						Specialized Investigations		
	Basic Hema-tology	Blood Bioche-mistry	Micro Biology	Immuno-logy Serology	Cytology	Basic Stool / Urine	CSF (Spinal fluid) Histopa-thology	X-ray				Ultra-sono USG	MRI/ CT*	ECG	Colour ECHO	Endoscopy Cystoscopy etc.
								Skeletal (Analog)	Skeletal (Digital)	Barium	IVU					
Destitute & Ultra poor	Free	Free	Free	Free ¨	Free	Free	50	50	NA	100	1000	50	1,000	Free	Free	Free
Poor	Free	50-150	100	100	Free	50	200	50	NA	200	1000	150	2,000	100	500	200
Lower Middle Class	100	100-300	150	150-250	500	100	400	125	NA	500	2000	300	2,500	150	700	500
Middle Class	200	100-400	200	150-300	700	100	600	150	250	600	2500	400	3,000	200	1000	1000
Upper Middle Class	250	150-450	250	200-400	800	200	700	175	300	800	3000	450	3,500	250	1,200	1,200
Rich	300	150-500	300	250-500	900	250	800	200	400	1000	3500	500	4,000	250	1,500	1,500
Non Insured	400	300-600	500	300-600	1000	300	1000	250	500	2000	4000	600	6000	300	2,000	2,000

Source: Official data of GK, 2015

* At selected GK Hospitals

NA= Not Available

Table A4: GK Social Class Based Health Insurance (HI), Co-payment and Benefits Provided: Specialized Investigations of Essential Medicines, Blood Transfusion & Alternative care

Social Classes				Essential Medicines & Blood Transfusions **					
	Ayurvedh	Physiotherapy							
	†	Rural	Dhaka City	Oxygen (O2)	Oral & Parental Medicines	Nutritional Supplements	Nebulizer		Exchange Blood Transfusion
Destitute & Ultra poor	Free	Free	Free	Free	50% of Govt. approved price (MRP)*	70% of Govt. approved price (MRP)	Free	Free	Free
Poor	100	50	75	Free	80% of MRP	80% of MRP	50	Free	1,000
Lower Middle Class	200	100	150	Free	at MRP	at MRP	75	Free	2,000
Middle Class	500	200	250	Free	at MRP	at MRP	100	Free	5,000
Upper Middle Class	500	250	400	Free	at MRP	at MRP	150	Free	7,000
Rich	500	300	500	Free	at MRP	at MRP	200	Free	9,000
Non Insured	1,000	500	600	Tk. 300 per hour or less	at MRP	at MRP	250	Free	12,000

Source: Official data of GK, 2015

* At specified GK Hospitals.

** Blood Transfusion is free. But the cost of blood bag, giving set and compatibility tests will be charged.

NA= Not Available

Table A5: GK Social Class Based Health Insurance (HI), Copayment and Benefits Provided: Clinical Service

Social Classes	Clinical Services															Urban Home Service **		
	Hos-pital Admi-ssions	Daily Seat Rent (Food not provided)	Daily Special Cabin Charge (Without of food)	ICU/CCU Daily Charges (No extra charge for equipments used)	Specialised Consultation for Indoor patient		Operative Surgery											
							Circumcision		Minor surgery	Medium surgery	EYE		ENT	Major General Surgery / Gynae/ obstetrics	Ortho-pedic /Pediatric Surgery/ Urology	Trained Paramedics Day & Night Nursing care 12 hour shift	Qualified MBBS Doctor + Para-medic Visit*	Qualified Physio-therapist and para-medic Visit & Care
					9AM-8PM	9PM-8AM	Rural	Dhaka City			IOL	FACO						
Destitute & Ultra poor	Free	Free	Not Admis-sible	Free	Free	Free	Free	Free	Free	500-1000	500	N/A	500	1,000	2,000	N/A	N/A	N/A
Poor	Free	Free	Not Admis-sible	Free	Free	Free	200	300	500-800	1500-3000	1,000	N/A	3,000	5,000	6,000	N/A	N/A	N/A
Lower Middle Class	Free	Free	Not Admis-sible	2,500	Free	400	300	600	700-1300	4000-6000	2,000	N/A	5,000-8,000	9,000-12,000	10,00-12,000	N/A	N/A	N/A
Middle Class	Free	Free	3,000	5,000	Free	600	500	1,000	1000-2000	5000-7000	3,000	10,000	8,000-12,000	12,000-18,000	12,00-15,000	750	2,000	1,000
Upper Middle Class	Free	Free	3,000	5,000	Free	800	600	1,200	1200-2500	6000-9000	3,500	15,000	10,000-15,000	15,000-20,000	15,00-25,000	750	2,000	1,000
Rich	Free	Free	3,000	5,000	Free	900	700	1,500	1500-3000	8000-10000	3,500	15,000	12,000-20,000	17,000-20,000	15,00-25,000	750	2,000	1,000
Non Insured	1000	500	4,000	8,000	Free	1200	800	2,500	2000-4000	10000-15000	4,000	20,000	15,000-25,000	20,000-25,000	20,00-30,000	1,000	3,000	2,000

2015 Source: Official data of GK, 2015

Table A6: Impact evaluation of the prepaid health schemes

Name of Scheme/organization	Evaluation studies and major findings	Any plan for future evaluation?	Comments
Dhaka Community Hospital (DCH)	There is n study on the insurance component yet	Currently there is no plan to evaluate the scheme	
Gonoshasthaya Kendra	Islam et al (2012) evaluated the impact of this scheme on ANC	Currently there is no plan to evaluate the scheme	
BADAS	Undertaking a research by icddr,b	Not Applicable	Pilot phase has been completed
Sajida Foundation	Sajida regularly conducts MIS data based evaluation. However, there is no mentionable impact study on the beneficiaries	Not yet	
Grameen Kalyan	Hamid et al (2011a, 2011 b)	No provision for internal evaluation.	
Amader Shasthya (ICDDR,B)	None	Not yet	
DIISP	None	Not applicable	The pilot period is over
Niramoy (Institute of Microfinance and Green Delta Insurance Company Ltd)	None other background papers	Not applicable	The pilot period is over

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