

Community-based health insurance (CBHI) in Bangladesh

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Questions

- *What are different models of community-based health insurance programmes/ health insurance schemes for formal and informal sector implemented (especially for the workers of garment manufacturing sector) in Bangladesh, and the challenges faced in effectively implementing it?*
- *What are the evidences on impact of CBHI in terms of better access to health and health equity in Bangladesh?*

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1. Summary

Nearly half of all wage workers in Bangladesh report unsafe workplace conditions, resulting in illness and injury, as well as decrease in work productivity (Rockefeller Foundation, 2013). There have been several models of community-based health insurance (CBHI) programmes and health insurance schemes in Bangladesh to address this issue. This rapid review highlights the following key points, particularly relevant for workers in the 'ready-made-garments' (RMG) industry. This industry has over four million workers employed in 5,400 factories, according to the Bangladesh Garment Manufacturers and Exporters Association (BGMEA, 2015):

- Bangladesh had its first National Health Policy (NHP) formally approved by the Parliament in 2000.
- Existing reforms, such as community clinics and maternal care vouchers, provide access to limited health services only (WHO, 2015: xxii).
- Since NHP revisions in 2011, new issues that have been introduced include a health insurance scheme for formal institutions, and the provision of health cards for the ultra-poor and deprived (WHO, 2015).
 - It is reported that there is no health protection scheme available for government employees in Bangladesh (Siddiquee and Rahman, 2013; Hamid, 2015). The proposal for health insurance for formal sector workers does not address the workers in the informal and rural sector (WHO, 2015).
 - Penetration of health insurance and social protection is low among informal workers, even with national health insurance, in Bangladesh (Rockefeller Foundation, 2013).
 - Workers in the RMG sector benefit from health micro-finance schemes, such as that from Cashpor and Grameen banks.
- Private health insurance is nearly absent - existing only in some pocket areas run by NGOs (Molla and Chi, 2017). One such NGO, the Bangladesh Rural Advancement Committee (BRAC), charges premiums based on the economic capacity of the individuals for its health insurance scheme.
- Challenges faced in effectively implementing health insurance schemes include the lack of relevant infrastructure for the massive informal sector in Bangladesh (Hamid, 2015). There are also issues with introduction of "pre-payment" national insurance schemes.
- However, CBHI schemes in Africa and Asia have been shown to increase the utilisation of medically trained providers (MTPs) among informal workers (Spaan et al., 2012).
- Although there is little evidence on the impact of CBHI in terms of better access to health and health equity in Bangladesh, it is reported that as a result of health insurance:
 - workers have increased access to affordable health services;
 - RMG factory owners' ensured better health facilities for their workers;
 - the average health seeking behaviour of the worker increased, and
 - the return of investment in health is seen to have a positive impact and contributes to improved working conditions and productivity (Uddin, n/d).

Although some NGOs have piloted innovative low-cost health insurance schemes in recent years (such as SSK and HAEFA; zero-cash transaction APON and SNV Netherlands business model, and fee-based UPHCSDP), it may take a longer period of time to gain wider public acceptance as the concept of health insurance is still growing in Bangladesh (Islam and Biswas, 2014).

- Growing Corporate Social Responsibility Initiatives include partnerships between large international companies carrying out voluntary initiatives to improve health within the agricultural communities in which they work (Rockefeller Foundation, 2013).
- The Bangladesh Garment Manufacturers and Exporters Association (BGMEA) and Telenor Health aim to identify opportunities for innovative and affordable solutions and services to help RMG workers take better care of their health. It is an opportunity for the future.

The evidence used in this rapid review is from both academic and grey literature sources, as well as anecdotal reports. However, there were few systematic reviews available, and little impact evaluations. There are also gaps in the literature in terms of recent updates to health insurance schemes, including pilots, and reviews specifically on RMG workers' health schemes.

As the majority of RMG sector employees are female (over 70%), the data found focusses on women's health, as well as available services and insurance programmes benefiting their families. However, no data confirmed that giving responsibility for health insurance to women results in more health-care, not just for women but also for the entire family. Disability was not a focus for this rapid review. However, the introduction of affordable health insurance schemes for the poor, elderly, disadvantaged and disabled will benefit several Bangladeshi communities.

2. CBHI models and health insurance schemes

Introduction

Bangladesh's labour-intensive apparel industry has 4.2 million workers employed in around 5,400 factories, according to the Bangladesh Garment Manufacturers and Exporters Association (BGMEA, 2015). Approximately 4 million 'ready-made-garments' (RMG) workers in Bangladesh directly contribute to the economic progress of Bangladesh. **Between 70 and 80% of these workers are reported to be women** (Kabir, 2018).

While the country has made strides in the health sector, these **workers have almost no access to health-care services**. They work six days a week, often working overtime. Both financial and time constraints are barriers for them to accessing basic health-care services. While some factories do have medical facilities, these factories are limited in number and the facilities are often perfunctory (Kabir, 2018).

The large manufacturing sector in south Asia has received renewed attention following a series of devastating factory fires and collapses in Bangladesh (Rockefeller Foundation, 2013: 55). According to *Business Insider*¹ more than 700 people have died in Bangladesh factories since 2005, mostly in the garment industry. In November 2012, 120 workers were killed at a Tazreen

¹ "Wal-Mart And Sears Don't Plan To Pay Victims Of A Bangladesh Factory Fire That Killed 120." *Business Insider*. <http://www.businessinsider.com/wal-marts-bangladesh-factory-fire-2013-4>.

Fashions factory making clothes for several European brands; since November 2012, the country has also experienced 18 other non-fatal factory fires² (Rockefeller Foundation, 2013: 77).

Nearly half of all wage workers in Bangladesh report unsafe workplace conditions

(Rockefeller Foundation, 2013: 7) – resulting in illness and injury. Occupational injuries are costly to families: poor families lost about a months' wages/year due to illness (Rockefeller Foundation, 2013: 7). It also impacts the industry as a whole: if a worker is not physically or mentally fit, they cannot give their best. Therefore, both from a humanitarian angle and from the economic aspect, access to health services is essential (Kabir, 2018).

Universal Health Coverage is one of the Sustainable Development Goals (SDG) for 2030. Bangladesh is one of several countries which is committed to universal health coverage (UHC) (Rockefeller Foundation, 2013: 38). Health insurance offers a way of compensating an individual for the financial loss associated with health expenditure, by pooling regular small payments of many individuals over time (Rockefeller Foundation, 2013: 38). The following section details some of these insurance schemes in Bangladesh; examples of past and current models are provided later:

Definitions of insurance schemes

Community-based health insurance (CBHI)

Voluntary (often flat-rate) community insurance contributions are made by a defined 'community' employed outside the formal sector (Spaan et al., 2012). Several community initiatives for ensuring low-cost services have been initiated (WHO, 2015: 54). Schemes are sometimes managed and developed by community groups (micro-insurance); as well as those developed by government, non-governmental organisations (NGOs), or other civil society organisations (Ensor & Dave-Sen, 2000: 11). **CBHI schemes in Africa and Asia have been shown to increase the utilisation of medically trained providers (MTPs) among informal workers.**

Health insurance

Bangladesh had its first National Health Policy (NHP) formally approved by the Parliament in 2000 (WHO, 2015: 24). The latest policy revision in 2011 emphasises primary health and rural health. **Existing reforms, such as community clinics and maternal care vouchers provide access to only limited services, while the proposal for health insurance for formal sector workers will not address the majority of those engaged in the informal and rural sector** (WHO, 2015: xxii). In Bangladesh, no mental disorder is covered by social insurance (WHO, 2015: 20).

New issues that have been introduced include a health insurance scheme for formal institutions, and the provision of health cards for the ultra-poor and deprived (WHO, 2015: 141).

Except for through the public budget, very few of the existing funding mechanisms of Bangladesh (0.2% of total health expenditure), private or public, use any pre-payment method such as health

² "Bangladesh Factory, Site of Fatal Fire, Made Western Brands." The New York Times: Manik, JA & Yardley, J. 27 January 2013, sec. World / Asia Pacific. <http://www.nytimes.com/2013/01/28/world/asia/bangladesh-factory-site-of-fatal-fire-made-western-brands.html>

insurance. While private insurance companies offer individual and group insurance to private persons and corporate clients, these health insurance initiatives cover a very small share of the total population of Bangladesh (WHO, 2015: 54).

The concept of health insurance is still growing in Bangladesh, with some pilots of community health insurance by NGOs, contributions from public sector employees, and contributory schemes for formal private sector employees (WHO, 2015: 146). As the concept of health insurance is still growing in Bangladesh, it may take a longer period of time for these schemes to gain wider public acceptance (Islam and Biswas, 2014).

Costs to the individual

Health-specific resources, such as earmarked taxes and introduction of mandatory health insurance, can generate additional resources for health (WHO, 2015: 138). According to a literature review by Rawshon (2015: 13), people are willing to pay “only in the range of BDT 20 to 60 (USD 0.24-0.72) per person per month.” Cost sharing health-care for the worker is estimated at 45% (low risk) or 50-70% (medium risk) (Rawshon, 2015: 15).

Pooling of funds

It is recognised that some form of insurance involving risk-pooling and “pre-payments” could be an effective mechanism to ensure universal health coverage (WHO, 2015: 141). Examples of pooled funds include:

- The International Centre for Diarrhoeal Disease Research, Bangladesh (Icddr,b) ensures health-care for its employees with a health insurance scheme including contributions from staff members.
- Bangladesh Rural Advancement Committee (BRAC) has recently initiated health insurance for its employees against a premium of BDT 150 (USD 1.80) per month.
- In the private corporate sector, Grameen Phone among others secure health-care for its employees with contributions from the employer.

Despite the examples of pooled funds above, it needs to be emphasised that such funds correspond to a very small proportion of the total health-care fund of Bangladesh (WHO, 2015: 69). Research from 2016 over the last seven fiscal years suggests that budgetary allocation for health dropped from 6.2% to 4.3% of total government expenditure (Hassan et al., 2016). 2017 data from the Research Institute for Social Transformation (RIST) reveals that the per capita health expenditure in Bangladesh stands at USD 32 – almost half that of India (USD 111).³

³ The proposed budgetary allocation for health and family welfare sector for the fiscal year 2017-18 is BDT 20,679 crore (USD 246 million), which amounts to 5.2% of the total budget. This is much lower than the 15% budgetary allocation recommended by the WHO.

Health insurance for formal and informal sectors

There are several different health insurance programmes/ schemes - for both formal and informal sectors. Information on those that have been implemented (especially for the workers of garment manufacturing sector) in Bangladesh is listed below:

- **Formal sector**

Formal workers are employed by a company under an established working agreement. This includes salary, health benefits, and defined working hours. In Bangladesh, there are approximately one million public service employees, which covers a sizable portion (approximately 6%) of employees in the formal sector (Hamid, 2015: 5).

A review explored existing health protection schemes for formal sector employees, including the RMG sector in Bangladesh. It found that **no health protection schemes are available for government employees in Bangladesh** (Siddiquee and Rahman, 2013; Hamid, 2015: 6). Recently, the government started to revise the labour law. However, the proposal for health insurance for formal sector workers does not address the workers in the informal and rural sector (WHO, 2015: 142). Since the Rana Plaza collapse, efforts have been made to establish an Employment Injury Insurance scheme in Bangladesh, which would provide compensation to workers in event of workplace accident or disease.⁴

Earlier Initiatives

The Health Economics Unit (HEU) of the Ministry of Health and Family Welfare conducted a study immediately after its inception in 1998⁵, exploring the health insurance options of civil servants of Bangladesh for the first time. The study mainly highlighted sources of financing, costing and management issues. In addition, the study argued for establishing a *Health Insurance Commission* to administer the insurance funds, oversee the insurance scheme, and to monitor health-care quality and health-care provider network functions. The report also suggested that the *Health Insurance Commission* introduce medical audits to evaluate the quality of care provided for civil servants. However, the study did not sketch out benefit, premium contribution, and implementation procedures. **Since then, there has been little recent data available to support or oppose certain initiatives.**

Current initiatives

Three health insurance approaches for civil servants in Bangladesh include:

- 1) Family savings: **The most common approach to health-care spending.** Also known as out of pocket health expenditure by households (OOP or private spending). Due to insufficient public spending, OOP is much higher which is about two-third (64.7%) of total

⁴ http://trade.ec.europa.eu/doclib/docs/2018/september/tradoc_157426.pdf September 2018.

⁵ Health Economics Unit (1998). Health Care Financing for Civil Servants of Bangladesh. Research Note No. 11, Ministry of Health and Family Welfare, Dhaka, Bangladesh.

health care spending in Bangladesh (Hassan et al., 2016).

II) Health maintenance organisation (HMO)-style managed care plan: Administrators act as middlemen by contracting with both health-care providers and enrollees to deliver medical services. Subscribers benefit from reduced health-care costs, and health-care providers profit from a guaranteed client base. In addition, there is no waiting period for coverage of pre-existing conditions, and no maximum lifetime limits on benefits. Many HMOs also provide other services, such as dental care and eye exams.

All civil servants are enrolled in limited government schemes that can be classified as social insurance or payroll-based systems. A sum of BDT 700 (USD 8.35) is paid monthly as a medical allowance to each government employee. A payment of BDT 90 (USD 1) is deducted from the monthly salary of employees for a group insurance and benevolent fund, against which a maximum total of BDT 100,000 (USD 1,192) can be claimed for expensive medical treatment once in a lifetime period. Further, government employees are entitled to a reimbursement (not-fixed share) of up to BDT 20,000 (USD 238) for health-care payments from the Bangladesh Employee Welfare Board (WHO, 2015: 73-75).

III) Private health insurance: According to the Bangladesh Household Income and Expenditure Survey (HIES 2010), the average contribution to private health insurance is BDT 8 (USD0.10), compared to social health insurance (BDT 142- USD9.40). **However, private health insurance is nearly absent - existing only in some pocket areas run by NGOs (Molla and Chi, 2017) – examples of which are noted in the *Current Initiatives* section below.**

Potential Initiatives

In his concept paper on designing a health insurance scheme for government employees, Hamid (2015) outlines the structure of a contributory and cashless health insurance scheme for public servants and their eligible family members, initially for a block period of 5 years. The estimated premium is Bangladeshi taka (BDT) 500 per month (USD 6): BDT 400 (USD 4.80) for health insurance and BDT 100 (USD 1.20) for life and accident related disability insurance).

- **Informal sector**

Although there are no precise figures available to confirm this, the informal sector (or grey economy) in Bangladesh is described as “huge” (WHO, 2015: 137). Informal employment is often invisible, as workers are mostly excluded from national labour laws and regulations, social protections, and high-level discussions. As a result, these workers fall through the cracks in systems, including most UHC schemes, that serve formal workers on the one hand and the unemployed on the other (Rockefeller Foundation, 2013: 2). Many informal workers work in unregulated factories that do not meet industry codes of conduct, are illegally constructed and lack proper fire safety measures such as fire extinguishers and emergency exits, which can result in devastating factory fires. **However, penetration of health insurance and social protection is low among informal workers, even with national health insurance, in Bangladesh** (Rockefeller Foundation, 2013: 5).

Community financing and not-for-profit health insurance schemes

Micro-health insurance is a special form of community insurance where beneficiaries are involved to some degree in the management, and that is initiated by an organisation outside the public social security system (Ensor and Dave-Sen, 2000: 11). Micro-finance initiatives offer loans and health micro-insurance for health access at the worker level. Bangladesh microfinance NGOs started to introduce health insurance services to their clients in the late 1990s and early 2000s. The important bodies in health micro-insurance are Cashpor micro credit, Gonoshashtho Kendro (People's Health-care, GSK), Grameen Kalyan (Rural welfare, GK), Sajida Foundation, Shakti, Dhaka Community Hospital, Nari Uddug Kendra, Dushtha Shasthya Kendra, Integrated Development Foundation and Society for Social Services, and BRAC (Ahmed et al., 2005: 7; Rockefeller Foundation, 2013: 22). Most of the schemes cover loan, life insurance, and health insurance. Though most of these schemes report good rates of operational cost recovery to finance the non-recoverable expenditures, these NGOs have external funding or they are cross-subsidising the resource gap from their other programme's income.

Example: BRAC, the NGO which targets poor and ultra-poor in Bangladesh, charges premiums based on the economic capacity of the individuals (Rockefeller Foundation, 2013: 41). It introduced a micro-insurance scheme that provides subsidised services such as medical consultation, pathology testing and medicines for an annual premium. This health insurance scheme is for its employees (both regular and contracted). Against a premium of BDT 150 (USD 1.80) per month, the employees, their spouses and dependents (up to age 25) will get specific health benefits. For any hospitalisation, a maximum of BDT 100,000 (USD 1,192) can be claimed, while the beneficiary will bear 10% of total expenditure, as well as the amount above the maximum ceiling (WHO, 2015: 73-75).

Current initiatives

While a number of private insurance companies offer individual and group insurance to private persons and corporate clients, a number of community initiatives for ensuring low-cost services also exist (WHO, 2015: xx.) – five are described below:

1. SSK: Shasthyo Shuroksha Karmasuchi

In a recent initiative, HEU has designed a health-care financing strategy (to be implemented over the period of 2012-2032) aiming to achieve UHC by introducing some alternative financing mechanisms, including health insurance for both formal and informal sectors. With support from Germany through KfW Development Bank, this pilot is overseen by the HEU's Shasthyo Shuroksha Karmasuchi (SSK) Cell⁶, and technical assistance is provided by Oxford Policy Management and management4health. Operated by a private insurance company under government contract, the scheme pays for services delivered, using predefined Diagnosis-Related Groups (DRGs). The strategy puts emphasis on pre-payment mechanisms with scope for risk-pooling, and separate mechanisms are suggested for people in different economic sectors (formal sector, informal sector, and people in poverty) (WHO, 2015: xxii).

⁶ SSK: a social health protection scheme for the rural poor via the Health Equity Fund/ National Health Security Office (an autonomous agency to handle the financing of the social health protection programme).

The SSK is a **non-contributory health insurance scheme** for the below poverty line (BPL) population to provide comprehensive inpatient care (Hamid, 2015: 6-7). Medical costs up to USD 570 per household per year are covered.

The insufficiency of drugs in public hospitals remains a major problem. To ensure that hospitalised SSK cardholders get the medicines they need, the three pilot sub-district hospitals have contracted a local private pharmacy to set up a special pharmacy for SSK patients within the hospitals (White-Kaba and Niechzial, 2018).

If successful, the benefit package is planned to be extended to include private health providers, popularly considered to provide better services than the public sector. This will further enhance attractiveness of the SSK scheme. White-Kaba and Niechzial (2018) note that a necessary complement will be introducing “a process of formal accreditation to maintain quality of both private and public providers of SSK-reimbursed services. The insurance scheme can play a role in quality control and standardisation by use of DRGs, and by only paying health facilities that are accredited. Thus introduction of national health insurance can become an important element of systems reform.”

2. HAEFA: Health Education for All

The WHO recommends development of social health insurance as part of the path to UHC^{7,8}. However, most NGOs work in poor areas cannot access the four million RMG workers as they are not available in these areas until late evening (Kabir, 2018).

The concept of HAEFA (Health and Education for All), Health on Wheels, is a plan to screen and link factory workers to quality health-care services for common non-communicable diseases (NCDs). Under this project, HAEFA, in collaboration with the Bangladesh government’s Directorate General of Health Services (DGHS) and owners of several garment factories, will provide medical check-up to 9,000 factory workers (Kabir, 2018).

Founded by Ruhul Abid of Brown University and Rosemary Duda of Harvard Medical School, HAEFA first started providing the ‘**cooperative health insurance**’ services to the RMG workers in Bangladesh in 2013 (Kabir, 2018). Since then, HAEFA has provided health-care to more than 8,000 RMG workers and 1,200 rickshaw-pullers. In 2016, Brown University Global Health and HAEFA developed a paperless, portable, electronic medical record (EMR) system and used it to perform medical check-up for 5,776 RMG workers in Sripur/Mawna, Gazipur, Savar and rickshaw pullers in Dhaka for diseases such as hypertension, diabetes, anaemia, asthma, high-risk pregnancy and tuberculosis (TB).

The project, ‘*Novel Workplace NCD and ID (infectious disease) Screening for Garment Factory Female Workers using EMR*’, is being implemented by HAEFA and Brown University (Kabir, 2018). This is initially a one-year project, from 1 April 2018 to 31 March 2019, to be extended further if successful. The first three months focused on preparation, recruitment of medical team members, training, and garment factory selection (Kabir, 2018).

⁷ <https://en.prothomalo.com/economy/news/178152/Taking-health-to-the-RMG-workers> 20 June 2018.

⁸ World Health Organization. The World Health Report Health Systems Financing-The Path to Universal Coverage [Internet]. Geneva, Switzerland: 2010. <http://www.who.int/whr/2010/en/>

The first health screening under this project was on 25 June 2018 and will continue for the next 10 months. If the project is successful, HAEFA will be eligible to apply for a larger project for three years to cover 50,000-100,000 RMG factory workers for annual health screening and treatment of chronic diseases (Kabir, 2018). Funded by Grand Challenges Canada, the project has scheduled health screening in seven garment factories in Sripur, Gazipur, Savar and Dhaka. It may extend its programmes to other factories and regions in Bangladesh (Kabir, 2018).

The project will also work to raise health, feminine hygiene, and nutrition awareness among the factory workers by organising workshops at the factories and discussions with the factory management. HAEFA will also introduce cervical cancer screening using digital technology for the garment factory workers for the first time. This is significant as cervical cancer is the second biggest cause of death in Bangladeshi women (after breast cancer). The project will also ensure that the diagnosed cases of hypertension, diabetes, tuberculosis, cervical cancer, etc., receive continued treatment from the nearby government upazila (sub-district)/ zila (district) health centres, BRAC centres, the Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders (BIRDEM), nearby pharmacies where HAEFA-designated physicians, and health workers.

Since October 2017, HAEFA's 22-member medical team has been operating in two Rohingya camps of Kutapalong and Balukhali. It has provided free treatment to over 31,000 Rohingya and local host community patients (Kabir, 2018).

3. UPHCSDP: The Urban Primary Health-care Service Delivery Programme

Overall, the Bangladesh health system is at a crossroad. Investment in health would contribute to the improvement of the health of the population and fulfil the government mission to achieve universal health coverage within the foreseeable future (WHO, 2015: 161-162).

The Urban Primary Health-care Service Delivery Programme (UPHCSDP) has set-up a promising **fee-based model**. Although the service is hosted by a non-health ministry and coverage remains slow, this model demonstrates a positive transition in patient behaviour from free health-care to fee-for-services.

This is also a successful model that has demonstrated that non-state providers engaged in supporting public health services under and private health sector can be brought under regulation by the government. Further evaluation of the UPHCSDP to tease out weaknesses would help in identifying a strategy to strengthen primary health-care in both urban and rural areas, for gradually reducing Bangladesh's dependence on donors for primary health-care by generating revenue in health. Further exploration of scope for linking the UPHCSDP model to community-based health insurance maybe an innovative approach for reducing catastrophic out-of-pocket (OOP) payments and establishing a sustainable health-care delivery system.

4. APON: Alor Pothe Nobojatray Foundation

The innovative new model APON aims to empower the workers of RMG manufacturing industry to increase their disposable income and build better, healthier lives by receiving subsidised health-care for their families, without forcing factory owners to increase worker pay. (Schiff, 2017). It does this by selling discounted consumer staples at a workers-only shop, where purchases earn the workers **points toward a workplace benefits scheme** (Schiff, 2017).

APON sets up and independently manages the shop inside an RMG factory, selling packaged food, hygienic products and other disposables to the employees at a slight discount - about 8% to 10% below market retail. Each purchase from the shop earns a worker points that accumulate on their APON account. For every BDT 100 (about USD 1.25) spent, the worker earns 1 APON point. With 200 points, the worker gains access to **APON's zero-cash health coverage**, allowing them to get free medical diagnoses and prescriptions from a doctor (Schiff, 2017).

The APON shops allow workers to increase their disposable income by saving on goods they already buy. At the same time, they gain access to reliable health-care services and other well-being benefits, perhaps for the first time in their lives, without relying on donations or grants (Schiff, 2017).

Long term, APON will need to reach about 20% of Bangladesh's RMG labour force, or nearly one thousand factories, to be financially sustainable (Schiff, 2017). Beyond medical coverage, other benefits hope to be added to the APON well-being scheme, such as subsidised education for children and even family entertainment options (Schiff, 2017).

5. SNV Netherlands Inclusive Business Pilot

The not-for-profit SNV Netherlands Development Organisation piloted an Inclusive Business project in RMG Industries in Bangladesh with the funding support of The Embassy of the Kingdom of Netherlands (EKN). The aim of the project is to test viable business solutions to improve workers health, with sexual and reproductive health rights (SRHR) the priority. SNV invited interested private sector and NGOs to offer innovative business models which would ensure **affordable, accessible and available health services** to the low-income worker. SNV also built the capacity of local providers in market analysis, design business model development, partnership building with RMG factories and business planning support to profitable business solutions (Uddin, n/d).

The price of the female workers health insurance is 500 Bangladeshi Taka (USD 6), and thus the total market size would be yearly BDT 2 billion (USD 24,000).

The business model was focused on low-income people working in the RMG sector in Bangladesh. Their income is almost uniform and average income is below USD 3 per day. The age gradation of the people ranges from 18-34 years; which indicates they are in the peak of reproductive age. Female workers are susceptible to sexual and reproductive diseases due to long lasting working hours, unhygienic menstrual management, malnutrition and poor working conditions. Most of the factories have their own medical centres with doctors. However, these are non-functional and thus workers health problems are unsolved, which also affects factory productivity and higher operational cost. Many of the factory owners and buyers are seeking amicable solutions but many are still far away, as most of the product and service providers have a lack of interest to serve low-income people (Uddin, n/d).

The model started with the health insurance scheme in three selected factories to cover SRHR services along with health education. The aim of the model was to engage the factory owner to institutionalised workers health services at the same time ensure available quality health services. The total services are monitored through a database which preserve workers health history. The health service is maintained both inside and outside the factory (Uddin, n/d).

Service provision inside the factory premises include:

- Availability of qualified doctors during working hours;
- Health education to make workers aware of health issues, and
- Management sensitisation for gender sensitive health services.

Service provision outside the factory premises include:

- Availability of qualified doctors and nurses with diagnostic and hospitalisation facilities 24/7.
- Health Insurance card provided for privilege health services.

Unique features of the Insurance:

1. Zero cash transaction: The supply chain of the services is maintained with a web base solution where all the payment is made with cashless transaction. All the stakeholders have the provision to monitor their respective factory workers total service delivered and frequency of patient.
2. Dedicated service provider: The health will be provided qualified service provider. The capacity of the provider was assessed, and technical assistance was given for gender sensitive service delivery.
3. Factory involvement: Factory management interest built through quantifying the business benefits with the business model which evidence is created from the earlier stage of the implementation.

3. Challenges faced in effectively implementing CBHI

The massive informal sector and lack of relevant infrastructure (e.g. appropriate hospitals, insurance companies, Third Party Administrator) are major barriers of introducing social health insurance in many developing countries, including Bangladesh (Hamid, 2015: 5).

Three examples of implementation challenges are described below:

- I. HMO-managed care plan: Although employees they benefit from low OOP costs, comprehensive services, preventative care, and no claim forms, they also have a reduced ability to choose their own doctors and limited out-of-area coverage.
- II. “Pre-payment” national insurance scheme: Introduction faces several issues, including:
 - identifying adequate fiscal space;
 - appropriate payment mechanisms that limit overuse and supplier induced demand;
 - regulation of use of pharmaceuticals, and
 - community acceptance and willingness to contribute to an insurance scheme.
- III. Initial challenges of the SNV Netherlands Inclusive Business project (Uddin, n//d) included:
 - Lack of willingness of the RMG factory owners to implement the project due to the cost associated with the initiative, and no proven business cases in the country;
 - SRHR taboos obligated by religious norms;

- Insurance companies had limited interest since higher risk associated with the coverage, and
- Workers and management have negative impression about the insurance scheme.

Ensuring such health-care for workers and their dependents is a challenge in many low- and middle-income countries. However, implementation and scale-up of CBHI schemes have the potential to address this challenge of UHC (Ahmed et al., 2018).

4. Evidence on impact

Health insurance as a mechanism for financing health-care has not yet been used significantly in Bangladesh. There are several employer operated schemes, both in the public and private sector. These schemes are essentially complementary, covering the costs of user charges and additional payments required in government facilities or user charges in private facilities. The proportion is unlikely to grow in near future due to the economic status of the population of Bangladesh. Evidence reveals the following:

- I. Since private insurance schemes are profit-oriented, these schemes may refuse insurance coverage or charge very high premiums, especially from at-risk groups such as the elderly, disabled or those suffering from serious health problems such as cancer or AIDS. It has a low effect on resource mobilisation and equity in the health sector.
- II. There is a relatively small literature looking at the impact of CBHI on health-care utilisation (Spaan et al., 2012). A multilevel logistic model was applied on the matched observations to estimate the impact of CBHI on MTP provider utilisation in Africa and Asia. Though the CBHI scheme showed significant impact on increasing the utilisation of MTPs, a good number of members utilised untrained providers such as drug sellers (22%) and village doctors (23%).
- III. In 2014, the Health Economics and Financing Research Group, icddr,b, in collaboration with Bangladesh Diabetic Somiti (BADAS, the Diabetic Association of Bangladesh) funded by The Swiss Tropical and Public Health Institute, conducted a baseline study to assess the impact of health insurance on access and utilisation of health-care and to estimate out of pocket expenditure of workers without health insurance and also the health seeking behaviour. The findings (Uddin, n/d) showed that:
 - 43% of RMG workers become sick and loose around 4 days salary due to sickness absenteeism.
 - 87% of workers seek health-care services, although 40% cannot afford the health services due to high cost.
 - 75% workers are willing to pay for health insurance.
 - As a result of the health insurance scheme the workers have increased access to affordable health services.
 - RMG factory owners also ensure better health facility for their workers. The average health seeking behaviour of the worker increased, and the return of the investment of the health is seen to be positive impact and contributing improved working condition and productivity (Uddin, n/d).

The initiation scaled-up the initiative to other factories at the end of 2016. However, there is no recent information available about this.

- In 2016, the Bangladeshi government took the initiative to launch health insurance for government employees and social health insurance for garment workers (RMG Bangladesh, 2016). The insurance schemes are part of the *Health-care Financing Strategy 2012*. The evidence on impact of CBHI in terms of better access to health and health equity in Bangladesh includes momentum around home-based workers: Such an extension of health insurance protection, to extend micro-insurance to homeworkers, as with Grameen Bank and BRAC in Bangladesh (Rockefeller Foundation, 2013: 49).

Future opportunities

- Some large international companies carry out voluntary initiatives to improve health within the agricultural communities in which they work. This is a growing sector as new partnerships among actors within global value chains (e.g. suppliers, agricultural enterprises, their employees/ unions, NGOs, and governments) emerge. Such initiatives can increase productivity, enhance brand reputation and create company loyalty among farmers. Although no evidence can be found for Bangladesh, the British American Tobacco Bangladesh is quoted as an example of a successful programme (Rockefeller Foundation, 2013: 60).
- The Bangladesh Garment Manufacturers and Exporters Association (BGMEA) and Telenor Health AS have been working together since 2017.⁹ Through the collaboration, existing Telenor Health services, which have already gained widespread popularity in Bangladesh, will be offered to RMG workers in several cities in Bangladesh. The two bodies will work together to identify and develop sustainable financing models for health and wellness services for RMG workers. They will also identify opportunities for innovative and affordable solutions and services to help RMG workers take better care of their health. The apparel industry accounts for 81% of total export earnings for Bangladesh. Telenor Health will be “a new and innovative approach for the Association to facilitate sustainability in the apparel industry.”

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