Draft

Health Insurance in rural Bangladesh: Proposal on a Pilot Project

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The Context

Bangladesh is politically and socially committed to attain the goal of Health for All (HFA) by 2000 AD. To this end, in recent years the health system of the country witnessed numerous changes and reorientations leading to considerable improvement in human and financial resources allocation, physical infrastructure development and essential drug supply. Despite that, the illnesses compounded with pervasive poverty still plague the health status of the people. Consequently, wastage of human productivity particularly of the toiling mass due to ill health continues to be alarmingly high in Bangladesh. However, the reciprocal interplay between health and poverty produced a vicious cycle of ill health and poverty entrapping particularly the rural poor. It is globally recognised that ill health of the population obstructs the economic growth and development. The Bangladeshi policy-makers, health managers and donor communities thus agree that the health status particularly of the toiling mass must be improved as quickly as possible to enhance the overall development of the country. Recognising the fact, both the government and non-government agencies alike have been working in partnership to have significant reduction in the level of poverty caused by diseases, and diseases caused by poverty. But the existing services and facilities still seem to be inadequate to meet the pace of the people's needs in general, and are not equally accessible nor equitably used by the people in particular. Indeed, sparse distribution of the government health facilities, and inadequate supply and low quality of services are often the major limiting factors towards people's access to basic health care services. As a result, most of the poor have no access to health services. Access, however, may be further hampered when government funding for health care is dwindled.

It is widely recognised that NGOs have been playing a significant role in improving the health status especially of the rural poor in Bangladesh. But their complete dependency on the external funds is another stumbling block to sustainable health service delivery by them. In fact, NGOs' funding especially in this region is severely shrinking due to shift in donors' priority and crises in Eastern Europe. Thus, the sustainability issue of health services is at stake in most poor countries with no exception to Bangladesh. These factors have led the policy makers to consider a spectrum of financing options for Bangladesh, ranging from user fees to health insurance for keeping afloat the health care services. BRAC, a leading national NGO has a history of effective health programme implementation. From the inception, BRAC has been pursuing ways to establish a sustainable health service system to benefit especially the poor.

In the mid-seventies, BRAC introduced a health insurance system in its Sulla project in greater Sylhet district where premiums were collected in kind from the participants. Later BRAC abandoned the initiative as it largely benefited the more affluent segment of the community rather than the poor who were in pressing need of the services.

However, BRAC policy-makers and health managers now plan to test a health insurance system again in an innovative manner. In the recent past, BRAC's health and population programmes prospered both by dimensions and size including fixed facilities. Alongside extensive preventive, promotive and educative community based health and population activities BRAC established over 40 health centres called *Shushasthyos* or BRAC Health Cetnre to provide primary and secondary curative services based on the PHC principles articulated in the Alma Ata Declaration in 1978. Such facilities are vital to manage a great deal of illnesses independently and thereby to support health insurance schemes at community level. Therefore, it is imperative to consider health insurance (HI) as a risk sharing mechanism to harness private funds for health care, and reduce the financial barrier faced by the individuals when seeking health care. Since majority of the people in Bangladesh live in rural areas, and therefore of prime importance are HI schemes that are accessible to the rural residents. The second prime function of a HI scheme is social including social equity. In essence, it is to remove financial barriers to obtaining health care at the time of illness for the vulnerable groups.

HI to generate health care financing through voluntary prepayment schemes is an option, but this requires a formidable and complex development process. In any case, it is in this context BRAC intends to organise an experimental HI scheme in pursuance of some of the objectives of community financing – primarily to recoup some of their recurrent costs from the users. Thus the specific objectives of the pilot project on HI are:

1. Develop diverse options for HI including service package, amount and mode of premium payment,
2. Design and test different options for HI schemes at community level for contributing to financing the Shushasthyo services,
3. Explore easy, effective and acceptable options for people's participation in the scheme, particularly by the poor,
4. Assess the efficiency and effectiveness of social insurance scheme for health services, and
5. Assess the link with Essential Services Package in Health and Population Sector Programme of Bangladesh Government.

2. Description of the Project

2.1 Target Population

The pilot will cover the whole population in the catchment area regardless of their socioeconomic ranks. But particular importance will be given to the members of the Village Organisations (VO) of BRAC and other NGOs, and the poor women and their families who are not associated with any NGOs. The populations in the project area will be classified into the following four sub-groups by means of some critical criteria such as status of NGO membership, land ownership, and selling manual labour by any working member of a household.

Category-A (Non-poor Non-members)

- Possess more than 50 decimal of cultivable land; and
- Not members of any NGO.

Category-B (Moderate Poor)

- Possess 10-49 decimal of cultivable land;
- Any working member sells manual labour for at least 100 days a year; and
- Members of any NGO.

Category-C (Extreme Poor)

- Have less than 10 decimal of cultivable land (except homestead);
- Any working member sells manual labour for at least 100 days a year; and
- Members of any NGO.

Category-D (Ultra Poor)

- Have no cultivable land (except homestead);
- Have no valuable assets like furniture, utensils, radio;
- Any working member sells manual labour for at least 100 days a year; and
- May or may not be member of an NGO.

For operational ease, the classification is done first as VO and Non-VO, and then the Non-VO is further divided into three as follows (Figure 1).

Category-A (NGO VO Members)

- They will be a heterogeneous group with a mix of non-poor, moderate poor, extreme poor and ultra poor;
- They will be landless to owner of any amount of land (cultivable + homestead);
- Any working member usually sell their manual labour at a range of days in a year; and
- Members of any NGO.

Category-B (Non-poor Non-members)

- They are considered to be the better-off section of the society;
- Have more than 50 decimal of cultivable land; and
- Not members of any NGO.

Category-C (Poor Non-members)

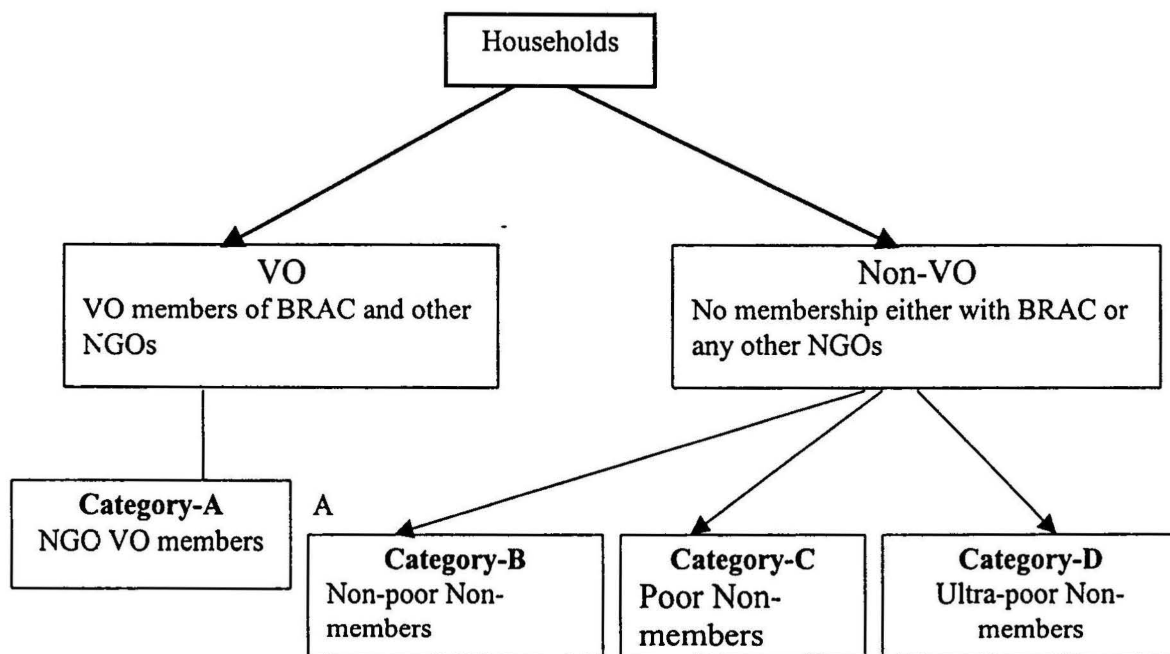
- Have less than 50 decimal of cultivable land (except homestead);
- Any working member sells manual labour for at least 100 days a year; and
- Not members of any NGO.

Category-D (Ultra Poor Non-members)

- Have no cultivable land (except homestead);
- Have no valuable assets like furniture and utensils;

- Any working member sells manual labour for at least 100 days a year; and
- May or may not be member of any NGOs.

Figure 1: Categorisation of the population for the scheme



small-scale baseline survey will be conducted to register the basic socioeconomic profile of these populations. This can be done even during the entry (registration) of a household in the programme based on the above criteria. Four types of cards will be developed for the above groups. Each group will be given one type of card for identification so that they can be easily accessed for premium. Variable rates of premium will be charged depending on the socioeconomic classification of the populations.

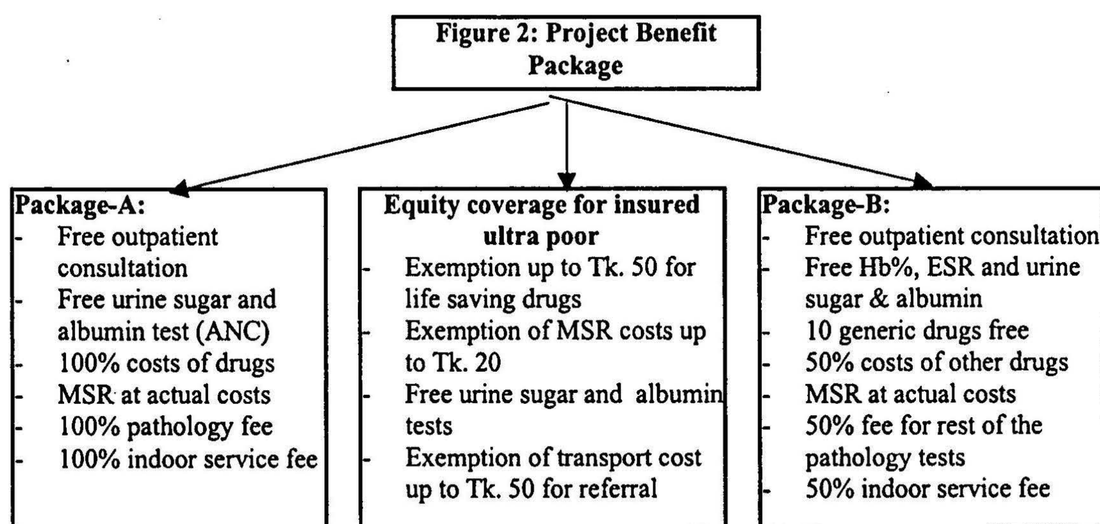
2.2 Service Provisions

The project will be developed within the existing service provisions and facilities available through the BRAC community-based approach and the Shushasthyo. The provisions will range from the information, education and counselling (IEC) and social mobilisation at the community level to offering services at Shushasthyo including referral arrangement from Shushasthyo to the higher facilities for further care. The services at Shushasthyo include out-patient counselling, consultation, examination and treatment for diseases/conditions being able to manage at Shushasthyo; the indoor care for vaginal delivery, post-abortion care, and child care (pneumonia, diarrhoea, medical emergencies for referral preparation, i.e. acute abdomen), pathological tests, and essential drugs services ***(Appendix-1)***. The referral

package will include information and advice on referral care, support for transport facilities and live-saving drugs for emergency situation. A list of drugs available at Shusasthyo is attached *(Appendix-2)*.

2.3 Project Benefits Package

For avoiding the complexity of calculations and keeping the mechanism simple and manageable, there will be two different packages of benefits that will be available on two different amount of payment system (Premium and Co-payment). The equity coverage with lower service charge, subsidy, and exemption will be on the basis of socioeconomic categories of the population and premium package (Figure 2).



2.4 Description of Benefit Package

2.4.1 Package-A

Through this package, the project participants (insured) will get outpatient services for IEC, consultation with doctors and prescription, drug dispensation, and the referral advice/suggestions if required for the listed conditions below.

1. General diseases (***Appendix-3***)
2. Ante-natal care including urine albumin and sugar tests
3. Post natal care including care of new-born
4. Minor surgical services for small cut injury, abscess drainage, dressing wound. The patients need to reimburse the actual costs of medical and surgical

requirement (MSR) such as disposable syringe, needle, catgut, cotton/gauze/bandage, etc.

5. Immunisation services with government supplied vaccine and MSR.

The patients will need to pay for drugs, MSR (syringe, needles, catgut, infusion set), pathological tests, and indoor services like delivery, post-abortion care, child health (pneumonia, diarrhoea), and other medical emergencies (acute abdomen, observation).

2.4.2 Package-B

With a separate set of premium and co-payment, the following package will be offered to the insured clients.

1. Services mentioned above under Package-A
2. The following 10 generic drugs will be given free of cost:
   i) Paracetamol
   ii) Phenoxymethyl Penicillin or Amoxycillin
   iii) Metronidazole
   iv) Salbutamol
   v) Chlorpheniramin maleate
   vi) Albendazole
   vii) Iron + Folic Acid
   viii) Antacid
   ix) Vitamin-A
   x) Benzyle Benzoic Acid
3. All other drugs at 50% subsidised cost;
4. Pathological tests for estimation of haemoglobin, ESR, and urine sugar and albumin;
5. All other pathological tests available at Shushasthyo at 50% subsidised cost;
6. Shushasthyo indoor services at 50% subsidised cost.

2.4.3 Equity Package

Only the insured ultra poor (category-D) will be eligible for the equity coverage. But the noninsured ultra-poor will get access to Shushasthyo services as per the existing financing policy with subsidy and exemption through user fee systems. The equity package with subsidy and exemption will include the following:

1. Services mentioned above under Package-A
2. The following 10 generic drugs will be given free of cost:
   i) Paracetamol
   ii) Phenoxymethyl Penicillin or Amoxycillin

iii) Metronidazole
iv) Salbutamol
v) Chlorpheniramin maleate
vi) Albendazole
vii) Iron + Folic Acid
viii) Antacid
ix) Vitamin-A
x) Benzyle Benzoic Acid

3. All other drugs at 50% subsidised cost;
4. Pathological tests for estimation of haemoglobin, ESR, and urine sugar and albumin;
5. All other pathological tests available at Shushasthyo at 50% subsidised cost;

2.5 Payment Systems

The imbursement structure (premium and co-payment) and the benefit package have been designed based on the assessment and analysis of morbidity pattern ***(Appendix-3)***, the categories of client attended the Shushasthyo (BRAC VO, Other NGO VO, Non-VO, Hard Core Poor), the maximum uptake of clients per months per centre and contribution of different service packages towards cost-recovery.

2.5.1 Payment Structure

Based on cost analysis, the payment and co-payment structure is illustrated below. However, the specifics of cost analysis and estimation of the premium and co-payment for both the benefit packages are shown in ***Appendix-4***.

3.5.1.1 For Benefit Package-A

HH Category	*HH Characteristics*	*Premium per Annum*	*Co-payment per Visit*
Cat-A	NGO VO Members	Tk. 125	Tk. 2
Cat-B	Non-poor Non-members	Tk. 200	Tk. 3
Cat-C	Poor Non-members	Tk. 150	Tk. 2
Cat-D	Ultra-poor Non-members	--------	------

2.5.1.2 For Benefit Package-B

HH Category	*HH Characteristics*	*Premium per Annum*	*Co-payment per Visit*
Cat-A	NGO VO Members	Tk. 350	Tk. 4
Cat-B	Non-poor Non-members	Tk. 550	Tk. 7
Cat-C	Poor Non-members	Tk. 400	Tk. 5
Cat-D	Ultra-poor Non-members	--------	------

There will be flexibility to change the amount of premium and the co-payment subject to the conditions/circumstances that affect the costs of the project operation. However, this change

will be incorporated at the beginning of a new cycle of insurance membership or a new calendar year. The cost analysis of both the premium packages is annexed in Appendix 5.

2.5.2 Mode of Payment and Renewal

The premium will be collected in cash by the project's newly recruited Community Motivators (CMs) once in a year for a household that need to be renewed yearly. A household can be registered at any time throughout the calendar year for a 12 months period. The insured households not using any medical care from the BRAC facility throughout the reference year of insurance will be entitled to get back 20% of their annual premium in terms of special service, or the amount will be recycled/carried over in the subsequent year's premium for the respective households.

2.5.3 Fee Structure, Safety Net and Subsidy

The fee structure of the services outside the benefit package will remain the same as per the current Shushasthyo Management Guidelines and user fee system. All the noninsured HHs will get access to Shushasthyo services under the payment systems through user fee. The noninsured ultra-poor will get services under the existing safety net procedures of Shushasthyo through user fee system. The insured ultra-poor, regardless of VO membership status will enjoy the special benefits of equity coverage under the service benefits package of the project. The costs of subsidised services and safety net coverage services will be met through cross-subsidisation of higher payment for the non-poor clients/HHs. The project has been designed to lessen this cost over a period of three years through cross-subsidy when the project will be able to achieve its 100% coverage of membership for insurance. During the 3-year transition, the costs to be accrued against subsidy and safety net can be generated through the contributions from BRAC or other agencies. However, BRAC's experience of mobilising bond money for ultra-poor TB patient, under TB control activities, can be used to mobilise funds from the community to subsidise the cost for ultra-poor. Other sources like pharmaceuticals, RDF or laboratory services can be used to minimise this cost.

3. Operational Procedures

3.1 Staff – The newly employed Community Motivators (CMs), existing Shushashthyo personnel and the staff of other BRAC programmes will jointly implement the project activities through BRAC's local and central management system. The present Shushasthyo staffs have already been functioning within a well-defined framework. Their specific responsibilities on health service delivery are clearly defined and regulated. They will carry on their routine jobs as it is or with required modifications. Introduction of pilot HI under selective Shushasthyos definitely will generate new responsibilities for its staff. This necessitates deployment of staff apart from the existing human resources in each Shushasthyo who will perform the emerging extra workload. The present staffs of a Shushasthyo include one Medical Officer, two Family Welfare Visitors/Nurses/Paramedics, one Aya and one Cook. Based on the workload, 3-4 local Community Motivators will be deployed to each HI working area who will be entirely responsible for community motivation, premium collection, liaison between the social organisations, community and BRAC, assistance to the health service providers and other management functionaries, and manage problems at field level. Each area will have an accountant-cum-pharmacist. The existing BRAC management (particularly RDP and HNPP) at the upper echelons of the Shushasthyo will extend the supervisory services to the areas under the HI pilot. In each village, a Management Committee will be developed drawing representatives from various segments of the population and given orientation. Besides, there will be general Management Committees at Shushasthyo levels (SMCs).

3.2 Training of Staff – The respective old staff (from Shushasthyos and other programmes of BRAC) will be given extensive orientation for 2 days on the modus operandi of the project. The new recruits will undergo a weeklong training aiming to make them fully capable for effective implementation of project work. A training module may be developed. Resource persons from among the experienced agencies will be involved in training.

3.3 Organising the Community for Prepayment for Health Services - Raising critical awareness of the key-person and opinion leader at household is the precondition for organising the people towards prepayment for health services. The CMs, Shushasthyo staff and other BRAC staff in cooperation with the community people including the Village Management Committee (VMC) and Shushasthyo level Management Committee (SMC) will impart education to the community on the importance of health services and health insurance by using the existing social organisations at villages, for example, landless cooperatives of NGOs, mosques, clubs etc. If the situation demands, they will need to organise alternative forums for the purpose on the one hand, and contact individually on the other. This will be a continuous in-built process of motivation and premium collection. But in the initial stage of the project, the motivational work should be done vigorously to conscientise the prospective potential participants of the scheme. Materials on information, education and communication (IEC) highlighting the features of the scheme, its importance including the premium rates, benefit of the scheme, referrals and other conditions will be

printed in Bangla and distributed. Besides, the IEC materials already developed by other agencies may also be used. The CMs and other grassroots workers will play a major role in developing IEC materials through learning by doing. However, the managers and Shushasthyo staff at various levels will also take active part in motivational work. Health insurance cards will be designed and printed for sale to the insured households. The CMs and other providers at grassroots will sale the cards.

3.4 Project Administration

Staff Supervision - As noted before, each project catchment area will have 3-4 CMs apart from the Shushasthyo staff and community workers. Each CM will be given a monthly endowment of Taka 1,000, while 10-15% of the premiums raised by a CM will be given as incentive each month. This system is expected to make the CMs self-propelling in motivational drive, collection of premiums, maintaining records, and help the management in day to day problem solving. The system will also give a lot of drive to the CMs to establish the scheme by increasing premium, and thereby increase their income by 10-15% in addition to the monthly endowment. The CMs and the Shushasthyo staff will be directly accountable to the Shushasthyo incharge. It is to be noted that the Shushasthyo staff will also play active role in motivational work along with premium collection. The Shushasthyo incharge will be reportable to the local........ The accountant-cum-pharmacist will primarily be responsible to the Shushasthyo incharge. The Shushasthyo incharge serves as a leader of the Shushasthyo's health care and CM team and is responsible for daily work, and schedules of visits to field, to satellite clinics based on the person strength and commuting time etc. The Shushasthyo staff is to follow-up the referral patients, as quality assurance measure of the services.

Progress Review – Each project office will arrange fortnightly meetings of the providers to review the progress of work, analyse the problems encountered and devise their possible solutions. There will be a monthly meeting where representatives from all the project areas including head office managers will attend to review the performance. Thus quality of the work will be tracked.

Accounts – The accountant will collect all the revenues including the revenues accrued from both card sale and user charges daily or weekly whatever is convenient at the end of daily or weekly work and will deposit the amount to BRAC accounts following the BRAC financial procedures. The local Shushasthyo management may have some financial responsibilities for the centre, and is expected to fund for stationeries, utilities and for managing referral cases. They may be allowed to spend some money locally for the purposes.

Recording and Reporting – An information system will be developed to serve the purpose of both the management functions and health information of BRAC, including membership registration, premium payment, service utilisation, drug order, purchase and sale, and financial accounting using a desktop computer or any other suitable mechanism available at

each facility. The health care team, the CMs and others involved in the process will use a daily contact log to register patients, and record their chief complaints, drugs prescribed or sold and referrals. Forms will also be designed for the monitoring of motivational works, premium collection, as well as high-risk individuals- defined as pregnant women, and individuals with serious ailments.

The Shushasthyo will collect service statistics from the persons involved in different layers below the Shushasthyo and compile the statistics, and prepare reports to send to higher tiers of management each month (Area Office, Regional Office, and Head Office). Reviewing the reports these offices will provide feedback to the lower tiers regularly for corrective measures. This will be a mandatory for all tiers.

Logistics – Generally the respective Shushasthyo especially the accountant will give indent to BRAC Head Office each month in advance and the HO will supply the indented items as per BRAC procedures.

HI Management Committees – Such committees will be formed at village and Shushasthyo levels. In each village there will be a 5-member Health Insurance Management Committee (VMC). The members will be drawn from all the social classes based on the villagers' consent. The CM of the respective village will act as member secretary of the VMC. Likewise, a broader committee can be formed for each Shushasthyo command area pooling representatives from each VMC, local elites, social leaders, NGO representatives and local doctors. The heads of the VMCs will be members of Shushasthyo level Management Committee (SMC) by virtue of their VMC membership. The Shushasthyo incharge will act as member secretary of the SMC. Both the committee members will visit villages to explain to the people about the role of VMCs and SMCs in HI scheme. They will motivate the people to participate in the scheme, to pay premium, and how to pay it. They will help resolve any emerging problem at community level.

Role of Different Programmes of BRAC – Although the project will be a tripartite initiative of Health and Population Division, Essential Health Care and RED, Rural Development Programme and BRAC Education Programme are expected to play a partnership role to make the project successful. These programmes can effectively mobilise the community to participate in the scheme by using their human resources and networks. On the other hand, RED will involve mainly in designing, planning, documentation, monitoring and evaluation of the project. It will also extend possible technical assistance to the project for its effective implementation.

Project Area: The will be implemented in two areas of Narsingdi district (Description be added).

Shushastho Service Provisions

The following facilities and services are routinely available at Shushasthyo (BRAC Health Centres):

1. Out-patient Services

1.1 Registration, waiting and health education;
1.2 Need-based counselling (STD/RTI; Family Planning; Breast-feeding and Nutrition);
1.3 Consultation, examination, prescription and drug dispensing for general disease as attached in Appendix-3;
1.4 Ante-natal and post-natal care;
1.5 Family planning services (Pill , Condom, injectables);
1.6 Immunisation and Growth monitoring; and
1.7 Minor surgical services for abscess, small cut injury, wound repair, surgical dressing.

2. Indoor Services

2.1 Normal vaginal delivery with or without episiotomy;
2.2 Pregnancy related complication (hyperemesis, PET);
2.3 Menstrual Regulation (MR);
2.4 Clinical family planning services (IUD, Sterilisation); and
2.5 Paediatric care for pneumonia, diarrhoea, malnutrition and other manageable illness.

3. Emergency Services (First-aid/resuscitation) and Referral

3.1 Medical and surgical (Shock, Hypertensive crisis, acute abdomen etc.);
3.2 Obstetrical (Complicated labour, Haemorrhage;
3.3 Paediatric (Premature delivery, Low birth weight, Neonatal asphyxia, Neonatal sepsis, Septicaemia, Very severe disease, Convulsion, etc.); and
3.4 Referral advise and suggestions on services, health facilities, mode of transport and costs.

4. Pathological Services

4.1 Clinical: Hb%, TC, DC, ESR, Urine R/E, Stool R/E;
4.2 Biochemical: Blood Sugar (Random/Fasting), Serum Bilirubin;
4.3 Immunological: Blood Grouping, Pregnancy test, Widal, RPR, RA test, ASO titre, HBsAg; and
4.4 Microbiological: Sputum for AFB, Gram staining, Malarial Parasite.

5. Essential Drug Services:

5.1 Availability of essential drugs (see Appendix-2); and
5.2 Drug dispensing.

Appendix-2

Shushatho Drugs Provisions
(Routine)
(IN GENERIC NAMES)

Name of Drug	*Presentation (Form)*
ANTIBIOTIC:	
1. Penicillin-V (Phenoxymethyl Penicillin)	Tablet; Syrup
2. Benzathin Penicillin	Injection
3. Cotrimoxazole	Tablet; Syrup
4. Amoxycillin	Capsule; Syp; Paed. Drop
5. Cloxacillin	Capsule; Suspension
6. Cephalosporin (Cephalexin)	Capsule; Suspension
7. Doxycycline	Capsule
8. Ciprofloxacin	Capsule
9. Erythomycin	Tablet; Suspension
10. Nalidixic Acid	Tablet
ANTI-PYRETIC / ANALGESIC / NSAID:	
11. Paracetamol	Tablet; Suspension
12. Diclofenac Sodium	Tablet; Suppository
13. Ibuprofen	Tablet
BRONCHODILATORS:	
14. Aminophyllin	Tablet
15. Salbutamol	Tablet, Syrup

ANTIHISTAMINIC:

16. Chlorpheniramine Maleate	Tablet; Syrup
17. Promethazine Hydrochloride	Tablet; Syrup
18. Mebhydroline	Tablet

ANTI-EMETIC:

19. Metoclopramide	Tablet; Syrup; Paed. Drop
20. Prochlorprazine	Tablet

ANTI-AMOEBIC:

21. Metronidazole	Tablet
Name of Drug	***Presentation (Form)***

ANTI-MALARIAL:

22. Chloroquine	Tablet; Syrup

ANTHELMINTIC:

23. Mebendazole	Tablet; Syrup
24. Levamisole	Tablet; Suspension
25. Albendazole	Tablet
26. Pyrantel Pamoate	Tablet; Suspension

ANTI-SPASMODIC:

27. Hyoscin-N-Butylbromide	Tablet

CARDIOVASCULAR DRUG:

28. Propranolol	Tablet
29. Atenolol	Tablet
30. Nifedipine	Tablet
31. Methyldopa	Tablet
32. Enalapril	Tablet

SKIN DISEASE:

33. Benzyle Benzoate	Emulsion
34. Neomycine + Bacitracin	Ointment
35. Betamethasone + Neomycine	Ointment

36. Benzoic Acid + Salicylic Acid	Ointment
GIT PROBLEM:	
37. Antacid	Tablet; Susp
38. Ranitidine Hcl	Tablet
39. ORS	Sachet
VITAMINS / HEAMATINICS / MINERALS	
40. Iron + Folic Acid	Tablet; Syrup
41. Vit-B Complex	Tablet; Syrup
42. Vit-C (Ascorbic Acid + Sodium Ascorbate)	Tablet
43. Riboflavin	Tablet
44. Calcium Lactate	Tablet

Name of Drug	***Presentation (Form)***
SEDATIVES/TRANQUILIZER	
45. Diazepam	Tablet
46. Clobazam	Tablet
DIURETICS:	
47. Frusemide	Tablet
EYE/ENT DISEASE:	
48. Chloramphenicol	Eye/Ear Drop
49. Xylometazoline Hcl (Nasal Decongestant)	Nasal Drop
ANTI-FUNGAL:	
50. Clotrimazole	Cream; Vaginal Tablet
51. Econazole Nitrate	Cream
52. Nystatin	Oral Suspension
CONTRACEPTIVES:	
53. Femicon	Tablet
54. Nordette-28	Tablet
55. Raja	Condom
56. Panther	Condom

LIST OF EMERGENCY DRUGS FOR SHUSHASTHO
(GENERIC NAMES)

Name of Drug	*Presentation*	*Amount*
1. Inj. Amoxycillin (250 mg)	Vial	4
2. Inj. Gentamicin (20 mg)	Ampoule	3
3. Inj Ceftriaxon	Vial	3
4. Inj. Hydrocortisone (100 mg)	Vial / Ampoule	3
or		
5. Inj. Dexamethasone (5 mg)	Ampoule	2
6. Inj. Lignocain	Vial	1
7. Inj. Methyl Ergometrin (0.2 mg)	Ampoule	5
8. Inj. Oxytocin (5 Int'l Unit)	Ampoule	5
9. Inj. Atropine Sulphate (0.6 mg)	Ampoule	50
10. Inj. Diazepam (10 mg)	Ampoule	5
11. Inj. Pheniramine Maleate (15 mg)	Ampoule	5
or		
12. Inj. Chlorpheniramine Maleate (10 mg)	Ampoule	5
13. Inj. Frusemide (20 mg)	Ampoule	5
14. Inj. Adrenaline (1 mg)	Ampoule	5
15. Inj. Calcium Gluconate (10% w/v in 5 ml)	Ampoule	5
16. Inj. Sodium-bi-Carbonate (7.5% in 10 ml)	Ampoule	5
17. Inj. Magnesium Sulphate		
18. Inj. Diclofenac Sodium (75 mg)	Ampoule	5
19. Inj. Ranitidine Hydrocloride	Ampoule	5
20. Inj. Hyoscine-N-Butylbromide (20 mg)	Ampoule	10
21. Inj. 25% Glucose (25 ml)	Ampoule	10
22. 5% Dextrose in Aqua (500 ml)	Bag	5
23. 5% Dextrose in Normal Saline (500 ml)	Bag	5
24. Normal Saline (500 ml)	Bag	5
25. Cholera Saline (500 ml)	Bag	5

Note: This medicine is to be kept in separate box labeled as EMERGENCY SUPPLIES and only be used with physician's prescription and under direct supervision of attending physician.

Appendix-3

Morbidity Pattern of Shushasthyo
(January – March, 2000)

Sl #	*Diseases/Conditions*	*Number of Cases*	*%*
1	Peptic Ulcer	16382	17%
2	Leukorrhoea/Vaginal discharge	5988	6%
3	Acute Respiratory Infection (ARI) / Pneumonia	5114	5%
4	Helminthiasis / Worm	5040	5%
5	Anaemia	4465	4%
6	Bronchitis	4448	4%
7	Urinary Tract Infection (UTI)	3950	4%
8	Fever / Pyrexia of Unknown Origin (PUO)	3871	4%
9	Dysentry	3284	3%
10	Arthritis	3259	3%
11	Chronic Bronchial Asthma	2971	3%
12	Hypertension	2387	2%
13	Fungal Infection/Ring Worm	2138	2%
14	Otitis Media	1805	2%
15	Lower Abdominal Pain / Pelvic Inflammatory Disease (PID)	1624	2%
16	Migrain / Headache	1461	1%
17	Scabies	1407	1%
18	Tuberculosis	1374	1%
19	Diarrhoea	1300	1%
20	Incomplete Abortion/MR	1146	1%
21	Allergic Reaction / Anaphylaxis	1082	1%
22	Snake bite/Dog bite/Insect bite	1061	1%
23	Malnutrition / Protein Energy Malnutrition (PEM)	883	1%
24	Eczema	826	1%
25	Tonsilitis	803	1%
26	Pharyngitis / Laryngitis	754	1%
27	Injury / Trauma	752	1%
28	Eye Disease / Infection	746	1%
29	Others	18937	19%
Grand Total		*99258*	*100%*

Appendix-4

Details of Cost Analysis for
Estimation of Premium and Co-payment

The amount of premium and the benefit package have been set based on the assessment and analysis of morbidity pattern ***(Appendix-3)***, the categories (BRAC VO, Other NGO VO, Non-VO, Hard Core Poor) of client attended the Shushasthyo, and the maximum uptake of clients per months per centre. In 1999, experience showed that the maximum monthly client load was 1100 per month (average 800 per month) at Fashitala Shushasthyo.

In the current approach of service delivery and financing (user fee), the actual average monthly costs of operating a Shushasthyo (Fashitala, Bogra) in 1999 was Tk. 45,000 and the average monthly income was Tk. 22,923. An analysis of income and expenditure in 1999 showed that the unit cost per patient treated was Tk. 41. The average income from a patient was Tk. 32 from a comprehensive package of Shushasthyo services and Tk. 9.00 from the outpatient consultation only.

In 1999, experience showed that the maximum monthly client load was 1100 per month (average 800 per month) at Fashitala Shushasthyo. In the current approach of service delivery and financing (user fee), the actual average monthly costs of operating a Shushasthyo (Fashitala, Bogra) in 1999 was Tk. 45,000 and the average monthly income was Tk. 22,923. An analysis of income and expenditure in 1999 showed that the unit cost per patient treated was Tk. 41. The average income from a patient was Tk. 32 with comprehensive package of Shushasthyo services and Tk. 9.00 from the outpatient consultation only. With the user fee system, the trend of clients categories in 1999 showed 70% BRAC VO, 15% other NGO VO, 13% Non-VO, and 2% hard-core poor (non-VO poor). The vast majority (95%) of the clients attended for consultation that contributed 55% of total income and the other package's contribution were 32% drugs, 8% indoor (mainly delivery) and 5% pathology.

The estimated population within a Shushasthyo's working area is 30,000 on average within 3 km of its radius that represents 6,000 households (HHs). With the disease prevalence rate of 138 per 1000 population (BBS, 1998), the estimated number of sick persons in 6,000 HHs within a period of 15 days would be 4140 (.138 x 30000). So, within a period of one month the total number of sick persons around 3-km radius of a Shushasthyo would be 8280.

Again, based on the statistics of health care seeking behaviour of 15% who seek care from static facility, out of these 8280 sick persons, a total of 1242 persons would come at Shushasthyo in a month provided 6,000 HHs are registered to be insured under this project. If we set a target to register 50% of the HHs that covers 3,000 HHs, then the estimated

number of sick persons who would seek care from the facility would be 621. Considering the doubling effect of insurance system on seeking behaviour, the estimated number of patients to be attended at Shushasthyo will be 1242. The experience shows that with the current staffing pattern and the service package available, a Shushasthyo can satisfactorily take care of this number of patients in a month.

According to the household survey done in December 1999 in Reproductive Health and Disease Control (RHDC) project area, the categories of households/population were as follows:

Category	*Description*	*Surveyed Proportion (%)*
CAT-A	NGO VO Members	37%
CAT-B	Non-Poor Non-members	40%
CAT-C	Poor Non-members	21%
Cat-D	Ultra Poor Non-members	2%

In order to attain 3,000 HHs to be registered with the insurance provision, the following targets have been set. Based on this calculation, the number of the population under the defined categories would be as follows:

Category	*Description*	*Insurance Target (%)*	*Estimated Households*
CAT-A	NGO VO Members	60%	1800
CAT-B	Non-Poor Non-members	20%	600
CAT-C	Poor Non-members	15%	450
Cat-D	Ultra Poor Non-members	5%	150
Total		100%	3,000

With a target of 100% achievement of registering 3,000 households by 3rd year of project operation, the cost analysis below with the set payment structures (premium and co-payment) shows that is required to attain 100% cost-recovery.

Cost Analysis for setting-up of Premium for Package-A

A) Monthly Expenditure for Providing Package-A:

Item	Amount
A.1 Monthly Operation Cost of a *Shushatsho*	45000
A.2 Monthly allowances for the community motivators	4000
A.2 Cost of providing subsidised services (Path)	4800
A.3 Costs of providing safety net services	600
Total	54400
So, the Annual Cost for package-A (54400x12)	**652800**

Safety net costs	
Path (60x.3x10))	180
Drugs (60x.05x50)	150
MSR (60x.1x20)	120
Transport (60x.05x50)	150
Total Safety net Cost	**600**

Subsidy Cost:	
Path (1200x.4x10)	4800
Total Subsidy cost	**4800**

B) Income from Package-A (with a maximum uptake of 1200 pt):

B.1 Income from Drugs Sale:

Cl cat	% Dist	# Client	Drug sold (Tk. 80/pt)	Inc/Surp (Avg 15%)	In/Annum
Cat-A	60%	720	57600	8640	
Cat-B	20%	240	19200	2880	
Cat-C	15%	180	14400	2160	
Cat-D	5%	60	0	0	
Total			91200	13680	164160

B) Income from Package-B (with a maximum uptake of 1200 pt):

B.1 Income from Drugs Sale:

Cl cat	% Dist	# Client	Drug sold (Taka)	Inc/Surp (Avg 15%)	In/Annum
Cat-A	60%	720	57600	8640	
Cat-B	20%	240	19200	2880	
Cat-C	15%	180	14400	2160	
Cat-D	5%	60	0	0	
Total			91200	13680	**164160**

B.2 Income from pathology:

Cl cat	% Dist	# Client	# Pt-Test (25% pt)	# of Test (Avg 2/Pt)	Income (Tk. 5/T)	In/Annum
Cat-A	60%	720	180	360	1800	
Cat-B	20%	240	60	180	900	
Cat-C	15%	180	45	135	675	
Cat-D	5%	60	0	0	0	
Total			285	675	3375	**40500**

B.3 Income from co-payment:

Cl cat	% Dist	# Client	Co-P rate	Income	In/Annum
Cat-A	60%	720	4	2880	
Cat-B	20%	240	7	1680	
Cat-C	15%	180	5	900	
Cat-D	5%	60	0	0	
Total				5460	**65520**

Income other than Premium per annum **270180**

So, the amount of premium to be collected **1109820 (Tk. 1380000 - 270180)**

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B.4 Income from premium:

HH cat	% Dist	# HHs	Prem rate	Collection	Incentive (5%)	Refund (.2 of. 1 hh)	Income
Cat-A	60%	1800	350	630000	31500	12600	585900
Cat-B	20%	600	550	330000	16500	6600	306900
Cat-C	15%	450	400	180000	9000	3600	167400
Cat-D	5%	150	0	0	0	0	0
Total				1140000		22800	**1060200**

In the above premium rate there is a shortage of the following amounts for 100% cost recovery:

Total expenditure per annum	1380000
Total income	1330380
Shortage in a year	49620
In a month	4135

This 4135 per month need to be raised from the non-insured household (50%) with the current user fee structure

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