Bangladesh Health Watch Report 2011

Moving Towards Universal Health Coverage

BANGLADESH
HEALTH WATCH

071

Publisher:

BRAC
BRAC Centre, 75 Mohakhali, Dhaka 1212, Bangladesh
Telephone : 9881265, 8824180-87,

Fax: 880-2-8823542, 8823614
Website: www.brac.net/research

First published 2012

Copyright © Bangladesh Health Watch 2012

All rights are reserved. No part of this publication may be reproduced or transmitted in any form or by any means without prior permission in writing from the Bangladesh Health Watch. Any person who does any unauthorized act in relation to this publication may be liable to criminal prosecution and civil claims for damages.

The analysis and findings presented in this report are based on six studies commissioned and conducted by the Bangladesh Health Watch (BHW). The views expressed and the choice of the presentation of the facts both in the text and illustrations are entirely those of the BHW. The opinions expressed therein are not necessarily those of the BRAC and do not commit the organisation.

Cover design
Md. Abdur Razzaque

Page make-up
Md. Akram Hossain

Layout & Printing
Color Line, 01715 812345

ISBN 978 984 8815 27 4

Published by Bangladesh Health Watch, James P Grant School of Public Health, BRAC University, Mohakhali, Dhaka 1212, Bangladesh

072

Chapter 1

Universal Health Coverage: The Next Frontier

A. Mushtaque R. Chowdhury, Abbas Bhuiya, Natalie Phaholyothin and Faruque Ahmed

INTRODUCTION

Bangladesh has made important progress over the past few decades. This is particularly true in the social sector which led some observers to call it 'a near miracle' (Huq 1991). Many of the inequities and deprivations that characterized this nation historically has either been corrected or reduced significantly. In human development, life expectancy has increased by over 50% - from about 45 years in the early 1970s to over 65 years currently. More importantly, women now live a longer life than men, as expected biologically and experienced around the world. The infant mortality rate has reduced from about 150 per 1,000 live births three or four decades ago to 51 in 2007 (NIPORT *et al.* 2009). The recent report of decline in maternal mortality ratio to under 200 per 100,000 births bears testimony to the nation's ability to address the pervasive social issues. Many strides have also been made in education, particularly at the primary level. The net enrolment rate has reached nearly 90%. Here also, the gender inequity has been removed. At the time of independence in 1971, girls' enrolment in school was about half of boys which has now been corrected with girls going to school in the same rate as boys (CAMPE 2009). The agricultural production has been trebled over the years since independence outpacing the population growth which just doubled during the same period.

However, challenges remain. Although Bangladesh is poised to achieve a few of the millennium development goals such as child health by 2015, the country has to strive harder to compete with others in South Asia such as Sri Lanka. It appears that the country has harvested all the 'lower hanging' fruits very successfully. So, the next challenge is to identify and act on the more difficult and formidable ones. The issues in health systems strengthening such as efficiency and good governance will require increased attention in the immediate future if Bangladesh has to move forward with the same pace of progress.

One of the important building blocks for a health system is financing. Health financing, in general, has three objectives, viz., generate resources (revenue collection), use resources optimally (purchasing), and ensure financial access to health services by all citizens (pooling) (Normand and Weber 2009). Although health financing is commonly misconstrued as only revenue collection or generating resources, indeed, from a citizens perspective, it is more important to understand how is this resources used and who gets what. This chapter introduces the concept of universal health coverage (UHC) which deals more with the latter issues of resource redistribution.

Universal Health Coverage the next frontier

It is now well recognized that poverty is not just about income or employment. Poverty is the manifestation of a much deeper array of deprivations that includes healthcare, access to education and environmental protection. In health, it has been shown in Bangladesh and many other countries that income erosion through health shocks and catastrophic illnesses leads to impoverishment and further poverty. For many people living in low and middle income countries, health services is obtained through out-of-pocket (OOP) payments at point of service. Globally such costs account for 19% expenditures on health. But for low income countries such as Cambodia, Ghana, India, Pakistan or Vietnam, it accounts for over 50% of total health expenditures (Garrett *et al.* 2009). For Bangladesh, the OOP is nearly 60% (Rannan-Eliya 2010). Bangladesh has one of the highest rates of catastrophic illnesses, varying, depending on how it is defined, from 7 to 25% which drive up to 3.8% of the population or 5.7 million people into poverty every year. According to a World

Bank report, health is the most important shock that happens to Bangladeshis accounting for 22% of all shocks (WB 2008). High OOP payments restrict long-term economic survival and lead to further poverty and impoverishment. Worldwide, 150 million people suffer serious financial hardships and up to 100 million people are forced into poverty (Carrin *et al.* 2008). Based on a study across many countries, Krishna (2010) found health shocks as the main reason for people falling into poverty. It has been argued that catastrophic health spending is not necessarily caused only by high cost medical procedure or any single hospitalization. A steady and continuous medical bill for chronic illnesses or disabilities can force people into poverty as well (WHO 2010).

Direct payments through user fees (formal and informal) deter people from using health services. It is estimated that about 1.3 billions of the world's poor cannot access healthcare because of their inability to pay. In Bangladesh, primary healthcare services are 'officially' free at *upazila* (sub-district) and levels below it. There is a nominal fee for services at tertiary and specialized hospitals. However, according to studies such as the Bangladesh Service Delivery Survey of 2003, 80% of the respondents reported paying for services, with 20% making direct payments to service providers (ILO/KFW Study team 2008). In addition, problems in terms of the quality of care such as the absenteeism of personnel, shortage of medical supplies and behavioural issues discourage people, particularly the poor, from accessing services at government facilities. They either forgo care or turn to private practitioners. It is well known that the private caregivers in great majority are informal providers who provide services of unknown or doubtful quality (BHW 2008).

The cycle of illness, impoverishment, and further poverty is best interrupted by the introduction of pre-payment schemes and health insurance through UHC. The UHC promises a better way of paying for health services against the regressive OOP methods. Instead of burdening the poor and the sick, this shares the costs more equitably across all population. The origin of UHC can be traced back to Bismarck's Germany which adopted social legislation that included the Health Insurance Bill of 1883, Accident Insurance Bill of 1884 and Old Age and Disability Insurance Bill of 1889. In the first half of the twentieth century, other countries of Europe began to follow Germany in adopting UHC. In Britain, the National Insurance Act marked the first step that led to the creation of National Health Service after World War II. Article 25 of the Universal Declaration of Human Rights in 1948 declared health as a human right, thus strengthening the need for UHC. The adoption of 'Health for All' agenda at Alma Ata in 1978 reflected the continuing evolution of coverage for all.

The World Health Assembly in May 2005 endorsed a resolution urging its member countries to work towards health financing, defining UHC as access to appropriate health services for all at an affordable cost. The 64th World Health Assembly in May 2011 re-emphasized the 2005 resolution and endorsed the various activities undertaken towards institutionalizing UHC in member countries and called upon the Director General to work towards having a UN General Assembly resolution on the subject (see Box 1.1 for the May 2011 resolution). The 2010 World Health Assembly has convened an international advisory panel for the Ministerial Working Group on Scaling up Primary Health Systems, with an emphasis on achieving UHC. The 2010 World Health Report was devoted entirely to universal health coverage, stressing that "reaching the 'highest attainable standard of health', as stated in the WHO Constitution, requires a new or continued drive towards universal coverage in many countries" (WHO 2010). The Executive Board of the WHO, of which Bangladesh is an active member, has recently decided to recommend a new resolution in the World Health Assembly to endorse UHC in stronger terms: "to ensure that health financing systems evolve so as to avoid significant direct payments at the point of delivery, and include a method of pre payment of financial contributions for health care and services, as well as a mechanism to pool risks among the population in order to avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking the care needed" (EB128/SR/10). Preparations are also being made to table a resolution in the UN General Assembly in September 2012 along the same line. Nobel Laureate Professor Amartya Sen and many other high profile personalities including human rights activist and former President of Ireland Mary Robinson and Harvard University Dean Julio Frenk have also signed up as 'global ambassadors' to promote the case for UHC.

Box 1.1. World Health Assembly Resolution 58:33, May 2005 on universal health coverage

The 64th WHA urges the member states, inter alia:

(1) to ensure that health-financing systems evolve so as to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health care and services as well as a mechanism to pool risks among the population in order to avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking the care needed;

(2) to aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity, so as to provide an adequate scope of health care and services and level of costs covered, as well as comprehensive and affordable preventive services through strengthening of equitable and sustainable financial resource budgeting;

(3) to continue, as appropriate, to invest in and strengthen the health-delivery systems, in particular primary health care and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

(4) to ensure that external funds for specific health interventions do not distort the attention given to health priorities in the country, that they increasingly implement the principles of aid effectiveness, and that they contribute in a predictable way to the sustainability of financing;

(5) to plan the transition of their health systems to universal coverage, while continuing to safeguard the quality of services and to meet the needs of the population in order to reduce poverty and to attain internationally agreed development goals, including the Millennium Development Goals;

(6) to recognize that, when managing the transition of the health system to universal coverage, each option will need to be developed within the particular epidemiological, macroeconomic, sociocultural and political context of each country;

(7) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government-inclusive stewardship;

(8) to promote the efficiency, transparency and accountability of health-financing governing systems;

(9) to ensure that overall resource allocation strikes an appropriate balance between health promotion, disease prevention, rehabilitation and health-care provision;

(10) to share experiences and important lessons learnt at the international level for encouraging country efforts, supporting decision-makers, and boosting reform processes;

(11) to establish and strengthen institutional capacity in order to generate country-level evidence and effective, evidence-based policy decision-making on the design of universal health coverage systems, including tracking the flows of health expenditures through the application of standard accounting frameworks;

According to WHO, the health financing system for a country should be designed in such a way that it (a) provides all its citizens access to needed and sufficiently good quality health services (including prevention, promotion, treatment and rehabilitation), and (b) ensures that use of these services does not lead the user to financial hardship (WHO 2010, Carrin *et al.* 2008). Although the models vary by country, the fundamentals of UHC include:

- Instituting risk-pooling and an equitable health system where the ability to pay determines financing contributions and the use of services is on the basis of needs for care
- Reducing user fees and other out-of-pocket payment
- Increasing the level of pre-payment in order to maximize the size of the pool.

Indeed, there is hardly any country in the world where some population groups are not covered at all (Wagstaff 2010). There are two ways through which countries are trying to reach UHC: the state financed National Health Service (NHS) as implemented in UK (also called the *Beveridge model*) and the insurance based model as implemented in Germany and many other countries (also called the *Bismarck model*). With the

Ministry of Health and Family Welfare being the provider of both financing (through salaries of health staff, and meeting costs of supplies and hospitals, etc.) and services, Bangladesh may be considered a NHS model. However, with very high OOP and inefficient use of resources, as mentioned above, Bangladesh seems to be an unsuccessful and failed example for the model. The challenge is whether and how the country can move to an insurance-financed model?

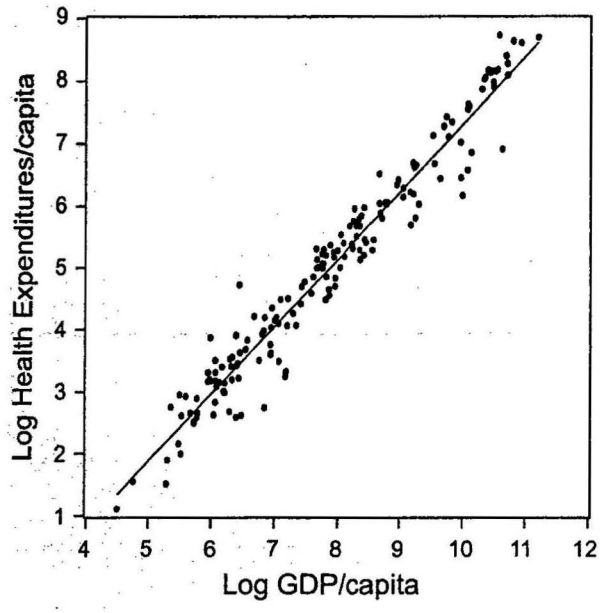
Why UHC?

The WHO defined universal health coverage or UHC as 'access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access (WHO 2005). There is hardly any difference of opinion on the merit of and need for UHC. Indeed, all countries and leading health agencies have enthusiastically endorsed it. Dr. Margaret Chan, the director general of WHO said, 'All countries, at all stages of development, can take immediate steps to move towards universal coverage (WHO 2010). Lamenting the failure to ensure UHC, leading medical journal the Lancet said, 'That universal coverage is so distant for so many people is unacceptable' (Lancet 2010).

There are at least three major reasons for countries to act fast on moving towards UHC. Briefly, these are:

1. It is ethically and morally correct; it represents social solidarity for poor and ill people as its successful implementation ensures health service to them
2. It is economically feasible; in line with the *first law of health economics*, spending on health is growing rapidly with the unprecedented growth of the economy as a proportion of the GDP, with an R-squared of 0.96 (Fig. 1.1 for 2004 figures). The increased health spending can be opportunistically utilized to meet the extra requirements for UHC. A small marginal investment can bring big return as has been shown in case of Ghana where an additional US$40 per year for six years spearheaded a big jump towards UHC (Rockefeller Foundation 2010).
3. It is politically timely; as democracy holds its foot in many countries the governments find it advantageous to win popular support through UHC reform as seen in Thailand (Pitayarangsarit 2004), Mexico and Brazil.

Figure 1.1. Link between total health spending and GDP, 2004



Source: Gaag and Stimac (2008)

For Bangladesh, the run-away OOP expenditures and the number of people moving to poverty due to health shocks and catastrophic spending every year are absolutely unfortunate and not acceptable, either morally or ethically. For any country it is an 'avoidable tragedy' (Bennett *et al.* 2010). For any popularly elected government this should be an issue of immense political significance. The civil society has been clamouring for reforms that would reduce the burden on the poor and other disadvantaged groups. With a marginal increase and simple readjustment of the current spending, Bangladesh can perhaps quickly move *towards* an effective UHC. With a lower base of capital assets and human resources, it will probably take many years to achieve a full-fledged UHC. As has been shown for many countries, with right policies and strategies, and more importantly, political commitment, Bangladesh can achieve substantial progress quite rapidly. According to a recent report, UHC is essentially a 'journey'; it starts with a broad coverage of a larger section of the population with a limited set of benefits but as countries consolidate and more resources are available the benefit package increases. It has been shown that substantial progress can be made in a short period of time if right vision, policy and strategies are adopted (Rockefeller Foundation 2010).

The example of China is relevant here. Before 1978, basic services were made available to all virtually free. With the transition to a more market-based approach the direct payments increased to 60% (from 20% in 1980). In 2009, the Chinese government reverted its earlier decision and decided to return to UHC and provide 'safe, effective, convenient and affordable' care to all (Meng and Tang 2010, WHO 2010).

Three challenges for UHC

The WHO report 2010 identified three challenges for countries moving towards universal health coverage. It also opined that every country could do more in addressing such challenges. Here are they:

Raising resources for health: Inadequacy of resources for health is a perennial problem. This is true irrespective of whether the country is rich or poor. Interestingly, achievement of UHC is not always related to the country's wealth. The United States with a per capita health spending of US$ 7,000 achieved almost the same coverage as Rwanda which has a per capita spending of US$ 37. It is essentially the way the countries decide to use their scarce resources. Nevertheless, implemen-ting UHC will require additional resources and many countries have found innovative ways to raise this. Indonesia, for example, has been able to raise its tax collection by encouraging compliance, a part of which is used for health. Ghana, as another example, meets most of its funding needs for its national health insurance scheme through a 2.5% levy on VAT. Bangladesh spends only US$ 16 per capita for health annually, a part of which comes from development partners. The country's tax base is small, only about 9% of GDP, one of the lowest in the world. However, there may be innovative ways to mobilize internal resources. These may include new taxes (earmarked and un-earmarked), diaspora bonds for the large number of overseas Bangladeshis, and (additional) excise tax on unhealthy products such as cigarettes, foodstuff and ingredients. The WHO 2010 report recommends many such innovative financing mechanisms. Improving the nego-tiating capacity of MoH with MoF could yield positive results in terms of increased allocation for health in the national budget paving the way for quick transition to UHC. More importantly, with the rise in the country's GDP, there will be more money available for health. A recent analysis shows that between 1998 and 2007, nominal growth rate of GDP per capita was 8.5% per annum whereas health expenditure rose by 11.1% (PI consulting 2011).

Reducing out-of-pocket expenditures: The devastating effects of user fees and direct payments (formal and informal) have been described already. A best way to deal with this is to share it. While on average only 5% of people fall ill in a given year, these people bear the brunt of national health spending. Introduction of some form of insurance or risk pooling is recommended as an effective measure to curb OOP spending. Similar to home or car insurance, which is used to protect oneself in case of an 'unplanned' emergency (a legal requirement in many countries), health insurance pools risk across the nation (or for a particular group in the population) and is used only in case of 'unplanned' ill health or health-related emergency (Rockefeller Foundation 2010). The 2010 WHO report narrated the story of a poor Thai casual labourer who met with a serious accident involving his motorcycle and describes how the UHC scheme helped him pay for all his treatment costs, recover and resume his normal life. However, the efficiency of such a risk-pool depends to a large extent on its size, the bigger the pool the more efficient and effective it is. The pooling is a most important aspect of UHC and will be covered in more detail subsequently.

Reducing inefficient and inequitable use of resources: Calling it 'haemorrhaging of money', the 2010 WHO report estimates that 20-40% of health resources worldwide are wasted. Reducing this waste would definitely help health systems perform better, reach more people with effective services and reduce inequity. Apart from cutting costs which maybe possible in selected cases, large gains can be made by improving governance. The 2010 WHO report identified ten leading causes of inefficiency in the health systems which included eliminating unnecessary spending on medicines, equipment, diagnostics and hospitalization, inappropriate staff mix and increasing their motivation, reducing medical errors and containing health systems leakages through waste, corruption and fraud. Having an insurance mechanism which separates providers from purchasers can help reduce inefficiency by introducing some form of pay for performance at different levels of services.

Risk-pooling and health insurance

Risk pooling (in health) has been defined as the 'aggregation of individual financial contributions to cover the total health costs of a broader population' (Lagomarsino and Kundra 2008). Risk pooling and pre-payment are integral to any insurance product, including health insurance. Indeed, there are three elements in any health insurance plans: revenue (premium) collection, pooling of all revenues into a common fund and its management, and purchasing (meaning transfer of health pool money to providers of health for providing the best possible services to the insured). Researchers have identified several benefits for a health insurance system as a way to ensure health services to all:

- Reduces out-of-pocket spending
- Improves final risk protection to all, particularly the poor and vulnerable
- Increases access to care and its utilization
- Improves quality of care
- Enhances equity
- Empowers women to seek care for themselves and their children
- Increases accountability and transparency of health system
- Gives freedom to people to choose providers thereby improving quality.

There are three types of health insurance systems that are commonly implemented in different parts of the world (Ensor 2007). These are:

Social health insurance (SHI): Much of the health insurance implemented in Germany and other OECD countries (the so-called Bismarkian model) belong to this type. This is financed largely from earmarked pay-roll tax based on both employee and employer contributions calculated as a percentage of earnings. As it stipulates collecting contributions from the payroll, it is a less appropriate mechanism for the informal sector, and that is for the many developing countries where the formal sector is small. In some countries, social health insurance is supplemented by other schemes that purport to cover others. In Vietnam, for example, the SHI covers the formal sector but to cover others the government has introduced separate schemes for the poor, young children and the elderly with state subsidies and voluntary schemes to include the 'nearpoor' such as farmers. This is now being extended to include the students as well (Tien *et al.* 2011).

Community or micro-insurance: In societies where there is a large informal sector, micro or community health insurance have been tried as an alternative. This is voluntary in most cases in the sense that the people or community members are given the choice to join or not. Since this is voluntary the pool is generally small leading to smaller benefits for the members. On the other hand, this is claimed to increase social solidarity as richer sections opt to contribute voluntarily on behalf of the community. Indeed, most of the SHIs that are implemented in most Bismarkian Europe can trace their origins to some forms of community schemes based around workplaces implemented earlier. The SHI is resulted through merger of such small schemes. The Thai UHC can also trace their origin to a few smaller schemes (health card). Ghana, for example, has extended coverage by linking several NGO-based schemes with social insurance (Ensor 2008). In Bangladesh, several NGOs are implementing community-based micro-insurance schemes with mixed success. One challenge with the community-based schemes is subsidizing for the poor. As mentioned by Ensor (2008) some level of government subsidy would entitle the poor to reap benefit of such schemes.

Private insurance: Private or commercial insurance is another way to insure for health. The private companies usually assess individual risk as a basis for premium calculations and pool risk of those buying insurance. In some countries such as India, the government contracts private insurance companies to provide insurance service to schemes financed by the state. The Rashtriya Shwasthya Bima Yojana (RSBY) is an example in this regard (see later).

Lagomarsino and Kundra (2008) have documented various health insurance schemes implemented in low and middle income countries. In their opinion, the 'transition to a national health insurance model requires either a wholesale shift in existing government health expenditures away from direct delivery and into insurance, or a significant increase in funds from another source (such as general taxation, payroll-taxes and donations)'. There are only a few examples of government-led reforms. Rwanda, Ghana, and some states in India are among in this list of countries.

Rwanda has done it with support from donors, particularly the Global Fund and the state of Andhra in India has done it through generous support from the central government. Other countries such as Colombia, Philippines and Thailand have used the opportunity of higher economic growth that facilitated more money for health. The community-based schemes also offer hopes as they may become building blocks for a future and larger national coverage scheme.

Dror (2006) studied the perceptions of the Indian poor population in seven states and found that most people were ready to pay for health insurance. As the poor were heterogeneous, he suggested that any insurance product should respond to their 'context specific needs, costs and willingness to pay levels'. He concluded that there was a solvent market for health insurance among the poorer population of India.

Experiences

As has been mentioned earlier, many countries have made significant progress in their march towards UHC in recent times. They comprise of countries from both low and middle income backgrounds. However, each country has taken a different strategy based on its own socioeconomic context, health status and political will. In the following we narrate the cases of four countries where significant attention has been given to UHC and important progress made. Table 1.1 shows how these countries have addressed different issues related to UHC implementation (Joint Learning Network 2010, Tangcharoensathien *et al.* 2011, Rockefeller Foundation 2010, WHO 2010, World Bank 2008).

Thailand: A long but successful road to UHC

In 1963, Thailand's formal health coverage was estimated to be 9%. In 1975, the Thai government introduced the Medical Welfare Scheme (MWS) or "Free Medical Care for Low Income" funded through general taxation, raising the coverage rate to 20%. This marked the beginning of Thailand's transition to UHC. In 1980, the Civil Servant Medical Benefit Scheme (CSMBS) was created to cover for government employees, their dependents and retirees.

Recognizing the problem of high OOP payments which was highly regressive, the Thai Ministry of Public Health (MOPH) initiated the Health Card Scheme (HSC) in 1990 that was voluntary in nature and subsidized by the state. The voluntary nature of HSC led to problems of bias selection with the healthy opting out but the sick seeking to be a member. In addition to targeting the poor and near-poor through voluntary health cards, MOPH implemented in 1992 the compulsory Social Security Scheme (SSS) whereby all private employees must contribute to a common fund through a tri-party arrangement: employees, employers, and the central government. This scheme now includes all private companies including those small businesses with only 1 employee. This type of scheme utilizes the notion of "risk-pooling" to maximize resources. In addition, in 1993, the Thai government introduced free medical care for children and subsequently, in 1995, for the elderly defined as 60 years and above.

In 1997, the Financial Crisis struck Thailand with devastating impacts on the near poor, poor and lower middle class. The adverse economic impacts of the Crisis lent a push towards reforms which ranged from political to financial as well as allowed health to be on the political agenda. The momentum for change and new bold policies resulted in the election of Thaksin Shinawatra from the Thai Rak Thai (TRT) party, in 2001, who won by promising populist policies which include the '30 Baht' Health Care Scheme.

In 2001, the four existing health schemes mentioned above, combined with a small percentage of private health insurance, covered approximately 75% of the population. The adoption of Thaksin's '30 Baht' scheme, which required the patient to pay 30 Baht (approx. 1 USD) per medical visit, steadily put Thailand onto attaining UHC. From 2006, the Democrat Party's government abolished the 30 Baht co-payment except for non-emergency services from unregistered facilities, and all Thais are eligible to utilize public medical services under the Universal Coverage Scheme (UCS), which are financed through general taxation. Currently, approximately 98% of all Thais are covered under the UCS (Table 1.1).

Ghana: UHC through community-based health insurance schemes

In 1957, Ghana gained independence and began to provide healthcare to its population through a network of primary care facilities, which was financed through

general taxation as well as contributions from international donors. In 1985, user fee was introduced that created greater inequities in health because access to basic and essential clinical services was limited by financial ability. Of the people who sought public healthcare they often faced catastrophic health expenditures which eventually resulted in bankruptcy.

In 1997, the Ghanaian government with support from development partners initiated a pilot project the National Health Insurance Scheme (NHIS). Before this, the Christian Health Association of providers began to experiment a 'community health insurance'. Soon, there were at least 57 district-wide health insurance schemes and over 100 other group-based schemes. In 2000, the New Patriotic Party (NPN) led by John Kufuorn was sworn into power, promising better healthcare and ending of user fees. In 2003, the parliament passed the National Insurance Act paving the way for the community-based NHIS. By 2009, there were 14.5 million people of Ghana were insured or approximately 70% of the population.

Financing under the community-based NHIS is done through several mechanisms:

- 2.5% health insurance levy added to VAT
- 2.5% from the Social Security and National Trust (2.5% deducted from payroll of formal sector workers)
- Interest earnings from the combined funds
- Allocations from the Ghanaian Parliament
- At local level, premiums from informal workers and subsidies from National Health Insurance Fund (NHIF)

Some of the challenges of the CBHI are that each of the mutual health insurance schemes that form the national scheme is actually operating as a separate risk pool. This implies that fragmentation remains an important issue as well as long-term sustainability of each community-based scheme (Table 1.1).

India: Health insurance for the 'below poverty line' population

Like Bangladesh, India's health care is financed through a variety of sources from individual OOP payments, central government and state tax revenues, donor assistance and private sector profits. It is estimated that 20% of total healthcare spending in India is publicly financed while over 75% is paid for by individual, unpooled OOP. In 2008, the government of India launched the Rashtriya Swasthya Bhima Yojana (RSBY) programme in 2008 for those living below the poverty line (BPL), implemented by the Ministry of Labour[1]. The central and state governments co-finance the premium to the insurer who is selected based on a competitive bidding process. Beneficiaries contribute Rs.30 (approximately $0.66) to register for the programme in which coverage extends to a family of five members.

1. It may be mentioned here that RSBY is one of the many schemes being implemented, perhaps the largest in terms of enrolment and geographical reach. Another scheme which has gained international attention is the Rajiv Aarogyasree model being implemented in Andhra Pradesh. India is also home to many micro-insurance projects implemented by NGOs.

Table 1.1. UHC implementation in four countries

Country	Date implemented	Name of health scheme	Coverage achieved	Primary source of funding	Types of benefits	Provider payment mechanism	Service delivery system
India	2008	Rashtriya Swasthya Bhima Yojana (RSBY)	100 million	The primary source of funding is general government revenues. Members pay a registration fee of Rs.30. Insurance premiums are calculated at the state-level and vary from Rs.400 to 600.	Hospitalization coverage up to Rs.30,000 ($700) per year per household. Covers primarily inpatient care.	Diagnosis Related Groups (DRG)	A network of 2,067 hospitals (1,516 private and 551 public) that work with the insurance company selected by the state. Insurance companies are tasked with recruiting and overseeing service providers.
Ghana	2004	National Health Insurance Scheme (NHIS)	14.5 million (70% of pop.)	70% of total funding is from a 2.5% health insurance levy added to VAT. 23% comes from contributions made by formal workers to the Social Security and National Trust (SSNIT). 5% comes from Premium payments.	Benefits package offers extensive coverage. About 95% of health problems reported by Ghanaian healthcare facilities are covered under the NHIS. These include in-patient as well as out-patient services, as well as dental care and maternal care, including antenatal and postnatal care.	DRG	A total of 2,334 service providers (1,368 facilities are public providers and 966 are non-state providers) are part of the NHIS. A primary healthcare facility is the first point of service, and includes health centers, district hospitals, polyclinics, quasi public hospitals, private hospitals, clinics and maternity homes.
Rwanda	2002	Community-based Health Insurance (CBHI)	9 million (85% of pop.)	Premiums ranging from $4.30 to $19.90 depending on the programme. Co-payment is set between $0.17 to $0.16 per disease episode. The government covers the premium and co-payments for indigents and other vulnerable groups. The government and donors also contribute to the fund.	Two types of packages exist: 1) Minimum Package of Activities (MPA) covers all services and drugs provided at health care centers: pre/post natal care, vaccinations, family planning, minor surgeries and essential and generic drugs. 2) Complementary Package of Activities covers a limited number of services at district hospitals including hospitalization costs, caesarian operations, minor and major surgeries and all diseases afflicting children under 5.	Capitation	Public health centers, district hospitals, government-assisted health facilities and private health facilities provide primary and secondary care. Government-assisted health facilities account for 40% of primary and secondary care delivered in Rwanda, and are run by NGOs, religious groups and other third parties, and are partially funded by the government.
Thailand	2001	Universal Coverage Scheme (UCS)	66 million (98% of pop.)	The primary source of funding is general tax revenues. When the scheme was launched in 2001, a co-payment of 30 Baht (approx. $1) was charged per medical visit in order to discourage over-utilization. This was abolished in 2006 for political reasons. The utilization rate did not vary significantly after the end of the co-payment.	Benefits are comprehensive and include both out- and in-patient care. The Thai UCS also emphasizes preventive care such as vaccinations, family planning, ante natal care, as well as pre-marital counseling. Recently, ARV treatment for HIV and renal therapy have been included under the UCS.	Capitation and DRG	Providers under UCS include both public and private facilities. A private provider will have to submit the required documentation as well as meet the standard criteria set by UCS prior to registration as part of the scheme. Public facilities are automatically registered under the network. The Thai scheme emphasizes the primary care provider as the gatekeeper to UCS.

Sources: http://www.jointlearningnetwork.org (Last accessed 17/02/2011) Rockefeller Foundation, 2010

The benefits package include hospitalization expenses of up to Rs. 30,000 annually (approximately $700) per family per year. Most diseases and surgical treatments in which hospitalization is required are covered under the scheme. Package rates for approximately 727 inpatient surgical procedures have been pre-defined and these also include maternity and newborn care. Furthermore, the benefits include one day pre- and five days post-hospitalization expenses as well as a transportation benefit that covers Rs. 100 per visit to the patient. RSBY does not cover some forms of treatment or procedures such as OPD expenses or expenses in the hospital which do not require hospitalization, congenital external diseases, drug and alcohol induced illnesses and sterilization and fertility related procedures.

Key features:

- *Beneficiary empowerment*: RSBY provides the beneficiary the freedom in the selection of the hospital because they can access any public or private provider in RSBY's network all over the country.
- *Business model for all stakeholders*: RSBY is designed as a business model, with incentives built in for each stakeholder.
  - *Insurers*: The insurer is paid a premium for each household enrolled in RSBY.
  - *Hospitals*: Payment to the provider is made for each beneficiary treated. As such, both private and public hospitals are incentivized to treat an RSBY beneficiary. Insurers are incentivized to monitor providers that no fraud or duplications exist in order to keep payments under control.
  - *Intermediaries*: RSBY includes intermediaries such as NGOs and MFIs as these organizations have a stake in assisting those living below the poverty line (BPL). Intermediaries under the scheme also act as service providers and are paid for the services they render to BPL households.
  - *Government*: The inclusion of public service providers into the scheme makes for a competitive environment where the both the private and public providers have to engage in healthy competition.
- *Smart card*: Every household registered under RSBY is issued a smart card that includes their fingerprints as well as photographs. Patient information is retrievable through the smart card as information is electronically stored. All hospitals under RSBY are IT enabled and connected to the server at the district level.
- *Portability*: A beneficiary who has enrolled in one district can use his/her smartcard in any RSBY hospital across India. This makes the scheme highly user friendly to those families who have to migrate for work.
- *Cash-less*: Transactions under the RSBY scheme are completely cashless. Beneficiaries do not pay cash for any services except if they exceed the Rs. 30,000 per annum coverage package. Claims between providers and insurers are also paperless as these are conducted electronically.

To date, RSBY is operational in over 25 states in India and has issued smartcards to nearly 30 million BPL households covering 150 million individuals and over 2,500 hospitals are part of the scheme.

Rwanda: community-based health insurance schemes in a low-income country

Rwanda is a small, landlocked and low income country in Central Africa with 10.7 million inhabitants. It has gone through a devastating civil war and a genocide that left between 500,000 to one million people dead. Although much left is to be done, Rwanda has made remarkable progress despite the violence it has endured. Rwanda has restored its economy to the pre-1994 level as well as achieved political and social stability. Today, Rwanda has a GDP/capita of $951 compared to $390 in 1994 (PPP-adjusted). Life expectancy is 55 years for men and 58 years for women, 80% of the population lives in rural areas and an estimated 50% lives below the national poverty line. In 2004, Rwanda lost 597 disability-adjusted life years (DALY) per 1,000 lives more than double the world average and higher than nearly all of its Sub-Saharan African peers. In addition, Rwanda faces an acute shortage of physicians 2 doctors and 2 paramedics per 100,000 people.

Despite these daunting challenges, the government has committed itself to providing health coverage to its population. The Rwandan health care scheme began in 1999 with the initial design and development of prepayment services, followed by 54 community-based pilot health insurance (CBHI) schemes. Once these CBHIs were set-up, local populations began enrolling in the schemes. Families paid about $4.30 to enroll and

co-paid $0.17 per treatment episode. Within one year, 88,000 members were enrolled or about 8% of the population.

In 2002, the pilot was extended to cover the entire nation with CBHIs as the core strategy of health care coverage in Rwanda. The Ministry of Health, in conjunction with the Ministry of Local Affairs and external partners including the Global Fund designed scale-up models that now cover 85% of the population.

The Rwanda model has two benefit packages:

- The minimum package of activities (MPA) which covers all services and drugs provided at the health centers, including pre- and postnatal care, vaccinations, family planning, minor sur-geries and essential and generic drugs.
- The complementary package of activities (CPA) with a higher premium covers a limited number of services at the district hospitals, including the cost of hospitalization, caesarian operations, minor and major operations, medical imaging and all diseases afflicting children under five.

Government assisted and partially funded health facilities account for 40% of primary and secondary care in Rwanda and are mostly run by NGOs, religious groups and other third parties. Tertiary care is offered at four hospitals of which three are public and one private.

Rwanda is the exemplar case of a low income country that has implemented a universal health coverage programme. Yet, achieving a high coverage rate is not an end to itself. Many challenges lay ahead, for example, building local institutional capacities to manage the health system as well as building capacities of local human resources in health. See Table 1.1 for more details.

Bangladesh: the way forward

The world is moving ahead in ensuring health coverage for its population. What was seen in 2005 (the time when the first WHA resolution on UHC was adopted) as *laudable but unrealistic* is now *bold and achievable.* It is now desirable and unavoidable (Preker *et al.* 2009). Twenty years ago Abel-Smith (1991) had said, "(HI) has the prospect of bringing in more money to the health sector, and it does not place at risk access to health care for the poorest and neediest." As the latest WHO report says, many countries in different levels of economic development are undertaking health finance reform and the programme that is seen closest to addressing the needs of their populations is 'prepayment and pooling' (WHO 2010). Instead of burdening the poor and the sick, such programmes share it equitably. As has been shown in the text, many countries have already achieved UHC and many more are on their way to achieving it. With the rise in the momentum for UHC as is seen now, few countries will remain untouched. Bangladesh cannot afford to miss the bus. For all conceivable reasons Bangladesh should embrace the challenge. The regressive system that has unfortunately been developed over the years must change and any decision to move towards UHC would shake it vigorously leading to a more equitable system. UHC means improved health and reduced poverty; it means that rich and poor, women and men, young and old, sick and healthy, urban and rural are all covered with a set of affordable health service packages.

It is not expected that Bangladesh will achieve UHC overnight. This is simply not possible for a variety of reasons including financial constraints, inadequate availability of service provisions and shortage of appropriate human resources. What is important, however, is for Bangladesh to express its strong political will and chart a road map with clear timeline. In this the government must play its stewardship and leadership role. The civil society and development partners will also have important responsibilities including making sure that the schemes benefit the poor (Joint NGO Briefing paper 2008, Gwatkin 2010).

The following is a tentative agenda that the country can consider pursuing with flexibility for in-course modifications.

1. Articulate clearly and unambiguously the government commitment to UHC through the next Health Nutrition and Population Sector Programme (HNPSP). This should include a 10-year road map with clear goals for 2015 and 2020.
2. As a step towards more accountability and better implementation, separate the purchasing function of MOHFW from the provider function by creating an independent purchasing authority in the like of NHSO in Thailand or RSBY in India.
3. Explore possibility for introducing health insurance (HI) for different groups in the population (through pilots if necessary), including:

- State employees
- Formal sector employees in big Industries
- Formal sector employees in small to medium industries including the garments sector
- Staff of NGOs
- Members/borrowers of micro-finance institutions (the poor)
- Members/beneficiaries of different social safety net programmes (the extreme poor)
- Women and children

The above proposal to introduce HI for specific groups may be seen as fragmentary and perhaps inefficient (producing smaller pool). But this may be necessary to creating the space and demand which can in the future be amalgamated as was done in many countries.

4. Encourage the big players in the NGO sector, such as ASA, BRAC and Grameen to join hands to develop and provide HI to their micro credit borrowers and the greater public through creating a joint pool. The three may also consider setting up a specialized health insurance company for the purpose. BRAC is already moving towards developing a scalable model for HI for its beneficiaries.
5. Involve and engage the media, professional groups such as the Bangladesh Medical Association and Bangladesh Economic Association and the civil society for advocacy work.

Fortunately, Bangladesh is not sitting idle. A lot has already being initiated as evidenced by the amount of activities being generated. The Prime Minister Sheikh Hasina in her inaugural address at the 64th World Health Assembly in Geneva in May 2011 made her commitment to achieve universal coverage for all its citizens[2]. A host of activities are already taking place (See Annex for an account of the current activities towards UHC). From the government side, there is an increased interest to learn more about its feasibility. The Health Economics Unit of MOHFW has already started the ground work for piloting health insurance in two upazilas. The civil society groups are already piloting their versions of health insurance with their members. The media has also started covering UHC. If the nation sets the goal to reach UHC by 2020, it may not be too ambitious. As mentioned in the text, UHC is a 'journey' and the first step has to be made immediately!

ACKNOWLEDGEMENT

The authors are grateful to Syed Masud Ahmed of BRAC and Ariel Pablos-Mendez and Heather Grady of the Rockefeller Foundation for comments on an earlier version of the chapter.

2. http://www.who.int/mediacentre/events/2011/wha64/sheikh_hasina_speech_20110517/en/index.html.

REFERENCES

Abel-Smith B (1991). Financing health for all. *World Health Forum* 12:191-200.

Bangladesh Health Watch (2008). Health workforce in Bangladesh: who constitutes the healthcare system? Dhaka: Bangladesh Health Watch. 96p.

(Bangladesh health watch report 2007)

Bennett S, Ozawa S, Rao KD (2010). Which path to universal health coverage? Perspectives on the WHR 2010. *PLoS Med* 7(11):e1001001.

Berkhout E and Oostingh H (2008). Health insurance in low-income countries: where is the evidence that it works? Oxfam International. (Joint NGO Briefing paper no. 112) www.oxfam.org.uk/resources/policy/health/downloads/bp112_health_insurance.pdf (accessed on 21 Mar 2011)

Campaign for Popular Education (CAMPE) (2009). State of education in Bangladesh, Dhaka: CAMPE.

Carrin G, Mathaeur I, Xu K, Evans DB (2008). Universal coverage of health services: tailoring its implementation. *Bul WHO* 86(11):817-908.

doi:10.1016/S0140-6736(10)62148-4

Dror DM (2006). Health insurance for the poor: myths and realities. *Econ Political Weekly* 41(43-44):4541-4.

Ensor T (2007). Assessing financing mechanisms for their ability to deliver an insurance function. Dhaka: Government of Bangladesh.

Ensor T (2008). Public funding for community-based skilled delivery care in Indonesia: to what extent are the poor benefitting? *Eur J Health Econ* doi: 10.1007/s10198-007-0094-x.

Garrett L, Chowdhury AMR, Pablos-Mendez A (2009). All for universal health coverage. *Lancet* 474:1294-99.

Gwatkin DR and Ergo A (2010). Universal health coverage: friend or foe of health equity. *Lancet* 16,doi:10.1016/S0140-6736(10)62058-2.

Huq M (Editor)(1991). Near miracle in Bangladesh. Dhaka: University Press Limited.

ILO/KFW study team (2008). Feasibility study investing in social health protection. Dhaka. (unpublished).

International Labour Organization (2008). Social health protection: an ILO strategy towards universal access to healthcare. Geneva: ILO.

Joint Learning Initiative (2010). Joint learning workshop: moving towards universal health coverage, Delhi, India, 3-5 February 2010 country case studies. (Workshop papers)

Krishna A (2010). Who became poor, who escaped poverty, and why? Developing and using retrospective methodology in five countries. *J Policy Analysis Management* 29:351-72.

Lagomarsino G, Kundra S (2008). Overcoming the challenges of scaling voluntary risk pools in low-income settings. Washington D.C.: Results for Development Institute. (Technical partner paper 6)

Lancet (2010). Striving for universal health coverage (editorial). *Lancet* 376(9755):1799.

Meng Q and Tang S (2010). Universal coverage of healthcare in China: challenges and opportunities. Geneva: WHO. (World Health Report, Background Paper No.7)

NIPORT, Mitra and Associates, and Macro International (2009). Bangladesh Demographic and Health Survey 2007 Dhaka and Calverton: NIPORT, Mitra and Associates, and Macro International. 346p.

Normand C and Weber A (2009). Social health insurance a guidebook for planning. Germany: ADB, ILO, WHO and GTZ.

Pitayarangsarit S (2004). The introduction of the universal coverage of health care policy in Thailand: policy responses. London: London School of Hygiene and Tropical Medicine. (PhD thesis)

Preker AS, Zweifel P, Schellekens OP (2009). Introduction: Strength in numbers. *In:* Preker AS, Zweifel P, Scellenkens OP (Editors). Global marketplace for private health insurance. Washinton D.C.: World Bank:1-26.

Rannan-Eliya (editor) (2010). Bangladesh National Health Accounts 1997-2007. Dhaka: Health Economics Unit, Ministry of Health and Family Welfare, Government of Bangladesh.

Rockefeller Foundation (2010). Catalyzing change: the reform costs of universal health coverage. New York: Rockefeller Foundation.

Tangcharoensathien V, *et al.* (2011). Health financing reforms in southeast Asia: challenges in achieving universal coverage. *Lancet* 377(9768):863-73.

Wagstaff A (2010). What's the 'universal health coverage' push really about? Blog: let's talk development. Washinton D.C.: The World Bank.

World Bank (2008). Poverty assessment for Bangladesh: creating opportunities and bridging the East-West divide. Dhaka: The World Bank.

World Bank (2008). World Development Report. Washington D.C.: The World Bank.

World Health Organization (2005). Resolution WHA58.33: Sustainable health financing, universal coverage and social health insurance. Geneva: World Health Organization.

World Health Organization (2010). World Health report: Health systems financing the path to universal coverage. Geneva: World health Organization.

Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J, Murray CJL (2003). Household catastrophic health expenditure: a multicountry analysis. *Lancet* 362:111-7.

Yates RM (2010). Women and children first: an appropriate step towards universal coverage. *Bull WHO* 88:1-2.

ANNEX: MOVEMENT FOR UHC IN BANGLADESH

Introduction

As the movement for universal health coverage (UHC) intensifies in other parts of the world, there is an imperative to prepare Bangladesh for it. Bangladesh, being a low income country with a vast majority of its people living in poverty, needs to protect its citizens against health shocks and run-away out of pocket expenses (OOP). This will also be an important and significant anti-poverty measure for which the country is pledge-bound. Fortunately, the country is not sitting idle and a good amount of investment is already being made by the government, NGOs and development partners. The following gives a summary of the different interventions/activities being implement-ted and/or are planned.

Government of Bangladesh: The government is committed to ensuring effective access to health services by the people, particularly the poor, as reflected in various plan documents. The Prime Minister Sheikh Hasina in her inaugural address at the 64th World Health assembly in May 2011 declared her commitment to universal coverage for all of its citizens[3]. A variant of demand-side finan-cing (DSF) for pregnancy care and delivery is being piloted in 35 *upazilas* (sub-districts) and the government has recently given a 'go ahead' to its Health Economics Unit to pilot a health insurance (HI) scheme in two *upazilas*. A few other activities are also being planned/imple-mented, some of which are narrated below. The vision for health financing is being articulated in the new document for the next Health Nutrition and Population Sector Programme (HNPSP).

Indo-Bangladesh Dialogue: In the last Indo-Bangladesh Dialogue (February 2010) in Dhaka, a session was exclusively devoted to UHC in which three papers describing experiences from Bangladesh, India and Thailand were presented. The participants, who included top government officials, civil society leaders and academics from the India and Bangladesh including Nobel Laureate Professor Amartya Sen, discussed the need and feasibility for UHC in the Bangladeshi context.

High-level visit to India and Thailand: Thailand has already attained UHC and India is moving fast towards it. To expose the policy makers in Bangladesh to such experiences in these countries, exposure visits by top officials of the Ministries of Health and Family Welfare are being undertaken. The delegation also includes representatives of the academic community and the civil society. In January 2011, the Minister of Health and Family Welfare Prof Ruhal Haque and a high-level delegation visited the Thai National Health Security Office in Bangkok to know for themselves how the Thai UHC system worked. Similarly, a delegation from Bangladesh attended a training workshop in Kerala, India on the functioning of the Indian Rashtriya Shasthya Bima Yojana (RSBY). In June 2011, a high level delegation led by the Chairman of the Parliamentary Standing Committee on Health Sheikh Fazlul Karim Selim visited Thailand and India[4]. Included in the delegation were MPs, senior officials of MoHFW, the Prime Minister's Office and NGOs and representatives of the media. They saw for them-selves how the UHC system worked in these two countries and how the learning could be used to develop a similar system for Bangladesh.

Leveraging the micro-finance (MF) platform: Bangladesh is the pioneer in popularizing micro-credit for poverty alleviation and women's em-powerment. More than half of the country's 160 million population are borrowers of MF and are connected with micro-finance institutions (MFIs). The Palli Karma Sahayak Foundation (PKSF) is an apex body through which the government provides funds to MFIs to carry out MF activities. The PKSF has recently decided to initiate a pilot to test how the MF borrowers (numbering over 10 millions) served by its 250+ partner organizations could be offered better health care through HI. Some big MFIs such as Grameen, BRAC and others are already piloting different insurance products. BRAC is also exploring possibilities of bringing HI to its all 7.5 million borrowers.

Pilot by ICDDR,B: The Centre for Health and Population Research (popularly known as ICDDR,B) is embarking on testing the feasibility of HI in Chakoria *upazila* in Cox's Bazar district. Chakoria is one of their field sites. This will make use of the availability of a large number of private providers in the area to provide HI services.

Bangladesh Health Watch (BHW) report: The BHW is an influential civil society initiative in the country that monitors progress in attaining good health for the people. With support from a selection of Bangladesh's leaders in health, the BHW has already produced three influential annual *State of Health* reports ('Challenging inequities in health'; 'Health human resources: who constitutes the health

3. Her Excellency Sheikh Hasina, Prime Minister of Bnagladesh: Speech to the Sixty-fourth World Health Assembly. http://www.who.int/mediacentre/events/2011/wha64/ sheikh_hasina_speech_20110517/en/index.html.
4. In India they visited the Rajib Aarogyasree programme in Andhra Pradesh and RSBY in Delhi and Haryana.

system?'; 'How healthy is health governance in Bangladesh?'). For this year, the BHW is focusing on UHC.

Health insurance for Social Safety Nets beneficiaries: Bangladesh implements a number of social safety nets programmes, most of which target the extreme poor population. A pilot programme to introducing HI for the beneficiaries is being planned by an NGO in collaboration with relevant government departments. Similar HI programmes are also being planned for the country's large ready made garments sector which employs millions of women workers.

Mutual insurance Company: An international MFI network with operations in Bangladesh, INAFI, that set up a mutual micro-insurance company has decided to offer health insurance to the poor micro-credit borrowers.

Centre of Excellence (CoE) on UHC: The BRAC University James P. Grant School of Public Health in Dhaka has set up a CoE on UHC. The purpose of the Centre is to engage in research, training and advocacy for UHC. In addition, the CoE will also work as the co-Secretariat (with Results for Development or R4D in Washington DC) for the Global Task Force which is being set up to promote UHC globally.

International Conference on UHC: Bangladesh hosted an international conference on UHC in March 2011. This will be repeated every year until 2015. The purpose is to provide a platform for discourses on UHC in low income settings.

The Lancet series on Bangladesh: The Lancet has decided to publish a series on Bangladesh. Although the paper titles are yet to be finalized, a potential candidate is health financing and universal coverage.

Engagement of development partners: Several development partners in Bangladesh have expressed their clear interest in promoting UHC. They include, among others, GTZ, KfW, The Rockefeller Foundation, Unicef and the World Bank (the protection cluster).

Media interest: The media is getting more interested in the area of UHC. In the recent past there has been a number of special reports in leading dailies such as the *Prothom-Alo*. The Presss Institute of Bangladesh (PIB) is planning to initiate a capacity development project for journalists who would be writing on health issues that affect the common people including the provision of UHC for the poor.

087