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Amader Shasthya
RESEARCH Brief

Bangladesh ■ Issue 01 ■ October 2013

Recent learning from a community health insurance scheme in Chakaria, Bangladesh

People of Bangladesh heavily encounter out-of-pocket healthcare cost, with the highest level in Asia. Catastrophic healthcare cost in Bangladesh often drags many people down below the poverty line. This is an important barrier to health improvement in general and to poverty reduction in particular. Thus, it is essential to find ways to reduce out-of-pocket healthcare cost for ensuring universal health coverage and health improvement. Keeping this in view, icddr,b has started a pilot study in its Chakaria field site in 2012 to develop a model to reduce out-of-pocket healthcare cost and to ensure universal health coverage. The study aims to provide a useful scheme for Bangladesh to pool money from the villagers by using the concept of risk protection as an incentive for prepayment. The scheme is named *Amader Shasthya*, meaning Our Health, to imply community ownership. A Bangla slogan *Chikitser kharochadi, eker bohja dosher lati* (treatment cost is a burden if borne singly, not so if borne collectively) is being used in promoting community solidarity. This brief highlights the experiences and the lessons learnt from implementation phases of the scheme during its first eighteen months.

Speakers in launching ceremony Credit: Shahidul Hoque

The implementation of the pilot scheme had two stages. Stage I involved collecting and analyzing data on healthcare cost both at the facility and household level, development of packages, and determining the amount of premiums. The work in Stage I also included analyzing data on the burden of disease, exploring the operational strengths and weaknesses of the existing healthcare financing schemes in the Dhaka region, followed by a study to provide an understanding of the existing conditions of the service providers within the communities in Chakaria. In this study, information was gathered on healthcare needs, cost of appropriate treatment, availability and quality of services, and current practices. A model for prepayment of healthcare cost was developed, based on an assessment of the healthcare needs of the population on the basis of actual burden of disease and cost of services provided by various for-profit and not-for-profit organizations. The estimated unit costs of the health services, based on the established treatment guidelines, were included in calculating the premiums. The calculation of premiums also included an element of safety factor to safeguard households against unforeseeable costs. Implementation of the scheme and monitoring its evolution marked Stage 2 of the scheme and is the focus of this research brief.

In Stage 2, the scheme was rolled out in four unions of Chakaria, along with a regular monitoring mechanism backed by computerized enrollment, patient-records, and an accounting system. This was done with the intention of real-time monitoring, enabling timely actions that could improve the system and serve the needs of the community. The rolling out of the scheme was preceded by (1) introducing and promoting the concept of prepayment

for healthcare cost and risk protection in the context of financial catastrophe to individual and family; (2) formation of a network of hospitals, drugstores, and diagnostic centres and management of the network; and (3) development of a computer-based real-time monitoring and information system through a relational database of patient-records, membership information, disbursement claims, household socioeconomic information, and the like.

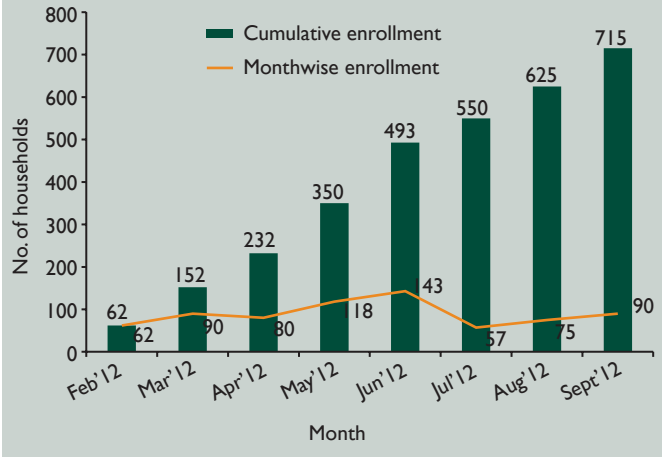
Promoting prepayment for healthcare cost

Step one

The marketing activities or promotion of the scheme started in December 2011, with an information-sharing meeting at the health fair organized by the Koyerbil Village Health Post, which was attended by hundreds of villagers. In addition to speeches by dignitaries, the event included a drama, promoting the value of insurance and community solidarity. The formal launching and enrollment in the scheme started in February 2012 in Kakara Village Health Post, which was attended by senior government officials from Dhaka and local administration. Following the official launching, members of the Village Health Post Committee continued to promote the scheme and raise community interest in this initiative.

Several health fairs were organized at three other Village Health Posts situated in other unions to expand the coverage. In those large gatherings, local people had the opportunity to question resource persons about the scheme. At the fairs, people were made aware of future health planning and the opportunity to enroll in the scheme. Various organizations working on health and development were invited to show their work in the health fairs. Street-dramas and open-air concerts were staged on the theme of risk protection. The theatrical drama depicted the consequences of healthcare cost on the household economy and the need for community solidarity to overcome difficulties. In this way, the ideas of prepayment for healthcare cost and protection against financial catastrophe and the importance of solidarity were reinforced in the community.

Figure 1. Monthly enrolment in *Amader Shasthya* first phase scheme, February –September 2012, Chakaria



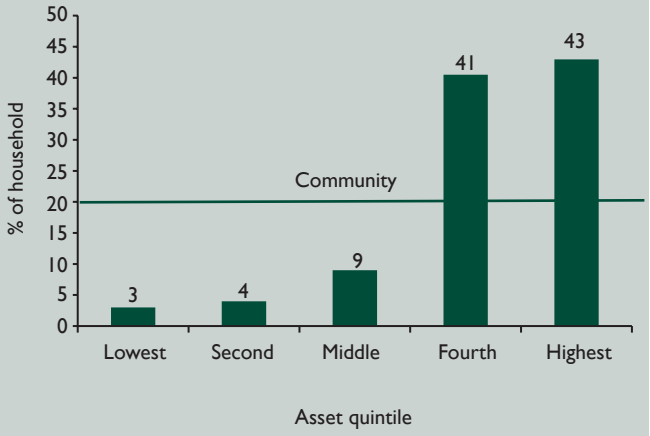
Popularizing of the prepayment scheme for increased enrollment has been a continuing activity alongside its implementation. This has been done through cluster meetings in villages, small group discussions in markets in the evening hours, one-on-one conversation during visits to the households, and through meetings of the NGO partners. The various village-based forums used for the purpose were: mothers clubs, school committees, local clubs, village elites, and kinship groups in *Paras* (small units of a village). Flyers and brochures on the scheme were also regularly distributed among the community people. Visits to households and one-on-one conversations featured the core marketing approach.

Packages and services

Step two

Amader Shasthya was first launched with two packages– one for the general population and another for pregnant women, marketed with the name *Prosuti*, meaning pregnant woman. Upon enrollment in the scheme, each household was issued an identification card with a photo of the head of the household for general package and another with a photo of the woman for *Prosuti* component of the scheme. The card was used in the process of access to the services. The following benefits were provided under the two packages:

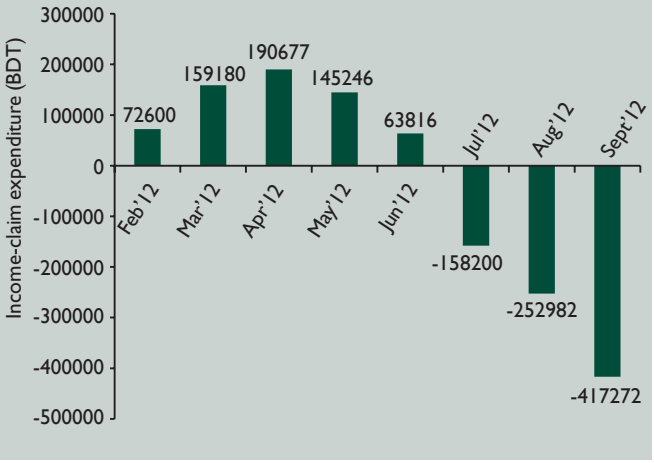
Figure 2. Enrollment in *Amader Shasthya* first phase scheme by household asset quintile, February - September 2012, Chakaria



Initial consultations for patients were provided at the community level in the Village Health Post by a Sub-Assistant Community Medical Officer (SACMO) and then the Project Medical Officer. Any cases needing further care were referred to Zam Zam, a private hospital in Chakaria. A memorandum of understanding (MoU) between icddr,b and Zam Zam was signed to ensure quality of care and re-imbursement by icddr,b when invoices would be sent by the hospital to icddr,b. Patients do not need to pay the hospital as long as the cost is within the entitlement of the patients defined by *Amader Shasthya*. The hospital is informed of the maximum amount that can be paid by the

scheme to the hospital with the referral note. MoUs were also signed with 23 drugstores to supply medicines to the scheme members upon presentation of their ID cards and a prescription from the project service providers.

Figure 3. Income minus expenditure of *Amader Shasthya* first phase scheme, February - September 2012, Chakaria



This newly-formed network of healthcare providers was connected through a computer-based management information system developed by icddrb's IT professionals. This computerized database and patient-record system enabled capturing of the real-time data and maintenance of clinical records for members of the scheme. The scheme ensured that no cash payment by the patients was necessary at the point of service, and they had a discount for drugs from the designated pharmacies. The hospitals, diagnostic laboratories, and drugstores submit bills to the icddr,b project office in Chakaria for reimbursement. Once the bills are received, these are verified both in the office and physically by visiting the patients, drugstores, and the hospitals. Once verified, the bills are reimbursed to the hospitals, diagnostic centres, and the drugstores. The disbursement process, on an average, took two weeks.

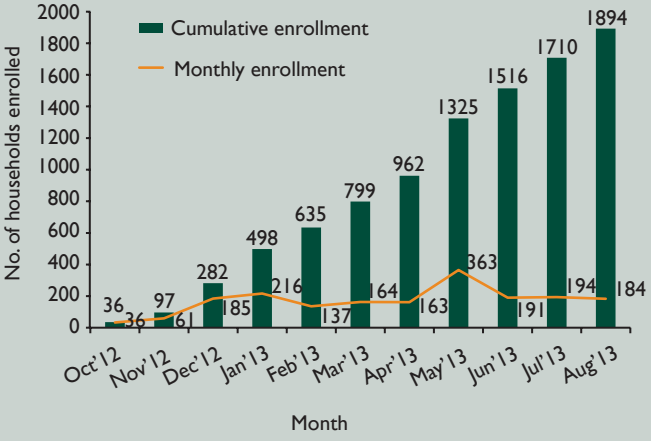
Monitoring and feedback

Step three

The collection of data on enrollment by socioeconomic status, financial performance, and cost recovery has been a continuous activity. It was found that there was steady enrollment in the scheme with the cumulative number of 62 members in February 2012 and increased to 715 in September 2012. The programme experienced stagnation in enrollment during June to August 2012 when a severe flood hit Chakaria. Analysis of the enrollment by socioeconomic status showed that 85% of the cards were bought by people from the two highest asset quintiles while people from the two lowest quintiles bought only 7% of the cards.

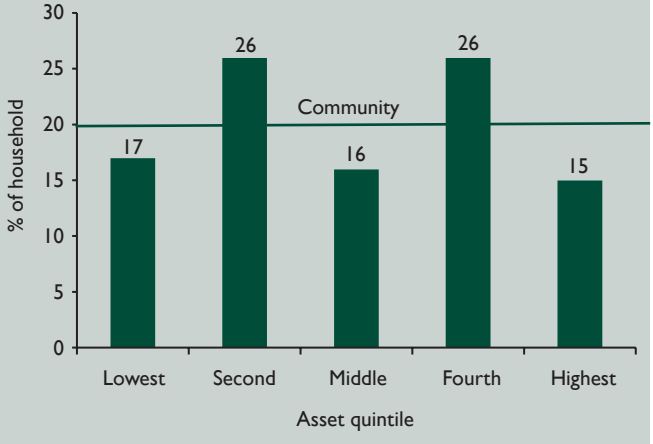
The data show that members in 41% of the enrolled households came for healthcare, and 80% of the claims were settled within two weeks. The proportions of the cost for services, excluding the personal cost, rent, and transportation cost, were: 50% for drugs, 24% for hospitalizations, 13% for investigations, 9% for pregnancy-related services, and 4% for consultations. The reimbursement of cost started to exceed the earnings from the premium from around six months of the implementation.

Figure 4. Enrollment in *Amader Shasthya* second phase scheme, October 2012 - August 2013, Chakaria



Monitoring yielded a number of findings that prompted a revision of the scheme. The high claim-to-revenue ratio might have a negative impact on the financial sustainability of the scheme and needed to be addressed. The low enrollment of the least wealthy households indicated that designing a more affordable package was necessary to ensure enrollment of the most vulnerable groups. To redesign the packages offered, a further analysis was conducted on a subgroup of the enrolled households (62 households with 372 members), who had enrolled toward the beginning of the program; 55% of the members sought treatment, and the projected annual expenditure on healthcare services offered in the scheme was found to be BDT 903 per person. The majority of the patients sought primary healthcare and received medications, with only 5% as inpatients.

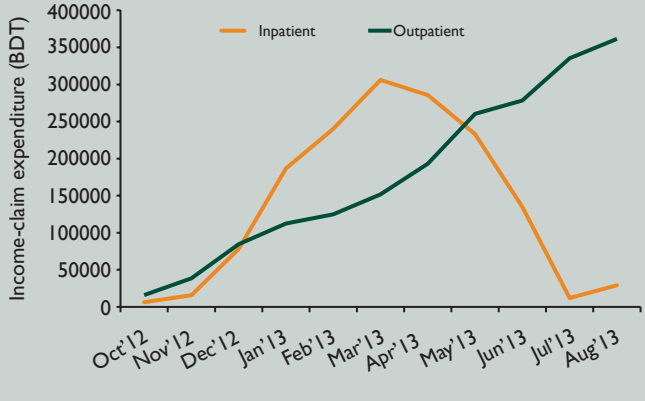
Figure 5. Enrollment in *Amader Shasthya* second phase scheme by asset quintile, October 2012 - August 2013, Chakaria



This analysis, combined with the negative impact on enrollment that occurred after a severe flooding in the project area and the finding that the *Prosuti* package had very limited enrollment, led to the revised 'indoor' and 'outdoor' packages that replaced the general and *Prosuti* packages. Notably, the revised package offered a low premium of BDT 500 per household for an outdoor package for the population in general and BDT 200 for households belonging to the lowest two asset quintiles. Both revised 'indoor' and 'outdoor' packages offered the most commonly-used services required by the people. Cost of diagnostic services was partially covered by the scheme, instead of full coverage as was the case before.

Following introduction of the revised packages in January 2013, enrollment increased rapidly from 498 in January 2013 to 1,894 in August 2013. It was also found that the revised packages had improved equity by having more enrollment of the poor compared to the first general combined indoor-outdoor package offered. The revised outdoor package, in particular, showed marked improvement with 17% and 26% card-holders from the lowest and the second-lowest quintiles compared to 3% and 4% enrollment of people from the same socioeconomic quintiles for the first general package.

Figure 6. Income minus expenditure of *Amader Shasthya* phase 2 scheme October 2012 - August 2013, Chakaria



The revised health insurance packages had also a beneficial effect on the income surplus (income minus cost of claims) of the scheme. The first general package, combining the indoor and outdoor packages, had a decreasing income from the fourth month of its implementation, with it crossing the threshold to increasing losses during its sixth month in the field. In contrast, the revised packages have shown a steady positive financial balance as of now. The declining surplus of the indoor package was an outcome of not offering the indoor for some time.

Claim verification has been a pre-requisite for all payments. This has been done in 100% of the claims in the beginning and subsequently limited to 10% randomly-chosen claims by an independent team of the project staff not involved in the implementation of the activities; 2% of the claims verified were found to have problems. The nature of the problems included: (1) charging more than agreed upon price for drugs by the drugstores, (2) supplying drugs for more days than prescribed, and (3) supplying drugs manufactured by others beyond the listed companies.

The data collected through monitoring and information system have been very useful to improve the design of the scheme according to the health needs, income and cost, and financial ability of the community. It is hoped that continuing monitoring will lead to an even better understanding of the enrollment and utilization of the services. This, in turn, will help improve the scheme and the system to achieve the goals of the scheme.

Lessons learnt

The concept of risk protection for healthcare cost through prepayment is new to most people. With appropriate communication strategy it is possible to increase the acceptance of the concept.

Flexibility for modification of strategies alongside the implementation, based on real-time monitoring of data, has been very useful.

System for claim verification should be thought out well in advance and be carefully monitored during implementation.

Inclusion of the economically-disadvantaged population in the scheme while targeting economic breakeven is a challenge at least in the short-term.

Full cost recovery from the premium is unlikely in the short run, if the scheme has an equity goal.

Acknowledgements

This brief and the study on which this brief is based were supported by the Rockefeller Foundation through its grant number 2010 THS 337 to the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) in support of a project to develop and implement a pilot health insurance scheme in Bangladesh. The opinions expressed in this brief are of the members of the project team and not necessarily of the Rockefeller Foundation or of icddr,b. The contribution of Mr. Abdur Rahim in editing this brief is highly appreciated.

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