Lessons learned from the health insurance program in Bangladesh – 2020 to 2023

In 2020, after several surveys, ATIA implemented a health insurance program in Dacca, Bangladesh. At the end of 2023, ATIA decided to close this program, mostly because 1) ATIA has not been able to find a partner organization willing to implement a mandatory membership for is members and 2) the voluntary members of the health insurance scheme were not willing to pay a contribution high enough to cover at least the cost of the health expenses.

The objective of this document is to share the lessons learned on this health insurance program launched in Bangladesh. For a more general review of mutual health insurance supported by ATIA, see https://reseau-pratiques.org/capitalisation-mise-en-place-de-mutuelles-de-sante/

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Implementation steps and learning from activities

Initial plan: Implement a health insurance with garment factories in collaboration with the IdKids group (on the basis of a mandatory membership)

In 2016, ATIA realized a feasibility study to evaluate the possibility of implementing a health insurance with garment factories in partnership with the IdKids group. The latter enterprise wanted to fulfil its social responsibility in Bangladesh, representing 60 percent of its sourcing of textile, by offering a health insurance to the garment workers.

The feasibility study confirmed that garment factory workers face numerous health issues that affect negatively their well-being in addition to their productivity. Specifically, the main issues faced by the garment workers were the following:

- The combination of long working hours for garment workers and long waiting hours at government hospitals and health facilities renders the access to healthcare almost impossible for the majority of garment workers.
- Most private clinics are too expensive for garment workers.
- As a result, garment workers usually go to the nearest pharmacy without prescription to seek treatment. A drug seller with no formal medical training/education usually runs the pharmacy, treating inadequately the visitors. This behaviour repeated for years has negative consequences on the health of the garment workers and their family as they need stronger and stronger drugs to treat their illnesses. They become more and more resistant to the drugs as they receive strong treatments from the pharmacists.
- Therefore, by reducing the cost of treatment in private clinics and health facilities, together with a health-awareness program, a health insurance could improve the access to adapted healthcare for garment workers.

Following this survey, it was agreed that a mandatory tripartite premium would be put in place whereby the workers, the factory owners and the brand (IdKids) would pay each a third of the contribution fee. At the start, the health insurance would be operational in two factories, and with time, the health insurance would become mandatory for all the factories working for IdKids.

However, shortly after this agreement, due especially to the rise of internet and more specifically on-line sales, the retail industry faced economic challenges and the launch of the health insurance in partnership with IdKids had to be cancelled.

Lessons learned

After discussing with other organization and funders, such as the GIZ (German national development cooperation), we learned that, probably partly due to the current economic context, brands are generally reluctant to invest long-term in projects increasing employee benefits. For instance, GIZ is currently working on a mutual accident fund project involving ten brands. The pilot project was planned to run for three years, but none of the brands are willing to commit beyond one year. As a result, to the best of our knowledge, and according to GIZ, no health insurance project collaborating with brands has gone beyond the pilot stage, despite the real needs of a health insurance for garment workers.

Besides, we also realised that obstacles are present with factory owners as they want to be competitive and offer the most attractive prices to brands. If factory owners pay a health insurance program for its workers, they will probably be less competitive than other factory owners who do not pay for this benefit. Moreover, factory owners are also wary that if they put a health insurance in place, the garment workers will ask for more and more benefits and will not hesitate to strike if their demands are not met. Finally, they also feared that if the brand stop collaborating with them and paying for the health insurance, their workers will demand for the factory owners to continue to pay for their health insurance, even without the support of the brand.

This kind of project could have a better chance to work with a small « family » factory where:

- the ties are very strong between the employer and the employees
- the owner believes that a health insurance could increase the productivity of the factory

In this case, a bipartite model (owner and employees), where for example the owner pays two-thirds of the health premium the first year, could be implemented. After the first year, his share will decrease and the worker's one increases. In fact, the worker will be willing to pay a higher contribution fee based on the positive perception of the health insurance as it reimburses the workers' healthcare expenses and as the health insurance manages to build trust with the workers through medical visits and awareness sessions. With time, workers would appreciate the health insurance program and, hence, would be willing to gradually pay a greater share of their premium.

Second plan: implement a mandatory membership among Water & Life's beneficiaries

During our feasibility study in 2016, we got in touch with the NGO Water & Life (W&L) and its partner Shobar Jonno Pani (SJP), which started to implement a program of access to drinking water for the inhabitants of the Bashantek slum. After the cancellation of the partnership with IdKids, we decided to conduct another feasibility study in 2018 for a health insurance for the vulnerable families living in the Bashantek. This study revealed similar issues in Bashantek as in the garment workers:

- the systematic use of a pharmacy (or drug store) without any medical visit,
- the renunciation of healthcare due to a lack of financial resources
- the inadequacy of the healthcare offering in terms of quantity, quality and reliability.

As a result, it was planned that each family living in the Bashantek slum and subscribing to the services of W&L (affordable drinking water) would also have to subscribe to a health insurance. After a few years, the two organizations would search for a new slum whereby it would be relevant to offer water services with a mandatory health insurance. This would give time for both organisations to learn from the pilot project in Bashantek and improve their collaboration and services in the new slum.

However, for political and social reasons, Water & Life faced some difficulties in implementing its services in the Bashantek slum. W&L had to focus on implementing its services successfully before introducing a mandatory health insurance to its members. For these reasons, it was decided that the services of the health insurance created by ATIA would be offered to the Bashantek slum dwellers on a voluntary basis, and no longer on a mandatory basis.

In 2023, W&L decided to start extending its services in a new slum in Dwaripara but without the services of the health insurance. They explained that they needed time to build awareness around their product and make sure that the inhabitants are satisfied with the services of the water services offered by W&L, before being able to enforce a health insurance system.

Lessons learned

Enforcing a mandatory health insurance can be done only when:

- the partner organisation has already established a trustful relationship with the community;
- the services provided by the partner organisation is particularly attractive.

ATIA has already been successful in implementing mandatory health insurance with Micro-Finance Institutions who had already established strong ties with the community. A mandatory health insurance with W&L beneficiaries did not work because W&L had started its programs too recently and because access to drinking water was not attractive enough for the inhabitants of Bashantek to accept an additional mandatory payment.

Mandatory health insurances are generally viewed as taxes: "we generally prefer avoid paying them, even if we enjoy the benefits paid by them".

Third plan: developing a sustainable voluntary basis insurance in the Bashantek slum

Given the important health needs in the area, ATIA decided to try to develop a voluntary basis insurance program in Bashantek and to create a partner organisation: Health Family Care (HFC). Besides, as the feasibility showed that the primary care services were very poor, ATIA decided to create and fund a small medical centre inside the Bashantek slum, with 2 doctors and free consultation for HFC members.

According to the feasibility study in 2018, the monthly contribution, required to cover health expenses, had initially been set at 250 Takas. However, the first membership started at the beginning of 2020. Soon after, during the COVID 19 epidemic, as slum dwellers of Bashantek were deeply affected financially, it was decided to decrease the membership contribution from 250 to 100 Takas per month even if we knew that this new amount was too low to reach the balance of the mutual fund balance. As a result, even the claims to premium ratio (the healthcare expenses reimbursed divided by the contributions received by beneficiaries) became very high, up to 449% in 2023. It means that the cost of health expenses was more than four times the amount of contribution received.

We assumed that with time, using regularly the services of the health insurance (medical centre, reimbursement of healthcare expenses, visits at home, etc.), the families would be satisfied with the services and would be willing to pay a higher contribution fee. Hence, in 2023, we were hoping to increase the contribution fee to 300 Takas. This would allow the mutual fund to be at an equilibrium.

However, a survey conducted in 2022 demonstrated that, although the vast majority of beneficiaries were very satisfied with the services of the health insurance and have improved their access to healthcare visiting HFC's medical centre when falling ill, they were not willing to pay a higher contribution fee.

Parallel to these issues, the facilitators hired by HFC, the local partner organisation of ATIA, had difficulty to convince the inhabitants of Bashantek to become members of the health insurance scheme. The renewal rate was low (below 50%) and it was difficult to find new members, so that we were able to reach 980 families in 2022, for a yearly cost of 150 000 euros, which means an average cost of 150 euros per family, while in others countries, the cost of health insurance supported by ATIA is closer to 60 euros per family. On top of the usual difficulties to convince people to pay for a health insurance, the inhabitants of Bashantek were also suspicious of new NGOs as previous organisations promised them many things but did not deliver anything.

Lessons learned

- If a contribution is reduced temporarily because of a specific event (such as the Covid-19), the temporary aspect of this reduction has to be clearly communicated, with a clear deadline (that can be later extended if needed).
- We realized that the facilitators were trying to convince new members to join or renew their contracts by telling them that they will save money, instead of focusing on raising awareness on insurance and risk management. As a result, members expected to save more than they paid and did not renew their contract when they actually paid more than the reimbursed health expenses. Similarly, the facilitators insisted on the free consultation at the medical centre and as a result, some beneficiaries visited the medical centre up to 4 to 5 times per month because they considered that they paid for this service, even when there was no real medical issue.

- The main conclusion is that a voluntary model is not a viable model, at least if the ambition for the health insurance is to be autonomous in the long run, as it is the case for all health insurances supported by ATIA. A voluntary basis scheme attracts the families that are in need of many health services, phenomenon known as adverse selection and as a result, the claims-to-premium ratio is always above 100%, thus hampering the financial autonomy of the health insurance. A voluntary model could work in a community with a deep understanding of risk management and a high risk aversion, but that is rarely the case of poor people who prefer to spend their money to cover current needs.

Fourth plan: create a partnership with another association/NGO/foundation/micro-finance

As we realised it was not possible to increase the contribution fee in the Bashantek slum, Health Family Care looked for a potential association or organisation interested in enforcing a mandatory health insurance services to another group of vulnerable families. Certain criteria were established to ensure that the identified group could lead to a potentially sustainable health insurance program such as: a minimum of 2 000 members in the group, a mandatory contribution model, capacity to pay 300 Takas per month per family, geographical location of the families, etc.

HFC met with over a dozen associations/organisations from May to October 2023. However, out of all the associations met with, none were interested in a compulsory membership model, and the capacity of payment of the beneficiaries was often questionable: some microfinance institutions were for example too worried that their beneficiaries would not accept to pay an additional fee.

Some of the organisations were also worried about the sustainability of HFC and were reluctant to implement a mandatory scheme with a relatively new organisation in Bangladesh.

Finally, many organisations met felt that there were important needs in rural areas, but from our evaluation, the needs in rural area were more on increasing the quality and number of health services rather than the capacity to pay of the patients.

Lessons learned

- Previous relationships must have been established with the other organisation to build trust prior to partnership. In other contexts, such as Burkina Faso and Togo, ATIA already knew the partner organisation beforehand, which greatly helped discussing the implementation of a mandatory health insurance. Similarly, the other organisation must have a good relationship with its beneficiaries and strong ties to the community leaders.
- The other organisation must be convinced in the relevance of a health insurance scheme for its beneficiaries, and can afford to face some of the detrimental effects of a mandatory membership (complaints and potentially loss of members).

Learning of the health habits and situation in Bangladesh

The health practises and habits of the inhabitants of Bashantek

Slum dwellers of Bashantek are under constant pressure to work, to make a living and to provide for their families. For this reason, when sick, they seek a powerful treatment that will allow them to work straight away and not miss a day's work, which can be vital to some.

The feasibility study conducted in 2018 underlined the bad practices of the population of Bashantek concerning their take of medication. In fact, when sick, the slum dwellers would take very strong antibiotics from the pharmacy. The belief that the pharmacist is a doctor is deeply rooted in the mentality of the population, mainly from the population evolving in an unfavourable socio-economic background. This means that Bangladeshis have great trust in the pharmacists. The latter dispenses very strong antibiotics that is detrimental to the health of the population in the long run. The Bangladeshis become more and more resistant to antibiotics having to take stronger ones for there to be an effect on their health. This was confirmed in our practise at our medical centre where our doctors realised that even children had developed a strong resistance to antibiotics and had to give more powerful antibiotics. HFC tried to change the habits of the slum dwellers by providing softer medication and by raising awareness around strong antibiotics. Unfortunately, many inhabitants were not satisfied and convinced by HFC's protocol. Many would then go to the pharmacy to receive a much more powerful antibiotic that would cure them quicker.

In our program, it's mainly women and their children who have used our services; men continue to go to the pharmacy when needed. This is explained by the fact that men seek to receive a quick and easy fix, meaning strong antibiotics that would cure them on the day. The men knew that the doctors in HFC's medical centre favoured a more adequate, reasonable and soft treatment which would be efficient but wouldn't heal them as quickly as they would like.

Saturated public health care centres

The public health care centres available around the Bashantek slum are always saturated and the wait is extremely long. This reality discourages many people from going to healthcare centres. Moreover, health centres tend to carry out a battery of tests on patients before making a diagnosis, which often represents a very high cost for families. As a result, some families are unable to access these health centres for financial reasons.

Our medical centre and a team of doctors was a good approach in this country as it allowed Bangladeshis to have quality time with a doctor and to understand the benefits of softer treatments. Moreover, it improved their access to healthcare that seemed pretty limited.

Concept of insurance and risk management, a new one for Bangladesh

The concept of insurance and risk management is uncommon in Bangladesh. The bonds of solidarity are almost non-existent amongst one and other, except within the family. As people do not seem concerned for others around them, the message of participation in a mutual solidarity fund is not adapted to Bangladesh, mainly in the urban context. It is questionable if the concept of a health insurance can currently be understood, and accepted by Bangladeshis, especially for vulnerable people.

Among the middle classes, very few families subscribe to a health insurance, even though private insurances are active in urban areas. Stories about not reimbursing health expenses are frequent, and

trust in these schemes is therefore very limited. Several organisations have failed to honour their commitments by taking money from beneficiaries and disappearing off the radar.
We heard the same stories among the families surveyed in rural areas, creating a trust gap between them and any new organizations. They are very sceptical towards organisations with a health program.

Banshatek slum dwellers distrustful towards new organisations

In the Bashantek slum, many organisations have implemented programs to help improve the socio-economic situation of the slum dwellers. Unfortunately, many of these organisations didn't think through their programs properly and closed quickly after they launched their program. They made big promises to the inhabitants that were never met as they quickly disappeared. This made the slum dwellers of Bashantek wary towards any new organisation wanting to implement a new program. It is a difficult setting to put in place a health insurance as the inhabitants are defiant towards the association and its intentions and as they are very demanding towards the health insurance, trying to get the most out of it.

Is it possible to launch a health insurance in different conditions?

As the results of the health insurance show, slum dwellers live in dire conditions and face many health hazards. A health insurance is a relevant solution to help these inhabitants improve their access to healthcare and to improve their socio-economic situation.

However, we are not sure that it would be possible to launch a health insurance with a mandatory membership in different conditions and in a different slum. For it to work, it would certainly need:

- A mandatory membership for the health insurance to be economically sustainable
- A trustful relationship with a partner organisation that is well settled in the slum with strong ties to community leaders and that believed in the relevance of a health insurance for its beneficiaries
- A community that would easily trust a new program (and that has not seen too many NGOs coming and going and making big promises that were not met)
- An area where there are enough and good health facilities. If it is not the case, setting up a medical centre can help, providing that restrictive rules be set up to prevent overuse of services.