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# Micro Health Insurance (MHI) Pilot of BRAC: A Demand Side Study

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BRAC Research Report



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# **Micro Health Insurance (MHI) Pilot of BRAC: A Demand Side Study**

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## INTRODUCTION

The cost of healthcare can be a strong determinant of its use as well as a cause of poverty in low and middle-income countries (Segall *et al.* 2002, Russell 2003). The adverse impacts of serious illnesses on households are costly and potentially irreversible. Crisis coping mechanisms (e.g., depletion of savings, selling productive assets, mortgaging land, or borrowing from money-lenders at high interest rates) that lead to 'catastrophic health expenditure'<sup>1</sup> pushing these households into a poverty trap from which they rarely recover (Whitehead *et al.* 2001). The market-oriented reforms (such as introduction of user fees) in the last decade have made health services costly for the poor. This phenomenon of poverty induced by encounter with health system is often called 'iatrogenic poverty' and is a matter of great concern in international public health (Meesen *et al.* 2003). They suggested a number of measures for protecting against this health-induced poverty such as social security, reform of healthcare provisions, health insurance and direct resource transfer to the poor. Factors favouring health insurance are its potential for raising additional and stable revenue to fund the cost of healthcare provision, its capacity to reduce financial barriers to healthcare utilization and its redistributive effects (Mills 1983). Micro Health Insurance (MHI) is a type of health insurance where accessibility to essential health services is ensured to individuals and families, who are unable to afford formal health insurance schemes provided by the private sector, through affordable premiums and low prices for health services (WEEH 2003).

## BACKGROUND

A growing literature on voluntary, non-profit health insurance schemes in recent years from low and middle-income countries of Asia and Africa is now available with varying experiences and lessons learned. An evaluation of Vimo SEWA or the Self Employed Women's Association Medical Insurance Fund in Gujrat, India found such schemes to be successful in protecting the poor households against the uncertain risk of medical expenses by covering people below poverty line (Ranson 2002). Case studies from two African countries, Ghana and Cameroon, assessed the performance of voluntary, non-profit health insurance schemes with respect to their linkage with social movement and concluded that insufficient evidence exists for the latter's contribution to the perceived success of the insurance schemes (Atim 1999). However, the importance of incorporating certain elements of social movement (e.g., greater community participation, accountability and autonomy) for design of a successful scheme is reiterated. Another study looked at the performance of a health card insurance scheme implemented by the govt. of Burundi and found it to be a useful tool for women to take healthcare decision independently, but at the same time adverse household selection' (selecting only the poor households) made risk-sharing sub-optimal (Arhin 1994). The authors concluded that improvements in the quality of care would encourage the participation of 'low-risk' households and broader risk pooling, even by increasing the cost of the card moderately. The role of NGOs in developing community health insurance schemes is examined in a comparative study involving Phillipines and Guatemala (Ron 1999). The Phillipines scheme proved to be a success compared to the other after three years of operation. The major underlying factors identified were the administrative structure provided by a cooperative, and controls in the delivery system and in expenditures. The study concluded that such schemes can benefit from national guidelines, a formal accreditation process and an umbrella organization providing assistance in design, etc. Another study from Burkina Faso looked at the willingness to pay (WTP) for a health insurance scheme and found that WTP information can be used for setting premium, keeping in consideration the difference between the WTP and the cost-benefit package (Dong *et al.* 2003). It further advised that the beneficiaries should be

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<sup>1</sup> Health expenditure exceeding 40% of effective income remaining after fulfilling subsistence needs.

enrolled at the level of households and villages in order to protect vulnerable groups such as women, elderly and the poor.

A multi-country analysis of household income-expenditure survey data for 59 countries, including Bangladesh, identified three key preconditions for catastrophic health expenditure: availability of health services requiring payment, low capacity to pay, and the lack of prepayment or health insurance (Xu *et al* 2003). Also, unofficial payments for supposedly free public health services and out-of-pocket spending on health services is the most common form of healthcare financing in Bangladesh (about 60%) (NHA 1999) and represent a significant financial burden for households. The income erosion effect of ill health for the poor households in Bangladesh, especially the extreme poor (36% of its 130 million+ population living on <US\$ 1 per day), is also well documented (Sen 1997, Sen 2003, Hulme 2003). In the absence of any risk-pooling or pre-payment/co-payment schemes, this aggravates the vulnerable situation of the disadvantaged population groups. Ultimately, this leads to untreated morbidity, reduced access to care, irrational use of drugs and long time impoverishment (Whitehead *et al.* 2001).

The pro-poor strategy of risk-pooling and pre-payment measures for healthcare financing has not drawn the attention of the policy makers in Bangladesh until recently. A few studies in the last few years examined some small scale experimental community-based schemes on health insurance initiated by voluntary non-profit organizations. One such study evaluated the two largest health insurance schemes in rural Bangladesh implemented by the Ganoshasthya Kendro (GK) and Grameen Health programme as a factor of social mobilisation for participation and managing healthcare delivery and financing (Desmet *et al.*1999). Besides, technical performance based on usual indicators for assessing health insurance schemes, the potential of the schemes to get communities involved in healthcare management in general, and scheme management in particular, was noted. They concluded that the natural link that exists between health insurance and micro-credit lending to decrease economic burden of illnesses on households, could further promote this process.

The MHI projects for poor rural women in Bangladesh funded by the International Labour Organization, supports community MHI schemes by eight voluntary non-profit NGOs, aiming at ensuring women's access to quality health care services (WEEH 2003). Generally, the benefits are open to all but with some variety in the service packaging and with differently applicable pricing programme for the members and the non-members. With some variability of components and pricing, the co-payment components are a set of common features of these projects. The micro-credit programmes work as the main institutional support structure for the MHI schemes. An early evaluation of the schemes found these successful in providing quality health services at low price and affordable premiums to a large disadvantaged group of people, especially women and children.

## **RATIONALE**

The BRAC-run MHI scheme (see Annex I for brief description of the project) is now 4 years old. The previous reports on Micro Health Insurance of BRAC (MHIB) and the enrollment records from the field shows that even though the rate of enrollment is quite high and reached the target goals, the renewal rate is very low among the village organization (VO) and non-village organization (NVO) subscribers. Another striking thing is that despite being completely free of cost, the rate of enrollment among the ultra poor is very low and the renewal rate among them is even lower. These observations motivated the current study to examine various factors related to the operation of the MHI pilot project.

## **GENERAL OBJECTIVE**

To study and analyze underlying factors responsible for enrolment and renewal decisions for MHI from the perspectives of both subscribers and non-subscribers.

### **SPECIFIC OBJECTIVE**

- To construct socio-demographic profiles of different categories of subscribers, non-subscribers and ultra poor people in the study area.
- To study motivation behind non-subscribers, subscribers, subscribers who renewed, and subscribers who did not renew though due.
- To study the marketing techniques used by the programme.
- To study the perspectives of different health providers of the area including the BRAC Health Center (BHC) doctors about MHIB.

## MATERIALS AND METHODS

### STUDY SITE(S) AND SAMPLING

BRAC has been conducting the MHI programme in Narsingdi and in Fulbari sub-districts (*upazila*). But due to time constraints, we have decided to carry out our study only in Narsingdi *upazila*. Out of three Area Offices (AO) in Narsingdi *upazila*, we focused on the Madhabdi AO, where MHI programme is strongly present. Two villages were chosen where the programme has been working from the beginning: one within two km of BHC and the other beyond five km.

### DATA COLLECTION

Both quantitative (household census) and qualitative methods (informal group discussion, in-depth interview) were used for data collection. Triangulation of different methods and sources has been done to maximize the validity and reliability of data and to reduce the chance of biases. The following Table shows an overview of data collection methods, samples and sample sizes, research instruments and research variables.

**Table 1. Data collection strategies**

Methods	Samples	Sample size	Instrument	Research variables/topics
Household census	Every household of the study villages	1189 households	Pre-tested interviewer administered structured questionnaire	Household type, economy, education, occupation, social participation, knowledge on MHI, client satisfaction, communication, and promotion.
Informal Group Discussion	MHIB clients (VO, NVO, UP) & POs	120 clients (10 in each group) & 4 POs	Checklist	Network and choice for consultation and its reasons, communication and promotion, client satisfaction & expectation. Social attitudes and family situation on the above mentioned issues.
In-depth interview	BHC doctors & other health providers	9 (3 BHC doctors & 6 others)	Checklist	Disease prevalence, client expectations, provider's limitations and suggested solutions.

## RESULTS

### VILLAGE PROFILE

#### Village 1. Khilgaon

Khilgaon is situated about 5 km east of the Madhabdi AO of BRAC as well as the BHC. Madhabdi Bazaar, which is the commercial center of the surrounding area and a major bus station, is located about 3 km southwest of the village. Narsingdi Thana Sadar is situated about 14 km north of the village. The Dhaka-Sylhet highway is 3 km away from the village. The village has 598 households where 3,220 people (50.4% male and 49.6% female) were found to live during the survey.

The villagers cultivate rice once a year but the major crop that they grow is potato. They bring home paddy in the month of *Boishakh* but at that time they have to pay a lot to the hired labourers for helping them. So they said they get more cash money in the month of *Ashar*, when most of the people take up fishing and boating as their profession. People also work in the nearby textile mills, which employ and pay on weekly basis. In fact, the majority of the villagers work both in agriculture and in mills in parallel.

In Khilgaon there is only one primary school and one Madrasa. There is no secondary school, no college, no BRAC school, or any other NGO school in the village. The nearest secondary school is situated about 4-5 km away from the village. The local POs informed us that the BRAC Education programme initiated a few schools in this village some years back but they had to close them down due to the extreme high rate of dropout. The dropout rate was high because of the higher tendency to marry off girl children at an early age as well as sending boy children to work in nearby mills and factories.

There are two village doctors who got LMF (local medical facility) training residing in the village, but they provide consultation to the patients at their medicine shops in the Madhabdi Bazaar area where many other medicine shops (10- 12) are also situated. In cases of casual illnesses the villagers mostly go to these medicine shops and take medicines recommended by the salesmen. In a few of the cases these salesmen are LMF doctors. But in cases of more severe illnesses the villagers have to go to the local private clinics or to the public hospitals in Dhaka. Apart from these conventional medical options, the villagers also go to the traditional healers who are about 10-12 in number.

BRAC and a few other NGOs have their micro credit programmes in this village but our survey data shows that the percentage of households who are not involved in any NGO activities was 34%. Moreover, the loan recovery rate was around 70%, which was even quite low comparing to other parts of the country. The villagers said that they were less inclined to take micro credit as they suffered from severe flooding every year, which eventually makes them totally penniless.

Percentage of households who have electricity is 77. There are one *pacca* road, 5 ponds and 2 *haors* in this village. The local Union Parishad has only one member from this village. About 6 to 7 people of this village work outside the country and send money to their families back home. The villagers have their easy access to the local branches of Krishi Bank and other commercial banks, all of which are situated in the bazaar area. The proportion of Hindu and Muslim population is almost equal in the village.

## **Village 2. Kurer Paar**

The another study village Kurer Paar on the Dhaka-Sylhet highway is about 8 km south to the Narsingdi Thana Sadar. It is situated about 2 km north of the Madhabdi AO of BRAC and 1.5 km north of the BHC. The Madhabdi Bazaar is located about 3 km north of the village. The village has 591 households where 2,827 people (50.7% male and 49.3% female) were found to live during the survey.

Kurer Paar is economically more solvent than the village Khilgaon. Here the villagers cultivate paddy thrice a year. But they mainly depend on the nearby textile mills for their income. They work in these mills and factories on weekly or on monthly basis. Here women also play a significant role in household earning. Our survey data show that the proportion of households where adult women were reported to be income earners is 19%, which is quite high comparing to the other parts of the country. The village has to face severe flooding once in four or five years, but they said that the last year's flood had left them financially in bad shape. The village has a substantial number of migrated people who have settled here due to its high job opportunities. They stay in rented houses. So, letting out houses is also a good source of income for the local people. Another interesting thing in this village is that a large number of girls do not leave their parent's home after getting married, instead the grooms start staying with their in laws. The reason of this unusual practice also lies in the high rate of job opportunities here. This increasing degree of migration has made the village quite congested. In Kurer Paar most of the people could save some surplus money in the month of *Joishtho* when they harvest paddy.

There is no primary school, no secondary school, and no college, but only two Madrasas in this village. The nearest secondary school is 1.5 km away. But there are three BRAC schools in this village and almost all the children attend these schools very enthusiastically. The majority of the parents were found to be quite responsive about the necessity of education. Moreover, the tendency of using child labour and marrying off girl children at an early age were also lower here compared to Khilgaon.

There is no health center in this village and the nearest health center is BHC. Four LMF doctors live in this village and one of them has a medicine shop at about 0.5 km away from the village. The rest sell medicine in their shops in the bazaar area. These doctors provide consultation to the patients but do not take any consultation fees from patients who do not have the ability to pay. Apart from these LMF doctors the village have around 8 traditional healers.

There are 8 BRAC VOs in this village and around 10 other NGOs are also working here presently and the villagers were found to be quite positive about the micro credit programmes of different NGOs. But our survey data show that the percentage of households with any NGO membership is 59%, which is even lower than the village Khilgaon. Around 88% of the households have electricity connections and the village has one *pucca* road and 8 to 10 ponds. Around 10 people of this village work abroad and send money back home. The villagers have their easy access to the local branches of Krishi Bank and other commercial banks, all of which are situated in the bazaar area. The majority of the villagers are Muslims.

## **QUANTITATIVE ANALYSIS**

### **General household profile**

The survey covered all the households in both the villages. The key characteristics of the households of the two villages are shown in Table 2 suggesting that both the villages are quite similar in almost all the key variables. The study villages are located in an economically vibrant area of the country, with good road communication, and significant employment opportunities for both men and women as weaving and spinning workers in the many textile

**Table 2. Key household profile of the study villages**

Key variables	Kurer Paar	Khilgaon
Total no. of HHs	591	598
% of HHs with joint family arrangements	22%	22%
Average number of earning member in HH	1.53	1.59
% of HHs where adult women reported to be an income earner	19%	14%
% of HHs whose main income source is...		
Agriculture	7%	10%
Agricultural labour	1%	4%
Non agricultural labour	45%	46%
Self employment	30%	36%
Service	15%	3%
Average monthly income of self employed HHs	TK 6,994	TK 6,195
Average monthly income of service holders	TK 3,331	TK 4,732
% of HHs reporting...		
Chronic deficit	8%	8%
Occasional deficit	14%	17%
Break even	36%	32%
Surplus	42%	43%
% of HHs not owning homestead land	14%	4%
% of HHs not owning any cultivable land	75%	62%
Median land owned (in decimals) of those who own cultivable land	60	70
% of HHs owning...		
Radio	32%	30%
TV	37%	31%
Watch	67%	61%
Poultry	56%	56%
Livestock	26%	33%
Cycle	11%	14%
% of HHs having electricity connection	88%	77%
% of HHs reporting adequate winter clothing for all HH members	87%	70%
% of HHs where HH head...		
Never went to school	53%	61%
Has up to primary level education	24%	27%
More than primary level education	23%	12%
% of HHs where the most educated person in HH ...		
Never went to school	12%	15%
Up to primary	44%	54%
More than primary level education	44%	31%
% of HHs having current...		
Brac membership	20%	27%
Other NGO membership	39%	39%
No NGO membership	41%	34%
Of HHs having current NGO membership, % having multiple NGO membership	28%	30%

factories. Both the villages have a high percentage of households having electricity connection and luxury assets like TV. Interestingly, despite over 10 NGOs including the major ones operating in these two villages, the percentage of households reporting no current NGO participation is quite high (41% in Kurer Paar and 34% in Khilgaon). Moreover, of the

households that reported current NGO participation, the extent of multiple NGO membership is also quite high<sup>2</sup>.

### Step one: knowing about BRAC's MHI

About 59% of the households in the two study villages had heard about BRAC's health microinsurance offer. Despite the small difference in the distance of the two study villages from the BRAC Health Centre (*Shushasthya*—BHC, hereafter), it did make a difference in terms of knowledge of MHI. The extent of this knowledge was significantly higher in the study village located close to the BHC compared to the one located 3-4 km away<sup>3</sup>. To get a better picture of the variables that may explain why some households knew about BRAC's MHI while others didn't, we carried out a logistic analysis (Table 3).

**Table 3. Explaining knowledge**

Variables	Beta	Sig.
Village dummy [1=village further away from BHC]	-1.300	***
NGO dummy [1=current NGO membership]	1.070	***
Sex of household head [1=women headed]	0.150	-
Number of male earners in household	0.100	-
Maximum education level in household	0.080	-
Whether the household owns a TV [1=Yes]	0.570	***
Whether the household reports 'surplus' status [1=Yes]	0.360	**
Land owned (in decimals)	-0.001	-
Land owned squared	0.000	-
Constant	-0.370	-
% Predicted correctly	67%	

Even after controlling for other possible variables that may influence whether a household knows or not about BRAC's MHI, we found that even small difference in distance remains to be an important variable affecting knowledge. As most of the communications about the programme most likely used BRAC and other NGO platforms, it is not surprising that whether a household had current NGO membership or not also turns out to be important. However, this finding opens up another way of interpreting the apparently surprising effect of small difference in distance. This could be explained by difference in the extent of NGO participation between the two villages, rather than distance per se--- the 'close to BHC' village has a significantly higher percentage of households who had current NGO membership compared to the other one<sup>4</sup>.

We included two variables pertaining to household's level of being well-off: whether the household reported to be in 'surplus' category in the self rated income-consumption status; and whether the household owns a TV. Though these two variables overlap to some extent, they capture different things--- while the first one is about attained level of economic security, an absolute measure, the second one is about aspirations and position signaling, a relative

<sup>2</sup> This could be due to significant employment opportunities, especially for women, and relatively higher percentage of better-off households, resulting in high opportunity cost of participating in NGO programmes. The importance of traders' credit arrangements could also be another possible reason. NGO participation dynamics in economically vibrant environment could be an interesting future research area.

<sup>3</sup> The percentage of households who had heard of BRAC's MHI was 45% in the 'distant' village, while it was 72% in the 'close' village. The difference is statistically significant at 1% level.

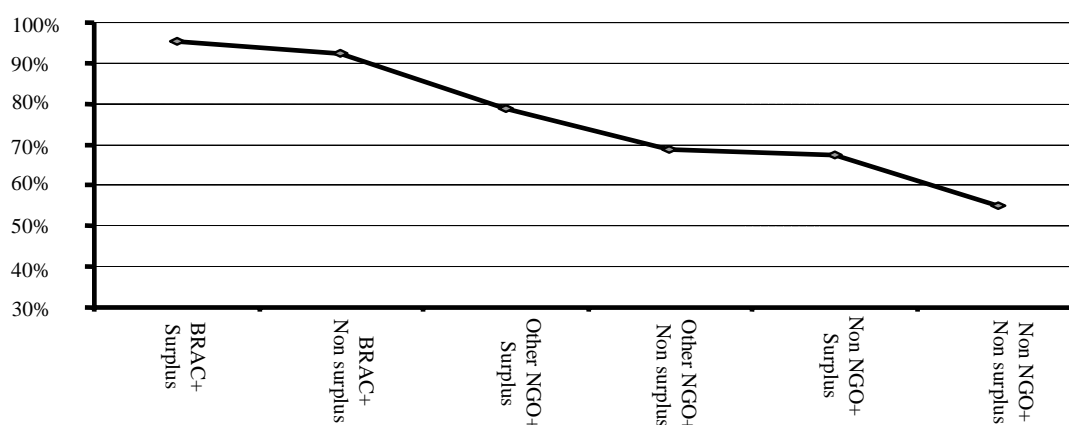
<sup>4</sup> The percentage of current NGO participating households is 66% in the 'close to BHC' village while it is 59% in the other village. The difference is statistically significant at 1% level.

measure<sup>5</sup>. We found that both these variables were important in explaining knowledge about MHI. The other variables included in the model all have the expected direction of relationship though they are not significant.

The logistic regression model can be used to estimate the probability of knowledge of MHI for a particular type of group. We did this by constructing different groups out of two key variables--- whether the household reported to be in surplus wealth category and the NGO membership status of the household. This gives us six mutually exclusive groups. Figure 1 shows how the estimated model probability of knowledge of MHI varies across these groups.

People knew very little about the MHI offer. There are serious gaps among relatively poorer households, especially if they do not have any NGO membership. This suggests that the communication platform currently used is predominantly BRAC's village organizations, this needs to be expanded and a broader community-based communication strategy needs to be developed.

**Figure 1. Probability of knowledge of MHI**



### Step two: deciding to enroll

Table 4 shows the different enrolment status of all the households in the two study villages. Overall, only 16% of the households took up the MHI offer. If we only consider the subset of households who knew about the MHI offer, 28% of those households subscribed. Most of the households either did not subscribe despite knowing about MHI (42%) or said that they were not interested when we described the offer to them (21%). However, over 20% of the households who did not know about MHI showed interest in enrolling when we described the offer to them, suggesting that more comprehensive social marketing strategy could increase the extent of enrolment.

**Table 4. Enrolment status-revealed and latent**

Status		Number (%)
Enrolled	Revealed demand	195 (16%)
Knows about MHI but didn't enroll	Revealed no interest	502 (42%)
Doesn't know about MHI but interested to enroll	Latent demand	247 (21%)
Doesn't know and not interested to enroll	Latent no interest	245 (21%)
Total		1189 (100%)

<sup>5</sup> While a much higher proportion (over 50%) of those reporting to be in 'surplus' category owned a TV, 29% of those in break-even and 14% of those in 'occasional deficit' category also owned a TV.

For programmatic perspective, the key group to understand better is the third one—those who didn't know about MHI but once explained became interested (latent demand, or LD hereafter). One useful way to gain a better understanding of this group is to compare it with the group of households that did enroll (revealed demand, or RD hereafter). This is done in Table 4 suggesting that the households in the LD group are more likely than the RD group to be involved in textile sector work as their major source of income. It is likely that households who rely mostly on textile sector work have high opportunity cost of participating in NGO-based activities and are, therefore, less likely to be able to reveal their demand for products such as health microinsurance, which appear to be communicated and mediated through NGO-based platforms. Compared to the RD households, the LD households tend to be less in the 'surplus' category, though they are not any more likely to be in the lower wealth categories than the RD households. The RD group of households tends to have significantly greater ownership of 'luxury' assets such as TV compared to the LD group. The heads of households in the LD group tend to be more illiterate, again suggesting that the latent demand for BRAC's MHI offer lies with a group of households which are relatively poorer than the ones who have enrolled.

The difference in NGO membership status of the households in the two groups reveals an interesting pattern—while a significantly larger proportion of the households in the RD group are BRAC members, the opposite is true for 'other NGO' membership, suggesting that a significant latent demand for the MHI offer exists among households having 'other NGO' membership. This is also true for households that do not have any NGO membership (Table 5).

**Table 5. Differences among groups: revealed and latent demand**

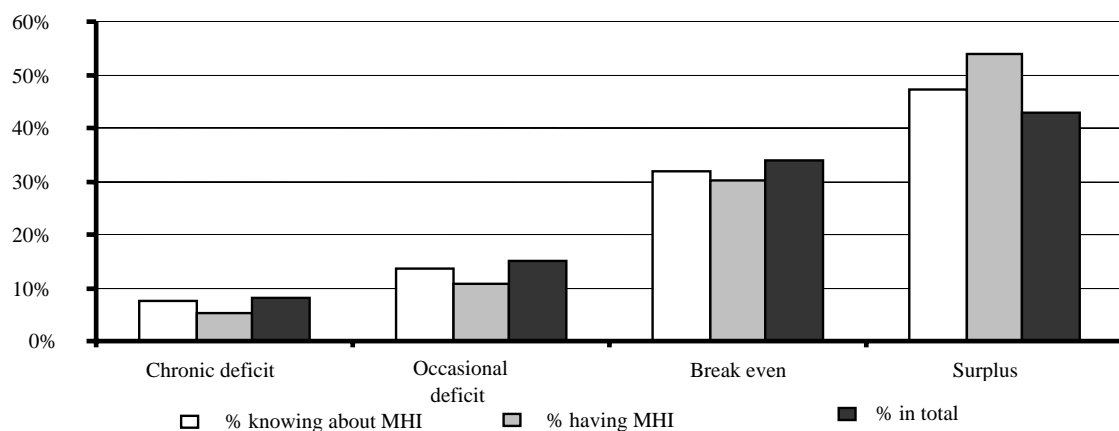
	Enrolled [RD group]	Doesn't know but interested to enroll [LD group]	t-stats
% of HHs whose main income source is...			
Agriculture	7%	7%	0.043
Agricultural labour	1%	6%	2.75***
Non agricultural labour (excluding textile)	18%	9%	2.75***
Textile worker	24%	36%	2.98***
Self employment	41%	34%	1.4
Service	9%	7%	0.91
% of HHs reporting...			
Chronic deficit	5%	7%	0.763
Occasional deficit	11%	15%	1.3
Break even	30%	35%	1.1
Surplus	54%	43%	2.29**
% of HHs not owning homestead land	6%	7%	1.005
% of HHs not owning any cultivable land	69%	62%	1.48
% of HHs owning...			
Radio	38%	28%	2.24**
TV	49%	27%	4.89***
Watch	75%	61%	3.29***
Poultry	63%	51%	2.64***
Livestock	33%	29%	0.943
Cycle	19%	10%	2.82***
% of HHs having electricity connection	85%	79%	1.52
% of HHs reporting adequate winter clothing for all HH members	80%	68%	2.75***
% of HHs where HH head never went to school	48%	60%	2.38**
% of HHs having current...			
BRAC membership	54%	15%	9.38***
Other NGO membership	32%	46%	2.89***
No NGO membership	14%	39%	6.05***

A shift in programmatic focus away from the ‘surplus’ and relatively better-off households to moderate poor households thus makes sense both from a programme expansion and an equity point of view. Moreover, targeting households having membership in other NGOs and those having no NGO membership may be worth considering as an expansion in enrollment strategy.

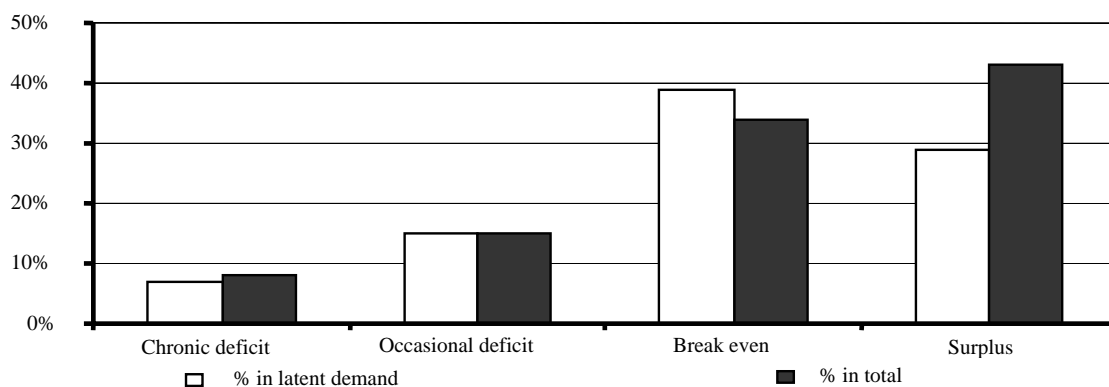
Figures 2 and 3 summarize the main arguments so far. Figure 2 compares the wealth distribution of those who knew about MHI, and those who subscribed to MHI with the wealth distribution in the overall study population. This tells us how equitable the knowledge of MHI and its uptake has been so far. We found that the distribution of knowledge of MHI has not been equitable, but it is more equitable that the actual uptakes of the MHI offer--- the share of the chronic, occasional deficit, and break even households in terms of knowing about MHI is less than their respective share in the study population, while it is more than its share for the surplus category households. This distributional pattern worsens when it comes to actual uptake of the MHI offer.

Figure 3 shows the distribution of different wealth categories in latent demand--- the group of households that did not know about MHI but expressed their interest when the basic offer was explained. Again, this is compared with the share of the same wealth categories in the overall study population. We found that the share of latent demand was more than proportionate for the break-even category and in proportion for the occasional deficit category households, while it is less than proportionate for the surplus category households. Thus, both from an equity and expansion opportunity point of view it is worth considering serious expansion drive to these two categories of households.

**Figure 2. How equitable is knowledge and uptake of MHI?**



**Figure 3. Where does the opportunity lie?**



### Step three: renewal

Most of the MHI subscribers whose annual subscription of MHI expired did not renew (Table 6). However, most of those whose annual subscription had not expired expressed an interest to renew their subscription.

**Table 6. Renewal status of MHI general package subscribers**

Renewal status	Number (%)
Renewed	41(27%)
Not renewed	85 (55%)
Not yet renewal time, but interested	19(12%)
Not yet renewal time, but not interested	9 (6%)
Total	154 (100%)

To get a better sense of what the determinants of renewal or interest to renew were, we used a logistic regression model, the results of which are shown in Table 7. The distance from BHC and the maximum education level of the household turn out to be important but only at 10% level. The most important variable influencing the decision to renew according to the model appears to be the perceived quality of services that the subscriber received from BHC—subscribers reporting that they were ‘satisfied’ with the services from BHC were significantly more likely to renew their subscription.

**Table 7. Determinants of decision to renew**

Variables	Beta	Sig
Village dummy [1=village further away from BHC]	-0.804	*
NGO dummy [1=current NGO membership]	-0.247	-
Sex of household head [1=male-headed]	0.140	-
Number of male earners in household	0.050	-
Maximum education level in household	0.546	*
Whether the household owns a TV [1=Yes]	-0.021	-
Whether the household reports 'surplus' status [1=Yes]	0.019	-
Land owned (in decimals)	-0.002	-
Land owned squared	0.001	-
Whether satisfied with SS service [1=Yes]	1.950	***
Constant	-3.045	*
% Predicted correctly	69%	

As satisfaction with BHC turns out to be an important variable in this part of our story, we estimated the following logistic model to shed some light on determinants of satisfaction with BHC. The results are shown in Table 8, which suggests somewhat paradoxically that the households who reside in the study village further away from the BHC were significantly more likely to be satisfied with the BHC services than the households who live in close to BHC village and avail its services. This could be due to both demand and supply side factors---households living far away from BHC village may have less options compared to the other villagers. However, this could also be due to supply side policies of BHC. Though not significant, BRAC members are less likely to be satisfied with the services they get from BHC compared to non-BRAC customers of BHC. Interestingly, customers who have membership in other NGOs are significantly more likely to report satisfaction with the BHC services. In general, the members of NGOs come from relatively poorer economic status and as most other

NGOs do not provide services such as BHC, the opportunity to avail it is very well received. What is somewhat worrying is that households who reported surplus economic status were much more likely to be satisfied with the services of the BHC than those who reported otherwise. On the one hand, this is encouraging as it suggests that BHC services are also attractive to the better-off customers, but on the other hand, it may compromise with the equity perspective in the service provision of the BHC and needs to be more carefully studied.

**Table 8. Determinants of satisfaction with BHC**

Variable	Beta	Sig.
Village dummy [1=village further away from BHC]	1.18	***
BRAC dummy [1=current BRAC membership]	-0.362	-
Other NGO dummy [1=Other NGO membership]	0.613	**
Sex of household head [1=male headed]	0.334	-
Number of male earners in household	-0.13	-
Maximum education level in household	-0.03	-
Whether the household reports 'surplus' status [1=Yes]	0.586	**
Land owned (in decimals)	-0.004	-
Land owned squared	0.002	-
Constant	0.6819	-

Whether a customer is satisfied with the BHC services or not is important not only because it affects the decision to renew MHI subscription, but also because it can adversely affect word-of-mouth marketing. Indeed, our data show that as expected all of those who reported that they were satisfied with BHC services said that they would encourage others to enroll in the MHI, while only 19% of those who were not satisfied with the BHC services said that they would encourage. We shall explore the BHC service issue in greater depth in the qualitative analysis below.

## QUALITATIVE ANALYSIS

### The perspective of the clients

#### *Knowing about MHIB*

From our group discussions with the people who have never subscribed MHI of BRAC, we found that the majority of the participants were more or less ignorant about the programme and they have many misconceptions about MHIB. They said that the MHI subscribers had to pay as much money as the non-subscribers paid and even that the BHC charges as much as the other hospitals charge. So to them, it's no gain to get subscribed in MHIB. When we asked them from where did they get these information, they said that they knew about this from the people who subscribed. They felt betrayed and eventually they discouraged others to get enrolled. Even the VO members, who are supposed to know about MHI from the VO meetings, did not know about the programme well because they are said to be irregular at VO meetings. But the encouraging fact is that even though very few women were found to be familiar with MHIB in this non-subscribed group, they talked positively about it. They kept on disagreeing with other women who were opposing the programme and was trying to amend the wrong idea that they had on MHIB. These women were interested to get enrolled in the near future.

When we had discussions with people who subscribed once but not renewed afterwards, we found that even though this group got enrolled in MHIB once, they did not know much about the package. This is because most of them got enrolled almost 2 to 3 years back and

neither used it nor renewed it. Even when they got enrolled they had not been well informed about the package. They were somewhat compelled to buy the insurance when they went to take micro credit. When the POs were asked about it they said they had to force people to some extent at the beginning of the project because at that time even they didn't have any clear guideline about the project but at the same time they had to fulfill a targeted number of clients and this situation forced them to force others in enrolling. But they opined that this attitude towards the clients eventually did harm to the programme. Another reason behind not knowing about MHI is that the majority of this group is not VO members. So, they do not attend the VO meetings, which eventually make them remain ignorant about the programme. It signals the weakness of the VO centered promotional activities of the programme. The groups of people who have subscribed and also renewed were found to be quite acquainted with MHIB. The majority of people of these groups are VO members, who are quite well-off and more or less educated. This finding supports the previous finding from the quantitative section that the promotional activities have somewhat failed to reach the relatively poorer households with no NGO membership and further proves the need to concentrate on more diversified communication techniques.

But one thing should be mentioned here that in many cases we found that the respondents actually knew about MHI but when outsiders like the researchers ask them about it they respond in the negative. The local POs explained that the village people responded negatively because they thought that the outsiders from Dhaka would force them to subscribe MHIB if they said that they knew about it. Another reason that they mentioned was that the villagers could recall about the programme and its packages only when they meet the “*card' er apa*” (the POs). So, it hints an information gap in the survey data that shows a large percentage (41.4%) of people did not know about MHIB at all.

#### *Most prevalent health problems of the study area*

When we enquired about the most prevalent health problems, most of the respondents, including the local doctors, reported mainly about different skin diseases, gastro-intestinal diseases and cold-related disease. They also reported about asthma, heart diseases, different gynaecological diseases and various complications related to maternity. But people claimed that usually they did not go to doctors more than twice or thrice a month. They mentioned that in terms of frequency children suffered the most. During flood and in rainy season the pervasiveness of different diseases increases and as such they had to visit doctors more frequently.

#### *Different health services that the study population prefers to take*

People in both the villages have their own preferences about different health services available in terms of distance, reliability and affordability. The rationale they have behind these preferences would give us a better understating of the client perspectives of MHIB. The health services that the study population prefers to take are discussed below. A detailed list of different health service providers of the study area is included in the appendix section, which would help get a clearer picture of the scenario.

In Khilgaon, for casual illnesses (fever, cold, gastro-intestinal problems, etc.) the villagers usually prefer to go to the medicine shops situated in the Madhabdi Bazaar area and buy medicines. In medicine shops the salesmen, who are not even LMF doctors in some cases, give them medicines knowing their problems. The villagers prefer these shops because here they do not have to pay any consultation fee. Moreover the poor villagers can go there by walking as the bazaar area is about 2.5 to 3 km away from the village. So it costs them only the price of the medicines, neither any transport cost nor any consultation fee. These people do not really prefer to go to BHC. Because to go there they have to take rickshaws, which would cost

them at least Tk.15. Moreover, in BHC they have to pay a consultation fee. But distance is not the only cause behind any preference. A FWC (Family Welfare Center) is situated within 1 km of the village, which is totally free for all. But the villagers do not prefer to go there because they said that most of the time the required medicines were out of stock and the doctors there give lesser amount of medicines to the patients which make no good to them. Apart from the quantity of medicines, the doctors and other staff behaved badly with the patients. The villagers also consult homeopaths and herbal healers in some cases, which they found as the cheapest.

On the other hand, for severe illnesses (like injury or any other emergency cases) the villagers are left with lesser options as only two local private clinics have the facility to offer treatment to these patients. So in these cases they have very little options but to go to the private hospitals situated in the bazaar area, even though it costs them a lot. They do not prefer much to go to the public (govt.) hospital in Narsingdi Sadar, because they found the public hospitals friendly with only peoples with good connections. But they have their faith on Dhaka Medical College Hospital (DMCH). If every other option fails they go to DMCH as a last try. In these cases they cannot rely on the BHC, as they do not have any Ultra-sonogram machine, or X-ray or ECG machine. They refer them to other hospitals when any complication arises, which they found very hazardous. But in cases of complications related to maternity they found BHC as most cost effective and reliable.

In Kurer Paar, people visit BHC more often than Khilgaon, as it is only about 2 km away from their village. But for causal diseases people also go to a LMF doctor who sits at his medicine shop, which is only 0.5 km away from the village. For more severe diseases they go to local private hospitals and even to Dhaka. They also go to the traditional healers and to the homeopaths. But for complications related to maternity almost all of them go to the BHC. In the cases of severe illnesses their preferences are more or less same to the villagers of Khilgaon.

*What do they do while seasonal poverty coincides with sudden illness?*

All of our discussants reported that in the cases of sudden illness during seasonal poverty they borrow loans from their relatives. Even when we talked to patients at one of the private hospitals of the study area, we found at least one well-off relative for every poor patient there who was helping them financially. So an informal social support network plays a very significant role here.

*What encourage people in enrolling?*

We found that the idea of getting medical service at a cheaper price encouraged the majority of the clients in enrolling. But very few of these people actually understand the idea of health insurance as a risk sharing mechanism. A large number of people also reported that the insurance scheme is good because it confirms good care during pregnancy and childbirth at a cheaper price. This impression too supports the previous statement that very few people actually could comprehend the rationality of investing on health before any crisis actually occurs. In fact they are found to be more interested in spending money when any concrete need arises.

“I’m a chronic patient of chest pain but my mother couldn’t afford medicine for me. Now after having ‘bima’ card, the BRAC doctors have made me almost cured.”

Shumi, An ‘equity package’ cardholder

“My daughter was dying, so I went to BRAC hospital and bought a card before the caesarian operation so that they would take lesser charge.”

Ambia, mother of a ‘PPP related care package’ cardholder

What encourage people in renewing?

A large number of people said that they did not need to consult any doctor during the insured period. But those who were benefited from such scheme were found to be the most encouraged to renew it further. They said that the insurance gives them a sense of security. Apart from these benefited people, those who did not find it much difficult to arrange the premium money were also found to be quite interested to renew.

What discourage people from enrolling?

Most of the participants said that for casual illnesses (fever, cold, gastro-intestinal problems, etc. the BHC costs more than the homeopathy doctors and the herbal doctors. In these cases the villagers usually take these alternative medicines or go to the nearby medicine shops which do not charge any consultation fee. On the other hand, for severe illnesses BHC cannot provide them with proper service, as they do not have any ultra-sonogram machine, or any X-ray or ECG machine. They refer them to other hospitals, which they found very hazardous. And this situation discourages them from getting enrolled in the programme.

**An incident reported: both sides of the story**

The patient's side: Abdul Ali, whose wife is a MHIB client, complained that a few days back his son fell down from the bed and became unconscious. He quickly took him to *Shushasthya*, but the doctors rejected to admit his son and suggested Ali to take his son to the Sadar Hospital. As the Sadar Hospital is quite far away, he had no other option but to take him to a local private clinic (Prime General Hospital). There they treated him with only a saline and released him within a few hours. It cost him about Tk. 800, which he felt quite high but even though he is pretty happy with their service. But the way he was treated at *Shushasthya* made him very hurt and he said he would never renew his card.

The doctor's side: When asked about the incident, the *Shushasthya* doctors said that they do not have any equipment to diagnose the reason behind a sudden collapse. So they cannot take the risk of treating a patient without proper diagnosis. It could have been fatal if the sudden collapse was due to a brain stroke. If anything bad had happened everybody would accuse the doctor on duty and at the same time it would tarnish the image of BRAC.

A good number of the participants also said that they found the annual premium quite high, which they could not afford. Many people also said that they knew about MHI but never felt the need to get enrolled because all of them have a very small nuclear family with no young children or no children at all and so their family members do not often get sick. Therefore, they did not feel the need to have any health insurance at all.

Some even said that they could afford to go to more costly doctors than the BHC because they were not that poor. They felt, the more costly private clinics give better service than the BHC and so they preferred to go to those clinics. As such, they did not find it worthwhile to get enrolled in MHIB. A few of the discussants also said that they were not willing to get enrolled because the people who had been its clients have discouraged them by saying that the BHC costs the subscribers the same as the non-subscribers. Thus, it appears that the weakness in the communication activities plays a significant role behind the low rate of renewals.

On the whole, people were found to be less inclined to invest on medical cure prior to any illness actually takes place. They lack a proper conceptualization of the idea of insurance or pre investment on health. Some people also expect every facility from BRAC totally free of cost. So they feel cheated or lose interest when they realize that they have to give a good amount of money to get the facility of 'low cost health service'.

What discourage people from renewing?

A moderate number of people reported that they were more or less satisfied with the services provided by the BHC when they went there as a MHIB card holder but could not afford to renew the card due to poverty.

**Defenseless but not ultra poor**

A group of women reported that all of them had been quite well-off and were subscribers of MHIB. But about one and half years ago an incidence of murder took place in their village and their husbands got sued in that murder case falsely. As a result, for the last one-year or so, the male members of their families are absconding and the families, who are left with no stable earning members, are still spending money and fighting the case to get them freed. This sudden poverty has made them unable to renew the insurance. Moreover, as they own small amount of land they do not even belong to the ultra poor group, and this shuts up their chance to get enrolled even in the 'equity package', which is free.

Some people also reported that at first they were somewhat forced to buy the insurance when they went to take micro credit, the approach which they did not like and that eventually discouraged them from getting renewed.

A large number of people said that they did not renew their cards because when they were enrolled they did not find any scope to use it. None of their family members suffered from any severe illness and as because for casual illnesses they did not prefer to go to the BHC, they found the insurance just as a costly wastage of money. So it also supports the previous finding that the study population lacks a proper conceptualization of the idea of insurance or pre investment on health.

How do they assess the programme?

When we asked the discussants to assess the MHI programme all of them gave their assessments on BHC. To them MHIB and BHC were almost synonymous. While assessing, at the beginning almost all the people said that they were more or less satisfied with the BHC as MHIB clients. But after some time, when they become more spontaneous, they start giving a long list of complaints against BHC. They claimed that the services of BHC played a determining role in their decisions to get enrolled in MHIB or not. The assessments given by the present subscribers and the dropouts are discussed below.

The ultra poor subscribers, even though they were few, were found to be quite satisfied with the programme that gives service to them almost free of cost. The subscribers of the 'PPP care package' were also found to be happy with the programme as it gives them a sense of security during the pregnancy period.

But the complaints against BHCs include a long list. Most of the respondents complained that even though the BHC is supposed to be open 24 hours a day; they did not find any doctor after 5.00 pm. Only the paramedics treat the patients then. They also said that in most of the cases they had to buy medicine from outside. BHC keeps only cheaper medicines. They claimed that the BHC staff sold out their stock of costly medicines which were supposed to be given to the poor people free of cost. They protested that the doctors behave well but the office staff, who distribute tickets to the patients behave quite rudely. They also added that in the cases of severe illnesses BHCs could not provide proper services, as they do not have any ultra-sonogram machine, or any X-ray or ECG machine. They refer them to other hospitals, which they found very hazardous. All of them said that they were willing to pay more if BHC could provide them with all kinds of pathological tests (they suggested to include at least X-

ray, ultra-sonogram, and ECG). They said for example that the local Prime General Hospital charges Tk 300 for an ECG and the Suhrawardy Hospital at Dhaka costs Tk 60 for doing the same. But for going to Dhaka they have to spend a lot for the transportation. So, they suggested that even if BHC charges Tk 100 for an E.C.G., it would be more convenient and affordable for the patients as well as would be more profitable for the BHC. They assessed the rate of insurance premium by saying that for the well-off people it's easy to pay the premium for the whole year together but for the poor people it becomes sometimes quite difficult. So, the poor are more interested to pay the yearly premium in a few installments.

Finally, this should be included here that all the respondents quite unanimously said that researchers from Dhaka kept coming to them quite often and they kept saying the same complains to them again and again, but all these were of no use and everything remained the same as it was before. So, if the problems they have mentioned not get solved in near future, they said that they were not much willing to renew their MHIB cards any more.

#### What do they expect from a health insurance?

- The premium should be less (Tk. 80 instead of Tk. 100).
- The poor are more interested to pay the yearly premium in installments. They are even interested to pay the premium in two installments in the same month.
- They are willing to pay more if BHC could provide them with all kinds of pathological tests (they suggested to include at least X-ray, ultra-sonogram, and ECG) because they have to pay it to other hospitals in any case.
- The reference money should be increased.
- The reference money should be given to the patients right after they are referred to other hospitals. Presently, the programme doesn't give the reference money to the patients when the doctors refer them elsewhere. They only give the money after submitting the record of further treatment. So in these cases the patients have to borrow the money from elsewhere which is not always easy for them.

#### **The perspective of the health service providers of BHC**

As the clients have claimed that the BHC play a determining role in subscribing MHIB, we have talked to the BHC doctors and asked them to identify the problems of BHC and also asked for their suggestions for its improvement. The doctors also believe that to make the MHIB programme successful, it is necessary to improve the BHC a lot, because people won't get encouraged to subscribe the MHIB cards unless they find the BHC reliable enough. So, the problems they have mentioned and the suggestions that they have given to make the BHC more effectual are discussed below.

The BHCs do not have the facility of doing some essential pathological tests, so in many cases the doctors have no other way but to refuse patients to get admitted there. For example, a few days ago a patient with acute asthma went to the BHC. The doctors claimed that asthma could happen both due to heart and lung problems. As they do not have any ECG machine, they could not offer the patient any treatment, because a wrong treatment could have been fatal for the patient.

In BHCs, the doctors, apart from their role as medical officers, also have to play the role of a manager (they have to collect blood, manage money from the patients, etc.) and of an

accountant (they have to keep records of all the incomes and expenditures). Due to this work overload they couldn't manage the time to properly follow up the condition of patients. As a result it hampers their performance as a doctor.

Most of the BHCs appoint only one doctor each. But a doctor always needs another doctor to consult with while taking any decision where any risk factor is involved. In many cases, the doctors have to perform surgeries with the help of FWVs (Family Welfare Visitors), which can be very dangerous (e.g. a few days ago in another *Shushasthya*, while doing a surgery on a carbuncle, suddenly it became very difficult to stop bleeding as the boil had its link with the blood vessels and the doctor felt very helpless as he couldn't get help from any other doctor).

In Madhabdi, the doctors and all other staff have to work beyond their office hour, but no remuneration is paid for this extra service, which eventually makes them a bit demoralized or less enthusiastic. But this problem is not present everywhere. It varies depending on the locality where the BHC is situated. For example, in Dinajpur (Bhabanipur), the workload for the doctors is far less compared to Madhabdi as almost 40% less patients go there (as it doesn't have the facility of blood transfusion or caesarian operations). So, there they do not have to do any overwork.

The infrastructures of the local private clinics are very attractive while BHC cannot even provide the patients with adequate space (like there is no children ward and even the male and female are kept in the same ward. Only the caesarian patients are kept in a different ward.) This aspect make the patients less willing to come to BHC as well as make them less willing to get enrolled in MHIB.

The local private clinics keep brokers who collect patients for them from the villages and in return get Tk 500 to Tk 1,000. On the other hand, the BRAC *Shastho shebikas* get only Tk. 100 for doing the same for the BHC and in some cases they don't even get this money on time. As a result, the private clinics some times bribe the *Shebikas* to bring patients to them, and eventually the BHC loses patients.

BHCs do not appoint any pathologist. They give a 6 months training to technicians and appoint them as pathologists. In some cases these pathologists give pathological reports in the name of BHC doctors but in reality the doctors do not perform any pathological test. As a result, the pathological reports given by any BHC is not accepted anywhere else in the district level and this makes the situation very hazardous for the patients.

### Recommendations

- To make BHC more effective and to attract more patients it should have at least the x-ray, ultra sonogram, and ECG machines. An incubator and free ambulance service (for 3 to 4 BHCs altogether) are also needed.
- To make BHCs run properly the fees on average should be increased. Or it could take more money from those who can pay more and less money from those who cannot pay more (the LAMB Hospital, which is situated near Dinajpur *Shushasthya* runs this way).
- The duty hour of all the staff should be strictly maintained or otherwise they should be given an extra pay.
- To run the Madhabdi BHC (where the patient turn out rate is quite high) properly, it should appoint at least a manager (preferably local) and an accountant.

- A BHC must have different wards for male-female-children and for people with different contagious diseases.
- Every BHC should have more than one doctor, preferably one male and one female, as female patients (majority of the patients are women and children) always look for female doctors and even in many cases they refuse to take medical help if no female doctor is available.
- The *Shastho shebikas* should be given more money for their service and it should be given on time. They should also be offered proper motivational training for doing their job.
- There should be at least one pathologist for 3 to 4 BHCs altogether and this could even bring profit to BHC, as pathological tests are a great source of earning for the private clinics everywhere.

### **The perspective of the MHIB programme organizers (PO)**

As we have seen from our previous discussions that the failure and success of the communication activities plays an important role behind enrolments and renewals, we found it very useful to conduct an informal group discussion with the programme organizers of MHIB. Our goal was to have a better understanding of the communicational activities that they do for promoting the project as well as to take suggestions from them for a more effective communication strategy.

When asked about what they do for promoting the programme they have mentioned that the POs organize and participate in meetings within 8 to 10 km of the AO and the SSs go up to 12 km. The MHIB POs attend different VO meetings (once a week per village) and VO leaders meetings; they also organize group meetings in villages. They attend BEP parents meetings, UP meetings and BEP teachers refreshers meetings once in 2 or 3 months. They also organize meetings in local schools and colleges (once a month), which are situated in Madhabdi Pourashava, Meherpur Union and Shilmandi Union. All these places are within 4 to 5 km from the AO. But renewing cards the POs visit door to door. For communicating the VO members of other NGOs they collect their VO meeting schedules and attend their meetings and promote MHI. They also communicate with the MELA loan borrowers of BRAC, who are NVOs. The only male PO of the programme goes to marketplaces once a week or in two weeks and convinces the businessmen. But they migrate to other places quite often, so it's a bit difficult for him to get them renewed. They distribute leaflets highlighting the programme packages while attending the meetings. The programme also organized 15 'Popular Theaters' for disseminating its messages. But staging of popular theater is stopped for the last one year.

### Suggestions for better communication

- The MHIB POs attend one VO meeting a month in one village. But as there are more than one VO in most of the villages, sometimes it takes more than a month to meet the same VO again. So the number of VO meetings should be increased.
- Every month in every village pre-organized group meetings consisting of 25 to 30 women should be arranged.
- Group meetings consisting of about 10 women in every *para* in every village should be organized. These could be arranged instantly.
- The BEP school parents meetings should be held at least once in two months.

- The number of meetings with UP members should be also increased.
- One volunteer per village can be arranged who would be given a certain amount of money if they could manage to fulfill the targeted rate of client enrollment.
- Meetings could be arranged in mosques on every Friday after *Jumma* prayer. These meetings help a lot.
- Meetings should be arranged with the village doctors recognizing their service in the health sector.
- Should participate in monthly cluster meetings of government primary schools.
- Only four POs have to do communication activities to 1,84,000 people. So the number of MHI staff at the field level should be increased to at least six.

### **SUMMARY OF QUALITATIVE FINDINGS**

The most prevalent health problems of the study area include different skin diseases, gastro-intestinal diseases and cold-related diseases. Asthma, heart disease, different gynaecological diseases, and various complications related to maternity are also common. During flood and in rainy season the pervasiveness of different diseases increases. But people usually do not go to doctors more than twice or thrice a month and most of the time, it is for their children that they go to doctors. When sudden illness coincides with seasonal poverty they borrow loans from their relatives. So, an informal social support network plays a very significant role here.

People in both villages have their own preferences about different health services available in terms of distance, reliability and affordability. In cases of casual illnesses (fever, cold, gastro-intestinal problems, etc.) the villagers usually prefer to go to nearby medicine shops and buy medicines from there. The villagers prefer these shops because in these sales centers they do not have to pay any consultation fee. Moreover, the poor villagers can go there by walking. So, it costs them only the price of the medicines, neither any transport cost nor any consultation fee. These people do not really prefer to go to BHC because it requires both transportation fee as well as consultation fee, along with the cost of medicines. But distance is not the only cause behind their preferences; they also count the quality of service. The villagers also consult homeopaths and herbal healers in some cases, which they find as the cheapest. On the other hand, in cases of severe illnesses (injury or any other emergency cases) the villagers are left with lesser options as only two local private clinics have the facility to offer treatment to these patients. In these cases they cannot rely on the BHC, as it does not have enough pathological facilities. It refers them to other hospitals when any complication arises, which they find very hazardous. But in cases of complications related to maternity they find BHC as the most cost effective and reliable.

The majority of the non-subscriber group is more or less ignorant about MHIB. They also have some misconceptions about the services it offers. But the groups of people who have subscribed and also renewed were found to be quite acquainted with it. However, the majority of people of these groups are VO members, who are quite well-off and more or less educated. It signals that the promotional activities have somewhat failed to reach the relatively poorer households with no NGO membership and proves the need to concentrate on more diversified communication techniques.

The offer to provide health services at a cheaper price have encouraged the majority of the clients to enroll. But very few of these people actually understand the idea of health

insurance as a 'risk sharing mechanism'. A large number of people reported that the insurance scheme was good because it confirmed good care during pregnancy and childbirth at a cheaper price. This impression too supports the previous statement that very few people actually could comprehend the rationality of investing on health before any crisis actually occurs. In fact, they were found to be more interested in spending money when any concrete need arises. Moreover, only those who got substantial benefit from the scheme were found to be the most encouraged to renew it further. They admit that the insurance gives them a sense of security. Apart from these benefited people, those who did not find it much difficult to arrange the premium money were also found to be interested to renew.

As most of the people did not find the BHC reliable enough in emergency cases, it discourages them from getting enrolled in MHIB. Some people said that they got discouraged to enroll since the annual premium was quite high. Again, people with small nuclear families and families without little children did not feel the need to get enrolled because they did not get sick very often. Some people felt that the more costly private clinics provided better service than the BHC and as they had money, they preferred to go to those clinics. As such they did not find it worthwhile to get enrolled in MHIB. There were also some people who expected every facility from BRAC should be free of cost. So, they feel cheated or lose interest when they realize that they have to give a good amount of money to get the facility of 'low cost health service'.

A moderate number of people reported that even though they were more or less satisfied with the MHIB facilities, they could not afford to renew the card due to poverty. A large number of people said that they did not renew their cards; because when they were enrolled as clients they did not find any scope to use it. So, they consider the insurance just as an 'expensive wastage of money'. Moreover, some people have also complained that they were somewhat forced to buy the insurance when they went to take micro credit, the approach which eventually discouraged them from getting renewed.

The services of BHC play a determining role in their decisions to get enrolled in MHIB. People had a long list of complaints against BHC. Most of the respondents complained that even though the BHC is supposed to be open 24 hours; they did not find any doctor after 5.00 pm. Only the paramedics treat the patients then. They also said that in most of the cases they had to buy medicine from outside, BHC keeps only the cheaper medicines. They also have complains about the way they are treated there by the support staff. An issue worth mentioning is that all of them said that they are willing to pay more if BHC could provide them with all kinds of pathological tests (they suggested to include at least X-ray, ultra-sonogram, and ECG) so that they can have one-stop service from it at a price slightly lower than the other profit-making hospitals. The poor were more interested to pay the yearly premium in few installments. They were even interested to pay the premium in two installments in one month. They also expected that the reference money should be increased and it should be given to the patients right after they are referred to other hospitals.

The doctors believed that to make the MHIB programme successful, it was necessary to improve the BHC a lot. Because people would not be encouraged to subscribe in MHIB unless they find the BHC reliable enough. They said that to make the BHC more effective and to attract more patients it should have at least the X-ray, ultra sonogram, and ECG machines. An incubator and a free ambulance service (for 3 to 4 BHCs altogether) are also needed. To run BHCs properly the fees should be increased. Or, it could take more money from those who can pay more and less money from those who cannot pay more. The duty hour of all the staff should be strictly maintained or otherwise they should be given an extra pay. To run the Madhabdi BHC properly where the out patient load is high it should appoint at least a manager (preferably local) and an accountant. A BHC must have different wards for male-female-children and for people with different contagious diseases. Every BHC should have more than

one doctor, preferably one male and one female. Lastly, there should be at least one pathologist for 3 to 4 BHCs altogether and this could even bring profit to BHC, as pathological tests are a great source of earning for the private clinics everywhere.

Our study reveals that the failure and success of the communication activities of the programme play an important role behind subscription and renewal rates. Currently, only four POs do communication activities among 184,000 people. So, for a more effective communication, the number of MHI staff at the field level should be increased to at least six. The number of VO meetings should also be increased. Pre-organized as well as instantly arranged group meetings should be held every month in every village. The BEP school parents meetings should be held at least once in every two months. The number of meetings with UP members should also be increased. The Pos should participate in monthly cluster meetings of the government primary schools. One volunteer per village can be arranged who would be given a certain amount of money if they could manage to fulfill the targeted rate of client enrollment. Meetings could be arranged in mosques on every Friday after *Jumma* prayer. Meetings should also be arranged with the village doctors recognizing their service in the health sector.

## CONCLUSION AND WAY FORWARD

As we have said earlier that previous studies on MHI in BRAC revealed that even though new enrolment reached target goals, renewal rate is very low and the ultra poor did not subscribe much or renew often. These findings motivated our study, which sought to investigate the underlying factors responsible for enrolment and renewal decisions. More specifically, the study intended to construct a socio-demographic profile of the MHI clients in the study area and to see what motivate the clients in deciding on MHI. It also intended to study the marketing techniques used by the programme and the perspective of health service providers on MHI.

Our analyses found that even in terms of basic communication of letting people know about the MHI offer, there are serious gaps. Even though 59% of the households knew about MHI. The two important determining factors behind knowing about MHI were BRAC membership and wealth status. It was found that relatively poorer households, especially if they do not have NGO membership, have a significantly lower probability of knowing. It was also found that insufficiency in basic communication is generating misconceptions about the package offers among its potential clients. This suggests that the communication platform currently used is predominantly BRAC's village organizations, needs to be expanded and made more equitable. For that a broader community-based communication strategy needs to be developed. BRAC has various platforms within a village and union, which could be used for this purpose.

We found that the distribution of knowledge of MHI was not equitable. The share of the chronic, occasional deficit, break-even and surplus wealth category households in the study population worsen or became even less equitable when it comes to the actual uptake of the MHI offer. Again, it was found that even though BRAC members and better-off households were more likely to enroll, a greater extent of the latent demand for BRAC's MHI offer lies with a group of households, which are relatively poorer than the ones who have enrolled. The census data show that only 16% of the households of the study area ever actually enrolled. Forty-two percent of the households knew about MHI but did not enroll. However, 21% of the households did not know but expressed interest when the product was described to them (the latent demand group). For programmatic perspective, the key group to understand better is the LD group. The households in this 'Latent Demand' (LD) group are more likely than the 'Revealed Demand' (RD or the ever enrolled group) group to be involved in textile sector as their major source of income. It is likely that households who rely mostly on textile sector have 'high opportunity cost' of participating in NGO-based activities and are therefore less likely to be able to reveal their demand for MHI, which appear to be communicated and mediated through NGO-based platforms. Compared to the RD households, the LD households tend to be less in the 'surplus' category. The RD group of households tends to have significantly greater ownership of 'luxury' assets such as TV compared to the LD group. The heads of households in the LD group tend to be more illiterate, once more suggesting that the latent demand for BRAC's MHI offer lies with a group of households, which are relatively poorer than the ones who have enrolled. Again, an interesting pattern revealed here is that a significant latent demand for the MHI offer exists among households having 'other NGO' membership (46%). This is also true for households that do not have any NGO membership (39%). Therefore it is suggested that a shift in programmatic focus away from the 'surplus' and relatively better-off households to 'moderate poor' (break even) households and to those having no NGO membership or have membership with other NGOs may be worth considering as an expansion in enrolment strategy. More intensive and appropriate marketing is needed for it.

We found that the idea of getting quality medical service at a cheaper price encouraged the majority of the enrolled clients in enrolling. But the idea of paying in advance for a probable event and risk sharing is not understood. They were found to be more interested in spending money when any concrete need arises. That's why people were found to be more interested in the pregnancy care package as they are sure of using it. Therefore, a lot more attention to social communication and social intermediation is needed. Popular theatre may be used for this purpose. More research on this aspect is needed.

Most of the MHI subscribers whose annual subscription expired did not renew (55%). Of those who subscribed to MHI and had the option to renew, 27% did. However, majority of those whose annual subscription had not expired (18%) expressed an interest to renew (12%) their subscription. Those who were benefited from the scheme were found to be the most encouraged group to renew it further. They said that the insurance gives them a sense of security. Apart from these benefited people, those who did not find it much difficult to arrange the premium money were also found to be quite interested to renew. But the most important variable influencing the decision to renew was found to be the perceived quality of services that the subscriber received from BHC. Subscribers reporting that they were 'satisfied' with the services from BHC were significantly more likely to renew their subscription. But the majority of the study population complained that in the cases of casual illnesses BHC costs them more (because it requires consultation fee and transportation cost) compared to different medicine shops and other independent homeopathy or herbal doctors, which charges only the cost of the medicine. On the other hand, they said, in the cases of severe illnesses they could not rely on BHC as it fails to provide proper services in want of proper and basic diagnostic equipments. Therefore, it is understandable that people are interested in MHI to address serious and expensive health shocks. But the premium paid is only a part of the cost that had to be incurred. Higher-level services require significant out-of-pocket expenses. So serious attention will have to be paid to the over all out-of-pocket cost to the client in availing referral services. Given BRAC is restricting its BHC operations, the need for developing effective referral linkages becomes even more critical.

Moreover, it was found that the clients found the existing referral system hazardous. The current referral system pays out after availing the service from the referral source which clients found inconvenient. Clients also complained about the paper work needed to claim the pay out. As one member said, 'it ultimately costs the same and it takes much longer—so why bother paying in advance?' Therefore, referral linkages have to be made more effective, both in terms of cost and reliability.

Households that enrolled but did not need to use MHI felt it was a waste. A large number of respondents also said that they did not renew their cards because when they were enrolled, no one in their families suffered any severe illness. As because they do not prefer to go to the BHC for casual illnesses, they found the insurance just as costly wastage of money. It was found that families with no young children usually neither suffer frequently nor feel the need to use the card often. Thus, packages targeting more vulnerable groups (like pre-school children, school going children, wage labourers, etc.) might get a positive response from the clients.

Some of our respondents said that they found it very difficult to pay the annual premium at once. Sometimes poverty prevents them from renewing the card. So, they suggested that they are more interested to pay the yearly premium in a few installments. They are even interested to pay the premium in two installments in the same month. They said it would be better for them if the premium installments coincide with their seasonal affluence. But it should be mentioned here that people also said they are willing to pay more as premium money if BHC could provide them with some basic diagnostic facilities (they suggested to include at least X-ray, ultra-sonogram, and ECG), because they have to pay it to other hospitals in anyway.

The study also revealed that some *Shastho shebikas* took clients to other private health service providers as they pay them more for bringing in patients. So, it is suggested that given a more competitive health care market the amount of incentives to *Shastho shebikas* need to be reviewed.

The study findings depicted the picture of a comparatively well-of area of Bangladesh near to the capital where different health services are available and people have job opportunities. It does not represent the majority of the country. So, it is recommended to conduct a similar kind of study in comparatively poorer areas where people do not have access to different health services. That may give us quite an opposite scenario.

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## APPENDIX I

### BRAC'S MICRO HEALTH INSURANCE PILOT PROJECT: A BRIEF

With a three-year financial and technical support from the ILO, BRAC formally launched a Micro Health Insurance (MHI) programme in November 2001. It was started as a pilot project in Madhabdi *upazila* of Narsingdi District and Fulbari *upazila* of Dinajpur district. The primary beneficiaries of this programme are poor rural women who do not have access to quality health care due to financial and cultural constraints.

#### Objectives of the project

- Increased access to BRAC's health care facilities for poor women and their families.
- Contribute to women's empowerment.
- Increased awareness of preventive health care including HIV/AIDS.

#### Target population

BRAC aims to enroll at least 10,000 poor rural women, including the ultra poor, and their families by the end of the project duration. The target was to enroll 30% of the target (3,000) women in the first year, 75% (7,500) by the second year and reach 100% enrollment (10,000) by the end of the third year. The indirect beneficiaries of the scheme will be around 50,000 people, who are the family members of the subscribers.

#### The insurance packages and fee structure

The MHI programme offers voluntary enrollment in the programme on an annually renewable premium. MHIB also has referral service links with a few government and private hospitals for cases, which the BHCs are not equipped to handle. In Madhabdi *upazila*, MHIB has an agreement with a particular private clinic and in Fulbari *upazila* with 4 private clinics to provide x-ray and ultra-sonogram services to cardholders at a 30% discount. MHIB has also negotiated to receive a 15% discount on all medicines from the programme's various pharmaceutical suppliers. The size of the family and whether the woman is a VO member or not, determine the premium costs and the level of co-payment. Basically three insurance packages are offered to the community. They are described below.

##### The general package

Under this general package the premium for BRAC VO members is Tk. 100 to Tk. 200 based on the number of family members. For other community members the premium is Tk. 200 to Tk. 300. Enrollment of the ultra poor is free of charge. The package includes subsidized doctor consultation fees, a free annual check up for the head of the household, a discount for essential diagnostic tests, medications, birth deliveries, and a once a year subsidy ceiling which helps to assist with costs incurred when referred to other facilities.

##### Prepaid pregnancy related care package

The premium for this package is Tk. 50 for VO members and Tk. 70 for other community members. Enrollment for the ultra poor is free. This package includes free monthly antenatal check up, a free monthly supply of iron tablets and folic acids, a tetanus toxoid immunization; supply of a safe delivery kit, a discount for delivery at a BRAC *Shushasthya*, a post natal home visit for the mother and new born, and a one time subsidy ceiling for treatment of complicated pregnancies and referrals.

##### Equity package

Under this package there is free enrollment, free consultations, free routine pathological tests, discounts for essential medicine. The enrollees in this package are the ultra poor.

### School health package

A pilot School Health Package is introduced in Fulbari, Dinajpur in January 2004. The package offers preventive/partial primary healthcare to schoolchildren. The package is now limited to the students of only one school. At the end of 2004, 1,000 out of 1,200 students of the school got enrolled in the package. The package charges Tk. 10 as yearly premium and offers free annual check up, free biannual immunization against common intestinal worms, free supplementary iron tablets for girls and 10% discount in pathological tests. MHIB is now planning to expand the package to other areas.

#### **Enrolment and renewal**

Table 1 shows that in both the places the rate of subscription is highest among the VO members and lowest among the ultra poor. As we know, Madhabdi is economically a more vibrant area than Fulbari. So, a low rate of subscription among the ultra poor can be said as expected here. But the number of ultra poor subscribers is also lowest in Fulbari, which is a poverty stricken area. Apart from this issue, the highest number of VO subscribers in both the places is another issue that demand investigation. But one thing should be mentioned here that the rate of enrolment decreased in 2004 because the programme has stopped enrolling new clients from the middle of that year.

**Table 1. Year wise rate of enrolment in programme areas** (Source: HNPP)

Madhabdi (Narsingdi)							
Year	General package			PPP care package			Total
	VO*	NVO**	UP	VO	NVO	UP	
Jan'02-Dec'02	1193	76	15	144	15	00	1443
Jan'03-Dec'03	1028	275	58	640	172	00	2173
Jan'04-Dec'04	541	190	49	143	498	00	1421
Total	2762	541	122	927	685	00	5037
Fulbari (Dinajpur)							
Year	General health package			PPP care package			Total
	VO	NVO	UP	VO	NVO	UP	
Jan'02-Dec'02	614	75	12	48	15	00	764
Jan'03-Dec'03	1207	270	162	419	352	00	2410
Jan'04-Dec'04	474	171	90	100	915	00	1750
Total	2295	516	264	567	1282	00	4924

\*VO= village organization member; \*\*NVO= non village organization member

In the cases of renewals (Table 2), even the rate has increased in 2004 compared to 2002, but the rate is far lower than the targeted rate in both the places. Moreover, the people in Madhabdi were found to be more interested in renewing than the people in Fulbari, which could be an indicator of the weakness of the programme in terms of its appeal to the more marginalized people.

**Table 2. Year wise rate of renewal in programme areas** (Source: HNPP)

Programme area	Jan'02-Dec'02		Jan'03-Dec'03		Jan'04-Dec'04	
	Target	Achievement	Target	Achievement	Target	Achievement
Madhabdi	525	114	1401	312	2240	954
Fulbari	202	00	1647	191	2242	842
Total	727	114	3048	503	4482	1796

## Health care delivery costs, income and cost recovery

**Table 3. A brief year wise financial statement of MHIB** (Source: HNPP)

Year	Income* (Tk.)	Expenditure** (Tk.)	Grants/Subsidy (Tk.)	Balance*** (Tk.)
Up to Dec'02	499,003	2,125,358	3,787,574	2,161,219
Jan'03-Dec'03	971,099	3,571,212	2,540,642	(59,471)
Jan'04-Dec'04	532,170	2,349,712	2,048,326	230,784

\* Insurance premium receipts and miscellaneous income. \*\* Including all operational costs.

\*\*\* Surplus/ (deficit) of fund balance.

### Staff structure

The MHIB project has employed 10 fulltime salaried staff for the scheme. Two of them, a National Project Coordinator (NPC) and a Documentation and Management Information Systems (MIS) analyst, are assigned to work at BRAC Head Office in Dhaka. The rest eight staff work at field level: two Team Coordinators (TO), and six Programme Organizers (PO). Among the POs, four of them work at Madhabdi and the rest two work at Fulbari. Apart from the above-mentioned salaried staff, a group of supporting staff, who work in different BRAC programmes, like the *Shasthya shebikas* (SS) and the Non Formal Primary Education (NFPE) teachers, are also engaged for promotional purposes. The SS and NFPE teachers get reference fee for every new cardholder they enroll. They get Tk. 10 for enrolling a VO member and Tk. 15 for enrolling a NVO member in the General Benefit Package and Tk. 5 for enrolling expecting mothers in the PPP Package.

### Technical support

The BRAC MHIB receives technical assistance from ILO. It also receives internal technical assistance from the BRAC Health Programme, Training Division, Research and Evaluation Division, Development Programme and Monitoring, and Accounts and Finance Departments. This assistance consists of support with capacity building and monitoring, development of annual work plan, training and aid in training material development, accounting and reporting, and networking with similar schemes at home and abroad. All staff and volunteers involved with MHIB activities have been given on the job training. During November 2003 to October 2004, a total of 697 training sessions were conducted for 10,279 volunteers. They are regularly given training and monthly refresher courses on building their capacity as advocates of the programme.

### Communicational and promotional activities

BRAC depends on its already established programme network and manpower to promote the scheme. BRAC MHIB staff disseminate policies to potential subscribers through weekly VO meetings, school meetings and UP meetings at the village. The project staff as well as the volunteers (SS and NFPE teachers) also make individual door-to-door visits to promote the scheme. Apart from these interpersonal and group communication, the programme is also promoted through visual aids such as posters, leaflets, cartoons, brochures, popular theatre, and videos. BRAC staff are given training on mobilization strategies through workshops.

## APPENDIX II

### MHIB WORKING AREA AT A GLANCE (MADHABDI)

- No. of Union: 06
- No. of Village: 147
- No. of Population: 1,84,202
- No. of Household: 36,101
- No. of BRAC VO: 282
- No. of BRAC VO member: 9,977
- No. of Grameen Bank VO: 60
- No. of Grameen Bank VO member: 1,480
- No. of ASA VO: 75
- No. of ASA VO member: 1,500
- No. of RIC VO: 58
- No. of RIC VO member: 1,420
- No. of BRAC School: 135
- No. of NFPE School: 60
- No. of KK (Kishor-Kishori) School: 17
- No. of PP School: 20
- No. of KK Pathagar: 13
- No. of GK Pathgar: 05
- No. of Darul Ahsania Mission School: 60
- No. of Health Worker: 08
- No. of *Shasthya Shebika* (SS): 80
- No. of *Shushasthya*: 01
- No. of ANC Center: 80
- No. of Government Primary School: 48
- No. of Higher Secondary School: 12
- No. of Collage: 01
- No. of Madrasa: 07
- No. of FWC: 04
- No. of RD (Rural Dispensary): 01
- No. of Satellite Clinic: 40
- No. of Private Clinic: 4
- No. of EPI Center: 120

*(Source: AO, Madhabdi)*

### APPENDIX III

#### FEE STRUCTURE AND BENEFITS OF DIFFERENT PACKAGES

**Table 4. Fee structure and package benefits of general package** (Source: HNPP documents)

	Pricing (Tk.)	
	VO member (BRAC and other NGOs)	Non VO member
Premium		
1-5 family members	100	250
6-8 family members	150	300
9-12 family members	200	350
Package benefits		
Consultation	2	5
Medicine	10% discount	10% discount
Pathology	50% discount	50% discount
Normal delivery	50% discount	50% discount
Referral benefit	500-1000	500-1000
25% discount on premium next year if services are not used by subscribers in the current year		

**Table 5. Fee structure and package benefits of pre-paid pregnancy related care package** (Source: HNPP documents)

	Pricing (Tk.)		Maximum coverage limit
	VO member (BRAC and other NGOs)	Non VO member	
Premium	50	70	
Package benefits			
ANC checkup at BRAC mobile/satellite clinic	2	3	N/A
Monthly supply of iron tablets and folic acid	0	0	N/A
Provision of safe delivery kit for home delivery	0	0	N/A
Support for pre-delivery complications (miscarriage, bleeding)	200-500	200-500	N/A
Normal delivery	50% discount	50% discount	N/A
Support for post-delivery complications (post-partum hemorrhage, fever)	200-500	200-500	42 days following delivery
Support in the event that newborn babies suffer from diarrhea or pneumonia within 28 days of birth	200-500	200-500	28 days following delivery

**Table 6. Fee structure and package benefits of equity package (Source: HNPP documents)**

	Pricing (Tk.)
Premium	0
Package benefits	
Consultation	0
Medicine	80% discount
Pathology	80% discount
Post-consultation follow up visits at home (at least 2)	0
Referral benefit	500-1000
Free annual check up with essential pathological tests	0

#### APPENDIX IV

#### A LIST OF DIFFERENT HEALTH SERVICE PROVIDERS IN THE STUDY AREA

##### Prime General Hospital (Pvt.)

It is the biggest hospital in Madhabdi Sadar Thana. It is situated at the Madhabdi Bazar area, which is about 1 km south of the Madhabdi AO of BRAC. It's a 25 bed hospital, of which 17 to 18 beds remain always filled up. The hospital mainly gets patients of surgery cases and other emergency cases. The hospital is well equipped with a wide range of pathological test facilities, Operation Theater (OT) facilities, physiotherapy and many more things. The hospital has nine specialist doctors who sit twice or thrice a week in the hospital. Every specialist doctors get 20 to 30 patients per day. The hospital gets 20 to 25 patients in their outdoor service and 8 to 10 surgery cases per day. The hospital has their own field officers who regularly visit different villages and bring patients to the hospital. The hospital authority claimed that they always try their best to give discounts to the patients in need. They said it costs the hospital around Tk. 10,000 per day to run itself, which means they earn at least Tk. 10,000 per day.

##### List of service charges:

1. Consultation fee: Tk.50 to Tk.100 (out door), Tk. 200 to Tk. 300 (specialist doctors)
2. X-ray: Tk.100 to Tk.900.
3. Ultra sonogram: Tk. 350 to Tk.500
4. Pathological tests: Tk. 20 to Tk. 600
5. Physiotherapy: Tk. 100 per sitting
6. EKG: Tk. 800
7. ECG: Tk. 200
8. Surgery (with bed and medicine): Tk. 8,000 to Tk. 15,000
9. C- section (with bed and medicine): Tk. 9,000 (general bed) and Tk. 12,000 (cabin).  
The hospital gives 20% discount in X-ray and ultra sonogram to patients referred by *Shushasthya*.

##### Madhabdi General Hospital (Pvt.)

This is the second biggest hospital in Madhabdi Sadar Thana and situated at the same bazar area. It is a 30-bed hospital, which is also well equipped with different pathological and OT services. It has 12 MBBS doctors and a number of specialist doctors. The MBBS doctors charges Tk 50 and the specialist doctors charges Tk. 200 as consultation fee. The hospital charges Tk. 50 to Tk.100 for X-rays and Tk. 300 to tk.500 for ultra sonograms. The hospital source said that around 50% of its patients come from poor economic condition and about 30% of them belong to the middle-income group. The rest are well-off people. They claimed that they give free service to at least 5% of the poor patients.

### **Kothamoni Diagnostic Center**

This pathological center is also situated at the Madhabdi bazaar area. It also has doctors who sit here once or twice a week as part time consultants.

### **Narsingdi Sadar Upazila Hospital (govt.) or Upazila Health Complex (UHC)**

This hospital is situated at Narsingdi Sadar, which is about 10 km away from *Shushasthya*. It takes around Tk.30 to Tk.40 to go to the hospital from the Madhabdi Bazaar using the cheapest way. In government hospitals like this one the consultation fee is Tk.4.40 and other pathological facilities are supposed to be free.

### **Mother and Children Welfare Center (MCWC)**

This hospital is also situated at Narsingdi Sadar and the transport cost is also same as above.

### **‘Shobuj Chhata’ Family Welfare Clinic**

This health center is situated in Paanchdona union, which is 5 km north of *Shushasthya*. Paramedic doctors give services in these clinics.

### **Marie Stopes Clinic**

MBBS doctors give consultation in this clinic only on reproductive health problems. It is situated at Bhela Nagar Union, which is 9 to 10 km north of *Shushasthya*.

### **Family Welfare Clinic (FWC)**

This government *upazila* health center is situated near the village Khilgaon and 3 km south of the Madhabdi AO. It gives service to the patients completely free of cost.

### **‘Shushasthya’**

It is the health center of BRAC. The usual services provided at *Shushasthya* are: I) out-patient care including treatment of common ailments, family planning, pre- and post-natal care, and treatment of sexually transmitted diseases (STD) and reproductive tract infections (RTI); II) in-patient care comprised of child delivery, minor surgery, menstrual regulation, clinical family planning, and treatment of common ailments; and III) laboratory services including routine tests for blood, urine and stool, sputum for TB screening and pregnancy tests. If patients were not treatable at *Shushasthya*, they were referred to different health care facilities of government and private sector for further care. The Madhabdi *Shushasthya* is staffed with seven personnel: three (one female, two male) MBBS doctors, one paramedic, one family welfare visitor (FWV), one laboratory technician, and one trained traditional birth attendant (TBA). The *Shushasthya* charges its patients at a subsidized rate.

### **Dr. Chayan (MBBS)**

He sits in his medicine shop in Madhabdi bazaar area and takes Tk 150 to Tk 200 as consultation fee.

### **Mr. Obaydul Bari (paramedic)**

He also sits in his medicine shop in Madhabdi bazaar area and takes Tk. 150 as consultation fee.

### **Mr. Shaheen (LMF doctor)**

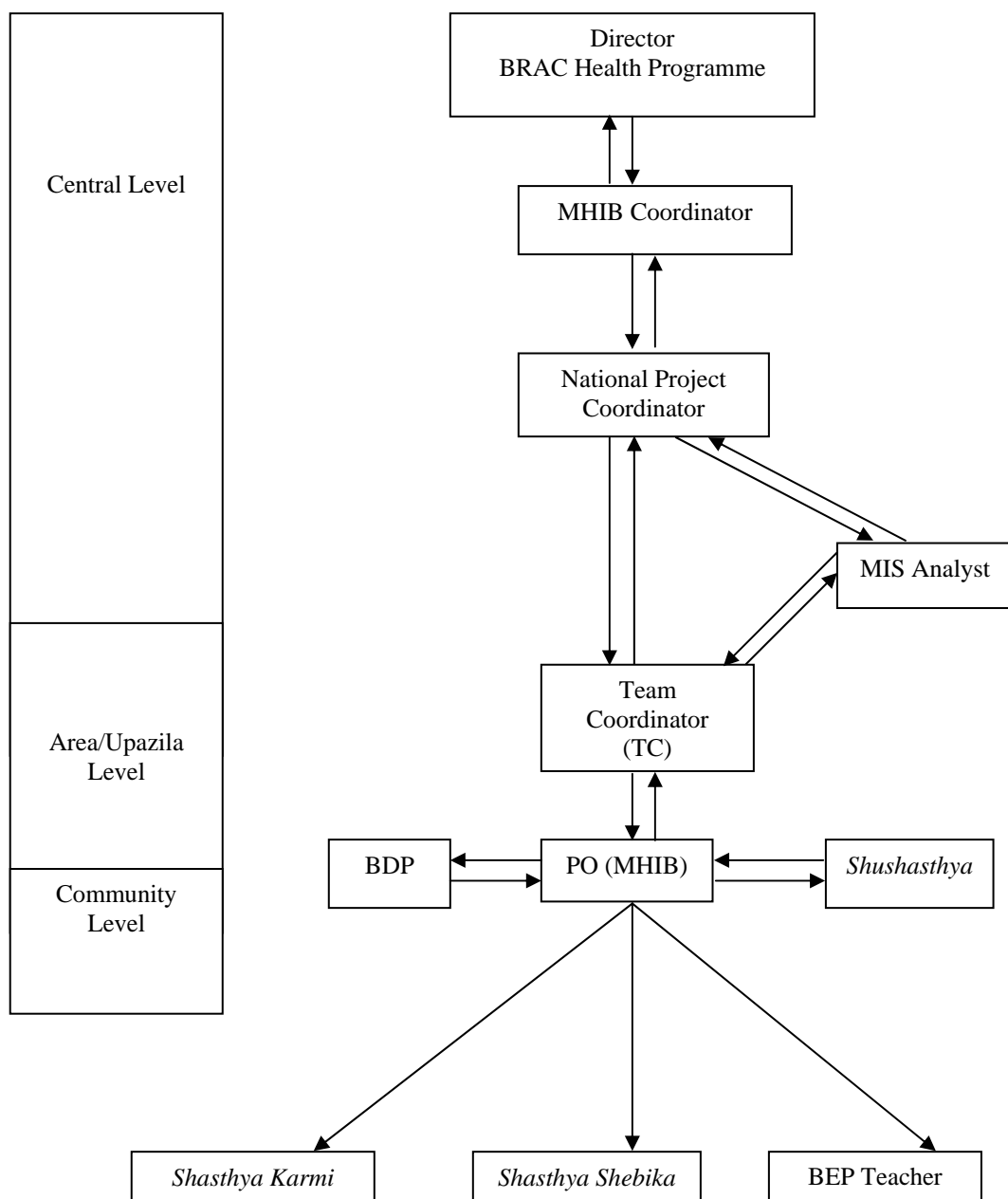
He too sits in his medicine shop near Madhabdi bazaar area and takes no consultation fee from poor patients. He also claimed that he tries his best to give medicines to the poor free of cost. But he takes fees from the well-off patients. He is very popular among the villagers and gets around 40 to 50 patients per day.

**Mr. Mustafa (LMF doctor)**

He lives in the village Kurer Paar and gives consultation to patients from his medicine shop, which is situated between *Shushasthya* and Kurer Paar. He is a member of the local Union Parishad and doesn't take any consultation fee from the poor patients. He gets around 40 patients per day.

Apart from the above-mentioned places, the villagers also go to different medicine shops where the salesmen suggest and sell medicines to them knowing their problems. These shops naturally do not take any consultation fee. There are also a good number of practitioners of different alternative medicines where the villagers go as well.

**ORGANOGRAM OF MICRO HEALTH INSURANCE (MHI) PROJECT OF BRAC**



(Source: HNPP)