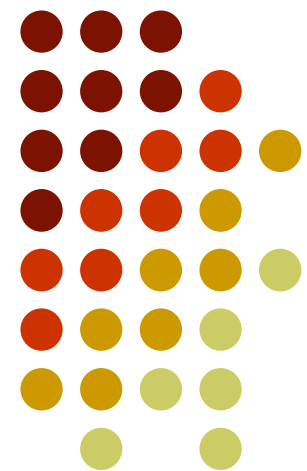


Health Risks in Bangladesh: How Can Microinsurance Prevent Vulnerability to Poverty?

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Executive Summary



- Micro health insurance (MHI) is a risk management tool that can reduce economic losses of low income or poor households which may arise out of adverse health events.
- Health is a critical factor in determining long term living standards via augmenting labour productivity;
- While short-run self insurance mechanisms allow poor households to ride out small health events, they typically do not allow them to deal with more serious health events - leaving the poor fully vulnerable
- Accordingly, the provision of meaningful health coverage would be seen as an important risk-mitigation force in the lives of the poor
- In Bangladesh, specialized insurance companies, health sector NGOs, as well as MFIs are all involved in the provision of microinsurance services



Executive Summary

- Bangladesh has made significant progress toward reaching the health related MDGs. In spite of the progress, there is still a long way to go. Current figures are much lower than those observed in middle income countries (e.g., Tunisia or Lebanon).
- Commercial sustainability acts as a major deterrent for insurers. There are many pilot type MHI schemes in operation, yet a review of the existing system suggests a low uptake of health insurance by the poor (pretty much universally).
- *Inferences in this study were made based on data taken from a PKSF-MES survey which covered a panel of 3,000 rural households over in four waves between 1998 and 2005.*

Executive Summary



- MHI faces many challenges:
 - A. Awareness & Demand
 - B. The Scale Issue
 - C. Delivery Channel
 - D. Selling Insurance
 - E. Adverse Selection
 - F. Co-payment and Moral Hazard
 - G. Claim Management
 - H. Premium and Cost Structures
 - I. Role of Subsidy and Endowment Fund
 - J. Covariant Risk & Reinsurance
 - K. Gender Dimension
 - L. Staff Knowledge
 - M. Regulatory issues



Executive Summary: Conclusion

- Modalities have to be found to implement well designed meaningful coverage that reflect the core principle of insurance, namely to limit the risk exposure of the insured while allowing for the remainder of the risk to be carried by the insurer, and the reinsurer.
- Financial subsidy regimes ought to be fully integrated in the insurance design so that long-run sustainability can be ensured.
- While large MFIs may serve as the insurer themselves, it would be more efficient for smaller MFIs to offer programs in collaboration either with a large MFI or dedicated risk carriers (i.e., commercial insurers).

Outline



1. Introduction
2. Health Risks & Vulnerability
3. Bangladesh Health Background
4. Overview of PKSf-MES Panel Data
- 5./6. Preliminary Analysis
7. The Role of MHI in Mitigating Risk & Vulnerability
8. Major Challenges
9. Closing Remarks



1. Introduction

- Health is a critical factor in determining long-term living standards by maintaining and augmenting labour productivity, and thus the economic cost of illness is two-fold: the cost of medical care and the loss in income associated with reduced labour supply and productivity.
- In the absence of significant savings or public pension schemes, the poor are often forced into deeper poverty by their limited ability to cope with such events.
- Short-run self insurance mechanisms (e.g. depletion of savings, selling of assets, loan from money lenders etc...) may allow them to ride out smaller events, but not health events that compromise the capacity to perform activities of daily living (ADL) - leaving them fully vulnerable.
- *The provision of meaningful health coverage would thus be seen as an important risk-mitigation force in the lives of the poor.*



1. Introduction

- Micro health insurance (MHI): is a risk management tool that can reduce economic losses of *low income or poor households*, which may arise out of adverse health events.
- Specialized insurance companies, health sector NGOs, as well as Microfinance Institutes (MFIs) are all involved in the provision of microinsurance services (sometimes in collaboration with each other)
- The MHI market in Bangladesh has evolved in a manner parallel to its precursor, microcredit, namely as a home-grown experimentation. Many NGO/MFIs have been offering a variety of MHI products in Bangladesh since as early as the 1970s.

2. Health Risk & Vulnerability: to come



3. Bangladesh Health Background

- Based on the Household Income & Expenditure Survey (HIES) of 2005, rheumatic fever and respiratory illness appear to be the two more common types of disease in Bangladesh (where rheumatism appears to afflict women more than men (12.3 vs. 8.5%))
- The most common practice of medical intervention for the rural population is to seek advice from the sales staff of pharmacies (41.3%), while a mere 18% visit a doctor.
- In terms of financing health expenses, the majority manage it out of household savings, while a small minority resort to selling and mortgaging assets or borrowing from money lenders.
- Accordingly, poor households are left vulnerable by using up regular income, savings or other assets in financing health expenditures.
- 28.3% of rural households reported high expenditure as the main reason for non treatment.

3. Bangladesh Health Background



- In spite of the handicap, Bangladesh has made significant progress toward reaching the health related MDGs.

Over the past decade:

- Life expectancy has increased by about 9%
 - Total fertility has declined by 22%
 - Infant mortality has fallen by 32% and 22% in rural and urban areas respectively
 - Unfortunately *rural* maternal mortality has not budged at all
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- In spite of the progress, there is still a long way to go. Current figures are much lower than those observed in middle income countries such as Lebanon and Tunisia.

4. Overview of PKSF-MES Data



- A survey was carried out by the Bangladesh Institute of Development Studies (BIDS) as part of an examination of Palli Karma Sahayak Foundation's (PKSF) Monitoring and Evaluation System (MES) in 4 waves over 1998 and 2005.
- The survey covered about 3,000 rural households all of whom had access to microcredit.
- Four repeat surveys were conducted on the matched sample during 1998, 1999, 2000 and 2004-5
- Though the focus of the survey was to learn of the broader impact of microcredit, there were some questions related to health related events which are relied upon here to draw inferences on the latent demand for health services and the willingness to pay for such services and thus indirectly on the demand for insurance among the rural poor.



7. Role of MHI

- Commercial sustainability acts as a major deterrent for insurers. Absence of adequate health related data for actuarial calculations, moral hazard and adverse selection and difficulty of controlling fraudulent activities have restrained them from penetrating this market on a commercial basis.
- There are many pilot type micro health insurance schemes in operation all around the world, yet a review of the existing systems suggests a low uptake of health insurance by the poor.
- The biggest criticism being that the products are ill designed to be of appeal to the public.
- In Bangladesh, *Grameen Kalyan* has launched micro health insurance since the late 1990s and presently covers over half a million people, making it the largest program as of now.
- Its premium is between BDT 200 (Grameen members) and 300 (non-members) per year and it operates 39 clinics in ten districts in Bangladesh.
- It uses a strategy of serving the community at large and of charging higher rates to the less poor.

8. MHI Challenges & Solutions

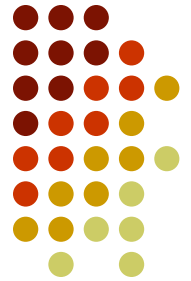


A) Awareness & Demand:

The necessity of having to pay a premium even if no illness had occurred is difficult to communicate to the poor

- Low renewal rates in Bangladesh may reflect:
 - Unhappiness with the service, inappropriate and non-cost effective design and financial hardship on the part of the insured.
- **Liquidity constraints:**
- Short term solution:
 - *To add the health premium to the loan amount offered by the MFI in question (i.e., if the potential insured are also recipients of microcredit programs)*
- **Timing of payment** (premium paid at the start of contract-- benefit claim upon occurrence of eligible illness)
- Short term solution:
 - *To offer a physical examination at the very start of insurance coverage. This ensures members realize benefits to the program, and also serves as an early detection & hence an effective preventive device.*
 - *To offer MHI on a group basis such that even if the program is compulsory for all villagers, the benefit claims are rationed on a group-basis.*

8. MHI Challenges & Solutions



B) The Scale Issue:

- Difficulty in pooling risks effectively unless the coverage is very broad.

C) Delivery Channel:

- Most common in Bangladesh is the full service model, aka the 'provider' model, where the health care provider is also the risk carrier
- Difficulties arise due to limitations in financial and logistical resources to offer suitable coverage to a large number of the insured in order to pool risks effectively, and set up proper health centers wherever coverage is in effect.
- As a result, *smaller programs are unlikely to be cost-effective*
- Due to the network of offices, human resources and by virtue of their past activities, NGOs/MFIs have gained trust of the villagers, borrowers and non-borrowers alike- a necessity when it comes to part with money in advance from the poor household's perspective.
- **It should be noted however that modality and experience required for successful microcredit operation need not be sufficient to run a cost-effective MHI product.**

8. MHI Challenges & Solutions



D) Selling Insurance:

- Many organizations employ local volunteers to sell insurance, which are advantageous in terms of trust and familiarity in the community.
- However, when it comes to explaining the underlying rationale, a valuable role can be played by outside professionals.

E) Adverse Selection:

- None of the Bangladesh schemes appear to incorporate any deliberate attempt to guard against adverse selection.
- Problematic is that non-members of the credit program subscribe on a voluntary basis, thus allowing free reign to adverse selection.

F) Co-payment and Moral Hazard:

- In Bangladesh, the co-payment structure seems very high, defeating the purpose of insurance (namely to limit the co-payment, and shift the bulk of it to the risk carrier).

8. MHI Challenges & Solutions



G) Claim Management:

- The determination of an insured event & settlement of the claim ought to be transparent and fast.

H) Premium and Cost Structures:

- No formal actuarial/statistical exercises are undertaken in determining the rate structure and the premium design does not include the administrative and office overhead costs.
- Accordingly, many MHI programs in Bangladesh experience substantial operating loss. [E.g., For 2004, premium revenue covered a mere 36, 22 and 4 % of total expenses for GK, BRAC & SSS, Ahmed et al. 2005]

I) Role of Subsidy and Endowment Fund:

- Most subsidy programs seen in the Bangladesh context to date have been limited duration events, typically by external donors. GK example.

J) Covariant Risk & Reinsurance:

- None of the existing MHI plans in the country allow for a contingency arrangement to deal with covariant risks.
- Extraordinarily large claim scenarios are however precluded by the design of the policy by limiting the coinsurance contribution in case of hospitalizations, which is contrary to the very essence of insurance.

8. MHI Challenges & Solutions



K) Gender Dimension:

- Empowering women
- If the female is the primary insured, the rest of the family is covered through her membership- enhancing female empowerment among the poor

L) Staff Knowledge:

- Most programs appear to be run on a trial-and-error basis; managers are not particularly trained as insurance industry experts and they did not engage insurance/actuary professionals in the design of their programs
- MIS and performance monitoring chores remain underdeveloped

M) Regulatory Issues:

- Bangladesh's regulatory framework standardizing operational procedures and quality assurance has largely been rudimentary
- The new Insurance Regulatory Authority (IRA) Act of 2008 is in its formative stage, and effective regulation would appear to be some distance away.

9. Closing Remarks



- Modalities have to be found to implement well designed (based on actuarial and statistical models) and meaningful coverage that reflect the core principles of insurance, namely to limit the risk exposure of the insured while allowing for the remainder of the risk to be carried by a more competent authority, namely the insurer, and the reinsurer.
- Financial subsidy regimes ought to be fully integrated in the insurance design so that long-run sustainability can be ensured.
- While large MFIs may serve as the insurer themselves, it would be more efficient for smaller MFIs to offer programs in collaboration either with a large MFI or dedicated risk carriers (i.e., commercial insurers).