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What could be the impact of the community financing approach of BRAC in health care to achieve the health goals of MDG in Bangladesh?

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ABSTRACT

A closure look at the indicators makes it evident that the achievement of the health goals of MDG does not require high quality health care, doctors or expensive technology. Rather the targets could be fulfilled by creating a health service network targeting the goals, an efficient group of health workers including nurses, paramedics, midwife in the accessible distance in need. BRAC have a large health service network that provides mainly the basic health care services especially to the woman. BRAC is working in 70,000 villages and 2,000 slums, reaching three quarters of the entire population with an integrated package of health. They are also providing health insurance service to the borrowers where MFIs are insurance company, health care provider and also has direct link to the clients and all these aspects reduces the twin problem of moral hazard and adverse selection.

Key words: Community Financing, Community Health Insurance, Health Goals of MDG, Micro Finance Institutions.

1. INTRODUCTION

Community financing in health care is synonymous to Community Health Insurance (CHI). CHI is defined as a method of financing health care with the involvement of the community in its organization and pooling of the health risks of insured members (Ogawa et al., 2003). MFIs (Micro Finance Institutions) in many developing countries are offering CHI to the borrowers as illness is considered to be one of the major reasons of payment default. The target group of microfinance is the poor class which is mostly excluded from the formal financial system. This exclusion makes this class more vulnerable in the time of emergencies. Low income people use financial services not only for business investment in their micro enterprises but also to invest in health and education, to manage household emergencies and to meet the wide variety of other cash needs that they encounter. The range of services includes loans, savings facilities, insurance, transfer payments, and even micro-pensions (Littlefield et al., 2003). In Bangladesh, most of the leading MFIs are using this community based approach to deliver health care services.

Households exposed to high health risk uncertainty are less likely to take advantage of growth opportunities, such as investing in new technology or expanding existing businesses (Dror & Jacquier, 1999; Jutting, 2003). This reality promotes the development experts to incorporate health goals in MDG, the current development agenda of UN. Among the eight goals of MDG, three goals specifically target the health care sector that includes maternal health, child health, reproductive health and prevention of epidemic diseases like HIV/AIDS, Malaria and Tuberculosis. These three goals are considered as health goals in this study. Bangladesh has got remarkable progress in achieving the targets of MDG. But still the country is burdened with one of the highest child and maternal mortality and a large portion of the poor people are being deprived of health care. Bangladesh ranked sixth among twenty two highest burdened countries with tuberculosis, over seventy percent of people seek health care from informal health care provider of which sixty two percent have little or no formal schooling. Prevalence of malnutrition among the children under five is more than forty percent and still two third of births are taking place without any trained birth attendant (BRAC Annual Report, 2011).

The contribution of micro finance in poverty reduction has been identified by UN declaring 2005 as the 'International year of Microcredit' (Ohri, 2004). The success of micro lending promotes MFIs to offer other services using the community spirit which is the driving force of micro finance mechanism. Community financing in health care or CHI is such an effort targeting the poor to pool them out from health risks. The services offered by the MFIs are open to all but the target group is mainly their borrowers. Some leading MFIs are providing CHI to the borrowers. This study focuses on the CHI schemes of BRAC, one of the leading MFIs in Bangladesh. The Village Organization (VO) is the heart of the micro finance operation of BRAC, a group of woman from the same locality. From this VO, the he of the study is to find out the potentiality of VO and the CHI scheme of BRAC to achieve the health goals.

2. MATERIALS AND METHODS

773 MFIs are working and majority of them are engaged in health sector but for the simplification, the study considers BRAC as the sample. The rationale behind the selection is that BRAC has the highest coverage in terms of lending and health care. Two MFIs are providing micro health insurance and BRAC is one of them. The study has sorted out the major indictors of each goal by which the progress could be measured. These indicators have been used to find out the impact of the services that BRAC is providing. The study has identified the basic health care services that the institution is offering which have impact on health goals.

Three goals, 4,5,6 specifically target the health sector, maternal, child and reproductive health as well as the health services that are addressing the epidemic diseases like HIV/AIDS, Malaria and Tuberculosis. These three goals have been termed as the health goals of MDG throughout the study. Secondary sources have been used to collect data. It is not possible to find out the impact of CHI so early, because CHI schemes in Bangladesh are mostly in pilot phase and has little coverage. The study has tried to show the potentiality of such schemes to achieve the health goals. The study has considered only CHI and health services of BRAC that are targeting the health goals.

3. RESULTS

To investigate the impact, the study needs a closer look at the different indicators under each goal which is presented in the following table:

Table 1 Reduce child mortality (Goal 4)

Targets	Indicators
4: To reduce the *under-five mortality rate* by two-thirds between 1990 and 2015	4.1 Under-five mortality rate
	4.2 Infant mortality rate

	4.3 Proportions of 1 year-old children immunized against measles

Source: *Millennium Development Goals (MDG) Database Metadata for Bangladesh, 2011*

The first health goal indicators are under-five mortality, infant mortality and proportion of one year old children immunized against measles. MDG progress report, 2011 shows that Bangladesh is among the very few countries that has been able to reduce child mortality by more than sixty percent. Yet the child mortality rate is considerably high in the country. According to UNICEF Annual Report, 2011, in Bangladesh, 14 babies under one month of age die every hour, 120,000 every year, three quarters of these new born babies die within their first week of life and almost fifty per cent die within the first 24 hours of birth, with most of these deaths occurring at home.

Table 2 Improve Maternal Health (Goal 5)

Targets	Indicators
5A: To reduce maternal mortality ratio by three quarters, between 1990 and 2015	5.1 Maternal mortality ratio
5B: To achieve universal access to reproductive health by 2015	5.2 Proportion of births attended by skilled personnel
	5.3 Contraceptive prevalence rate
	5.4 Adolescent birth rate
	5.5 Antenatal care coverage (at least one visit and at least four visits)

Source: *Millennium Development Goals (MDG) Database Metadata for Bangladesh, 2011*

The indicators of the second health goals are maternal mortality rate, births by skilled birth attendant, contraceptive prevalence rate, reduction of adolescent birth and antenatal care coverage. Bangladesh has one of the world's highest adolescent motherhood (Proportion of woman giving birth before age twenty). The main reason of which is early marriage of girls which has higher prevalence in rural areas. According to UNICEF Annual Report, 2011, the number of deaths of adolescent mother is double of the national average. Still eighty five percent of women are giving birth without a skilled birth attendant.

Table 3 Combat HIV/AIDS, Malaria and other diseases (Goal 6)

Targets	Indicators
6A: HIV/ AIDS have to be halted by 2015 and begun reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years
	6.2 Condom use at last high risk sex
	6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
	6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
6B: To achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral Drugs.
6C: Have Malaria and other epidemic diseases have to be halted 2015 and begun to reverse the incidence	6.6 Incidence and death rates associated with malaria
	6.7 Proportion of children under 5 sleeping under insecticide treated bed nets
	6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs

6.9 Incidence, prevalence and death rates associated with tuberculosis
6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course

Source: *Millennium Development Goals (MDG) Database*
Metadata for Bangladesh, 2011

The sixth health goal directly addresses the epidemic diseases that have higher prevalence in the developing nation of the current world. HIV/AIDS is not so prevalent in Bangladesh, one percent of people are HIV positive (UNICEF Annual Report, 2011). Epidemic diseases like malaria, measles and tuberculosis have higher prevalence in Bangladesh. According to Bangladesh Microfinance Statistics, 2010, currently 773 MFIs are working throughout the country and the annual growth of savings of MFI borrowers was 24.74 percent. The growth of saving shows that if community finance could be introduced to finance health care, especially of maternal and child health.

Table 4 Network of MFI

Total MFI	773
Cumulative Borrower(Both male and Female)	73,577,429
Female Borrower	
Cumulative Borrower (Female)	64,432,546
Rural	57,093, 248
Urban	10,339,298
Percen distribution of membership by Areas	
Rural	88.69
Urban	11.31

Source: *Bangladesh Micro Finance Statistics, 2010*

Among the 773 MFIs, only a few of them have introduced health insurance to the borrowers and most of them are pilot projects, in which, the response among the people was satisfactory. Bangladesh Rural Advanced Committee (BRAC), was established as a relief organization (known as Bangladesh Rehabilitation Assistance Committee) in 1970 and has been transformed into a development organization in 1973 which started micro credit operation in 1974 (BRAC Annual Report, 2002). From the inception, BRAC is following a 'Targeted' development approach where the rural woman is the main target group. To incorporate the poor into development process, BRAC first create a VO(Village Organization) made up of five to seven women, provide them training on any specific income generating activity, guide them to take initiative, provide them micro credit and also monitor the update through timely meeting with VO members. BRAC representatives meet the members of VOs on a regular basis. VO members take loans and bear the risk individually; no collateral is needed to get the loan. BRAC is working in 70,000 villages and 2,000 slums, reaching three quarters of the entire population with an integrated package of health (BRAC Annual Report, 2011). The micro health insurance for the rural poor woman started formally in November 2001 with the financial and technical assistance of ILO and the contract was made for three years. The program offered a number of services targeting different people of different income level and age. The service packages are:

The General Package: This package is open for all, members of VOs or not. Each policy holder gets a card upon paying the premium and gets services with co-payment at BRAC health centres. The services covered by the policy includes doctor consultation, a free annual check-up for the head of the household, pathology testing, discounted medicine, and birth deliveries and the annual premium for the VO members is USD 1.70 and for the non-VO members, the premium is USD 4.26 (Ahmed et al., 2005).

The Equity Package: The equity package is designed for the ultra-poor who are incapable of paying any premium. BRAC runs this package on the basis of cross subsidization, BRAC charges higher premium on the non-VO members. The policy holder of this equity package gets all the services under the general package completely free of cost.

Prepaid Pregnancy Related Care Package: BRAC has introduced special insurance package for the pregnant woman, prepaid pregnancy related care package in January, 2002 that includes services that were not widely available, such as pre-delivery

complications (abortions and miscarriages), post-delivery complications, and neo-natal care and the annual premium is USD 0.85 for the VO members and USD 1.19 for the non-VO members (Ahmed et al., 2005).

School Health Package: BRAC has started School Health Package in January, 2004 where the students get preventive and partial primary health care services including free annual check-up, free iron tablet for the girls, ten percent off the pathological test and immunization against common intestinal worm and the annual premium is USD 0.17 (Ahmed et al., 2005).

BRAC has created a Community Health Worker (CHW) pool made up of village health volunteers. This health care includes *Shasthya Shebika* (Female Community health Volunteer), *Shasthya Karmi* (Female Community Health Worker), Trained Birth Attendant and *Pushti Kormi* (Nutrition Worker) and all these women come from the concerned villages and slums where BRAC established health centres. They are trained by BRAC and are self-employed.

Table 5 Workforce of BRAC

Workers	Number
Shasthya Shebika(SS)	91000
Shasthya Kormi(SK)	8000
Trained Birth Attendant(TBA)	16000
Pusti kormi(PK)	1000

Source: *BRAC Annual Report, 2011*

BRAC Annual Report, 2011 is showing that, BRAC has trained ninety one thousands of *Shasthya Shebika*, eight thousands of *Shasthya Karmi,* sixteen thousands births attendant and one thousand *Pushti Kormi*. This workforce is not only working for BRAC, they are also assisting in GOB health projects, other national and international NGOs and as they are self-employed, they are also giving the services to the door steps of the villagers independently.

Table 6 BRAC Health service in 2011

Type of care	2011
Antenatal care	4.4 million pregnant woman
Delivery centres in Urban slums	390
Delivery with skilled birth attendant	213000
Essential new born care	427703
CHW motivated woman for breast feeding	837, 500
Sprinkles sachets distributed to combat iron deficiency diseases like anaemia	9036309
Immunized child in collaboration with the government	1607255

Source: *BRAC Annual Report, 2011*

The recent data presented in BRAC Annual Report is showing that BRAC has achieved notable success in providing maternal and child health care services which has a great impact in reducing maternal and child mortality in Bangladesh.

3. DISCUSSION

In formal insurance scheme, the main problems include adverse selection and moral hazard. Adverse selection can be defined as strategic behavior by the more informed partner in a contract against the interest of the less informed partner(s). In the health insurance field, this manifests itself through healthy people choosing managed care and less healthy people choosing more generous plans. Moral hazard refers to the change in behaviour when they are insured. If someone has health insurance then he might have a tendency to break the healthy rules and become careless about health as he is insured. CHWs are the member of VOs. Health workers are well aware about the socio economic environment, have direct connection with their clients, have perfect idea about their needs and problems and they have easy access and acceptability to their clients. That distinctive nature reduces the

possibility of adverse selection. Again the VO group meeting, costs and risk sharing in accepting credit reduces the possibility of moral hazard.

The health services of BRAC that are directly addressing the health goals include Oral Therapy Extension Program (OTEP), a cost effective method of treating Diarrhoeal diseases. Within 1980 to 1990, two thousand BRAC workers trained thirteen million women in use of ORT which impels great impact on the recent drop in infant and child mortality (Seelos & Mair, 2006). BRAC is providing a package of care, Essential Health Care (EHC) targeting mainly slums. The main component of EHC includes family planning services, immunization (Vaccination against six life threatening diseases), pregnancy related care and TB (BRAC Annual Report, 2011. BRAC also extended MNCH program also in the urban slums with the project named as 'Manoshi' in 2007 (Ahmed et al., 2010). BRAC operates specific program to detect TB and provides DOTS with direct supervision of SS to assure the course fulfillment. DOTS program already covered 93 million people in 297 sub districts of 42 districts (BRAC Annual Report, 2011). BRAC in collaboration with the GOB and other NGOs, are providing preventive and curative care in thirteen malaria-risk-prone districts including Chittagong hill Tracts which is the highest malaria prevalent area of Bangladesh. A total of 21,907 malaria patients have been treated so far in four districts, covering a population of 1.8 million (BRAC Annual Report, 2011). BRAC has started Maternal, Neo natal and Child Health(MNCH) Program in ten rural districts in Bangladesh in collaboration with UNICEF, GoB and other donors and further the programs extended to the urban slums (BRAC Annual Report, 2011).

4. CONCLUSION

Community finance where a group will bear the risk and finance as community is not so common in Bangladesh. The study here considers CHI as community finance in a sense that the precondition of getting the insurance is to be the member of VO for the sf BRAC as in Bangladesh is still in a premature stage Still the study considered CHI as a potential strategy to materialize health goals for two reasons-group motivation and accessibility. BRAC like many other NGOs are working with the woman to change their lt. If CHI would be integrated as mandatory with the lending activities, the recovery rate of MFI lending says that it will be successful. Such inclusion will give the poor woman access to basic services like pregnancy, mother and child care. Bodies like VOs may create awareness among them regarding different preventive measures like healthy habits, personal hygiene, raise consciousness against early or child marriage. As VO is taking the responsibility of taking the loan, they could also finance the health care creating revolving fund through community participation.

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