Inception of Social Health Protection Scheme for Public Servants: Prospects and Challenges

Submitted to

Dr. Md. Mizanur Rahman
Module director, Module-5
BPATC, Savar, Dhaka

Submitted by

Dr. Laila Akhter
Roll No. 101
130th ACAD

Bangladesh Public Administration Training Center

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Inception of Social Health Protection Scheme for Public Servants: Prospects and Challenges

Abstract

Health Policy 2011 and Health Care Financing Strategy 2012-2032 provides a framework for developing and advancing health financing in Bangladesh recognizing the importance of bringing more funds to the health sector and pooling the resources more adequately. Confronting the challenges of health financing, inception of social health protection scheme for public servants could be a step toward achieve universal health coverage. This study aims to assess the perception, prospects and challenges of Social Health Protection Scheme for the Public Servants of Bangladesh. A descriptive study was performed by collecting primary data by purposive sampling, personal in-depth interview and literature were reviewed for secondary data. From this study hundred percent (100%) respondents deem that, not only public servant should have social health insurance, but also (96%) also believe that every person in the society should be included in social health protection scheme, protecting them from catastrophic health expenditure. Even the retired officials must be included in the scheme. The public servants were spontaneously willing to surrender their medical allowance which they get from salary provided that government should ensure every kind treatment facility to them. Now it's the crucial time to establish a national Institution may be named as National Health Security Office (NHSO) or National Health Security Commission (NHSC) to shoulder, operate and maintain social health security scheme.

Acronyms

BBS	Bangladesh Bureau of Statistics
BNHA	Bangladesh National Health Accounts
BPL	Below Poverty Line
CBHI	Community-Based Health Insurance
CHE	Catastrophic Health Expenditure
DP	Development Partner
GDP	Gross Domestic Product
HCFS	Health Care Financing Strategy
HEU	Health Economics Unit
ILO	International Lobour Organization
JKN	Jaminan Kesehatan Nasional
MDG	Millennium Development Goals
MOHFW	Ministry of Health and Family Welfare
NHSC	National Health Security Commission
NHSO	National Health Security Office
OECD	Organisation for Economic Co-Operation and Development
OOP	Out Of Pocket Expenditure
PHC	Primary Health Care
SAARC	South Asian Association for Regional Cooperation
SDG	Sustainable Development Goals
SSK	Shastho Suroksha Karmoshuchi
THE	Total Health Expenditure
UHC	Universal Health Coverage
WB	World Bank
WHO	World Health Organization

Chapter -1: Introduction

1.1 Background:

Ensuring health care services to all citizens of the country along with other basic necessities of life, including food, clothing, shelter, education is the foremost responsibility of government which is stated in the Constitution of Bangladesh in Article 15(a) (The Constitution of the Peoples Republic of Bangladesh). To ensure health facilities for all, a vision targeted by Health Economics Unit is known as "Universal Health Coverage (UHC)". UHC is defined as ensuring access of all people to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality without any financial hardship (WHO 2020). To attain this vision, some strategic initiatives was undertaken since then include the formulation of the Health Care Financing Strategy 2012-2032 by Health Economics Unit, under Health Services Division, MoHFW. To carry out this vision, proper financing in health sector has immense importance. Introducing health insurance for government employees is the key factor for stepping towards universal health coverage in Bangladesh. This study attempts to assess perception of the government employees about health insurance; and willingness to join or contribute to an expected health insurance scheme.

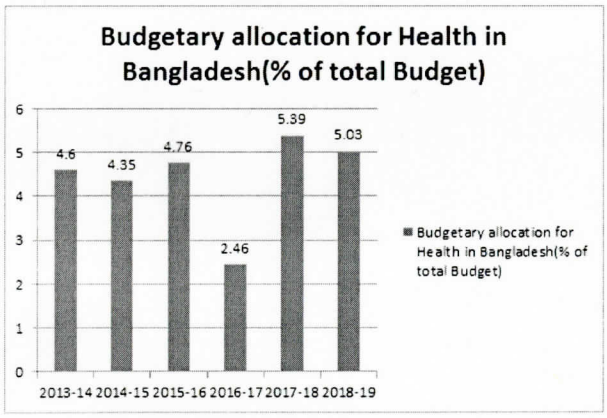

Figure 1: GDP share Source: Ministry of Finance, Government of Bangladesh, 2018

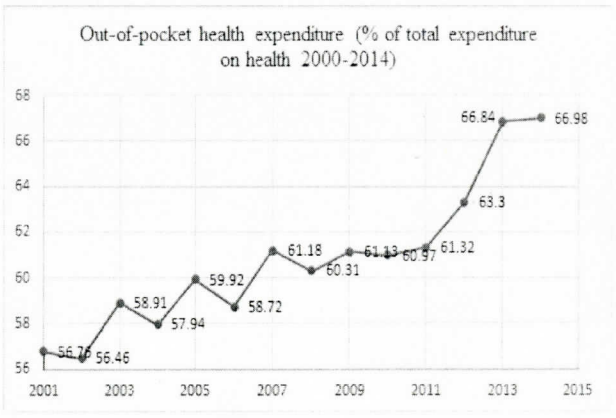

Figure 2: OOP trend in Bangladesh Source: Index Mundi, 2018

Country	% of total health expenditure
Norway	85.5
Japan	82.1
Thailand	80.1
Netherlands	78.8
Canada	69.8
Malaysia	54.8
Sri Lanka	43.9
Bangladesh	35.3

Figure 3: Percentage of total Health Expenditure of government

Social Health Protection Scheme

Social Health Protection is the security which society provides for its members through a series of public measures, against the economic and social distress that otherwise would be caused by the stoppage or substantial reduction of earnings resulting from sickness, maternity, employment injury, unemployment, invalidity, old-age and death. Social health protection consists of various financing and organizational options intended to provide adequate benefit health packages to protect against the risk of ill health and related financial burden and catastrophe (Aniza, et al., 2010). It also has positive impacts on economic growth and development of the country. Healthier workers are more productive, labour supply increases and morbidity and mortality rates are decreases. Conversely, the lack of access to medically necessary health care has significant social and economic repercussions, often driving people into poverty and out of the workforce. This aims to ensure that persons in need will not face hardship and an increased risk of poverty due to the financial consequences of accessing essential health care (ILO, 2007). Many countries of the world provided health security to their citizens through Social health protection mechanism. In United kingdom it is known as National Health Security System (NHS), in Thailand it is known as National Health Security Office (NHSO), in Philippines it is known as PhilHealth. Social health protection schemes have covered all Thai citizens since 2002.

Indonesia formally launched the universal health coverage (UHC) scheme under the banner of Jaminan Kesehatan Nasional (JKN) in 2014, which is operated by the social security administrator. JKN is one of the largest single-payer health insurance (SHI) schemes in the world (Manushi *et al.,* 2020).

Catastrophic Health Expenditure

World Health Organization (WHO) defined that whenever the health expenditure is equal or exceeding 40% of a household's non-subsistence income, it is considered catastrophic. The high global share of out-of-pocket payments (OOP) is most worrying which indicates a lack of coverage in social health protection especially health insurance. OOP is highest in low-income countries, where it ranges between 50 and 80 per cent of total expenditure on health, as in Africa and Asia (ILO 2007). Households in these types of countries can face difficulties even often impoverishment due to high health care cost (Wagstaff 2003, van Doorslaer et al. 2006, and van Doorslaer et al. 2007). OOP payments for healthcare impoverish 5 million people annually in Bangladesh (Van Doorslaer *et al.,* 2006). Another study found the people of Bangladesh to exhibit the highest incidence of catastrophic health expenditure (15.57%) among 14 Asian countries (Van Doorslaer *et al.,* 2007). Currently, at least half of the people in the world do not receive health services they need. About 100 million people are pushed into extreme poverty each year because of out-of-pocket spending on health (WHO, 2020).

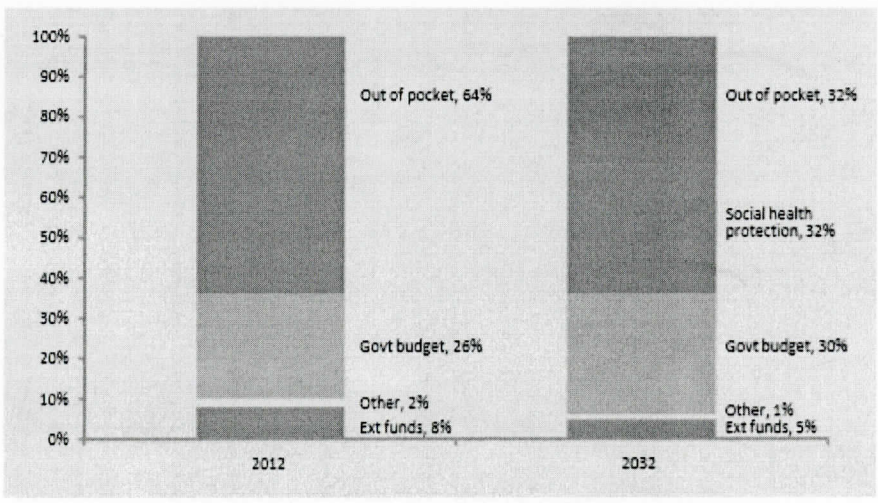

Figure 4: OOP & target in 2030 Source: HEU, HCFS 2012

Bangladesh has been plagued with the burden of unacceptably high out of pocket expenditure at the level of 64% of total health expenditure (THE) where government is spending around 26% only; the economically vulnerable population of the country is threatened with impoverishment in case of catastrophic illnesses, and the percentage of that population is too high moreover, there are no mentionable health insurance program (HEU, 2012). The Global scenario of health health-care financing is shared between governments, which contribute 33 per cent to global health expenditure, social insurance (covering 25 %), private insurance (20 %), and out-of-pocket expenditure and other private expenditure which accounts for 22 % of worldwide expenditure (Aniza, *et al.,* 2010). But in Bangladesh in scenario is much worrying.

Evidence shows that out-of-pocket outlays for health care (especially for NCDs and hospitalization) are a visible threat to the poverty reduction initiatives in Bangladesh (Hamid et al, 2014). Thus, health insurance is one of the most important strategic interventions to reduce OOP towards reducing poverty. Still now government's current health expenditure in Bangladesh is 5.03% of GDP in 2018 as which is the third lowest among the member countries of WHO (WHO, 2018). OECD countries spend 12.33%, AFR (African) regional countries spend 3.64%, and SEAR (South East Asian) regional countries spend 3.64 % of their GDP on health (WHO, 2014). As a consequence of lower government's health expenditure, OOP on health care is 67% in Bangladesh BNHA, 2016) which is highest even among neighboring countries. Around 6.4 million or 4 % of people in Bangladesh get poorer every year due to excessive health costs (Huda and Khan, 2014). Roughly 16.4 percent of the population in Bangladesh, who reported an illness in 2016, didn't go for the treatment for the high cost (World Bank, 2019). Protecting people from catastrophic payments is recognized as a desirable objective of health policy, 2011 (Filmer *et al.,* 2002, Kawabata *et al.,* 2002, Musgrove *et al.,* 2000, and Russel and Gilson, 1997).

Each year 100 million people in the world slide into poverty after paying for medical care and another 150 million people are forced to spend nearly half their incomes on medical expenses. That is because in many countries like Bangladesh people have no access to social health protection; that is, affordable health insurance or government-funded health services. Moreover, people in the world's poorest countries expend relatively more for healthcare than those in wealthy industrialized nations. For example, In Germany, where the average GDP is $32,860 per capita and almost a 100% of people have social health protection, 10 percent of all

medical expenses nationwide are borne by households. But in the Democratic Republic of the Congo, where GDP per capita is only $120 spent about 70% of the money from their own on medical care (WHO, 2020).

1.2 Problem Definition

A comprehensive study is obvious to know the perception of government employees on social health insurance to address the scope and challenges to introduce it. Research relating to health insurance of government officials is very few in our country as well as worldwide. In Bangladesh, similar kind of study was done by few researchers (Hamid *et al.*, 2014) a new research is necessary on this as we need the latest findings to implement social health insurance for the public servants now. A study was performed on Willingness-to-Pay for Community-Based Health Insurance (CBHI) among Informal Workers in Urban Bangladesh to identify its determinants among three categories of urban informal workers rickshaw-pullers, shopkeepers and restaurant workers

1.3 Rationale

But in Bangladesh this field was not studied as desired. Very little study was performed about Health insurance especially of government officials. This study helps to seal the knowledge gape about the perception of the employees on social health insurance scope and challenges. This study will help policy makers to make decision about benefit package and amount of scheme for Health Insurance.

1.4 Objectives

A) **General Objective**

To assess the perception, prospects and challenges of Social Health Protection Scheme for the Public Servants of Bangladesh.

B) Specific Objectives

i. To know the perception of public servants about Social Health Protection Scheme;

ii. To determine the prospects of Social Health Protection Scheme for public servants;

iii. To presume the challenges for execution of Social Health Protection Scheme

1.5 Limitations

Due to time and resource limitations, we are confined ourselves to operate our study within the Dhaka city and BPATC. However, this keeps the door open for the further study including other city and hospitals of Bangladesh.

Chapter -2: Methodology & Data Analysis

2.1 Sampling and Data

This study attempts to assess perception of the government employees about social health insurance; and willingness to join or contribute to a supposed health insurance scheme. Initially, literatures on social health insurance were reviewed for gathering comprehensive knowledge and understandings about the research topic. For this study both primary and secondary data has been collected. Primary data has collected from the concern public servants. So purposive sampling was used to collect information from government employees. Information on employees view and their job status was collected from primary data using a structured questionnaire and personal interview. Secondary literature was reviewed to apprehend the prospects and challenges to implement such health scheme. For secondary sources of data relevant documents such as: books, journal articles, newspaper reports, websites, related Acts, policies and strategies has been used. Descriptive and narrative information was tried to extract from these secondary documents.

2.2 Study area and study period

The study was performed during the period of November 2020 to December, 2020. Data was collected from government employees working in Dhaka city and BPATC on 1-3 December, 2020.

2.3 Data Analysis

We used descriptive statistics to analyze the necessity of a social health protection scheme for public servants of Bangladesh. A standard questionnaire was prepared to ask them different questions on their experience and purview of their knowledge about social health insurance. Interviewing twenty five respondents with the questionnaire was done during 1-3 December 2020. Numbers of male public servants were twenty one and females were four. They were aged between 33 years to 56 years ranging from 6^{th} to 4^{th} grade officers. Their educational qualifications were; one MBBS, One BSC engineer two PhD holders and the rests all have masters' degree.

Table- 1: Respondents information

	Number	Grade	Education
Male	**21**	6^{th} , 5^{th} and 4^{th}	**Engineer, Masters degree, PhD**
Female	**4**	5^{th}	**MBBS, Engineer, Masters degree, PhD**

This study reveals that almost every respondent (96%) heard about "Social Health Protection Scheme" except two persons (8%). But cent percent (100%) respondents deemed, they should have Social Health Protection Scheme or social health insurance protecting them from catastrophic health expenditure. They (96%) also believe that every person in the society should be included in social health protection scheme irrespective of their age and socio-economic status.

Table- 2: Willing to get share of premium from government

Percentage of share	0-19%	20%-39%	40%-59%	60%-79%	80%-100%
Number of respondents	4	1	6	2	12

Mode of premium payment should be given by both government and employee is opined by 72% officers. Others opted for sharing 20% from their own. It seems that willingness to join an assumed scheme is highly sensitive to the proportion of premium sharing. This study revealed that 48 percent employees are interested to pay less or equal to 20 percent of premium and 24 percent want to contribute respectively 40 to 60 percent to share of premium (Figure-5).

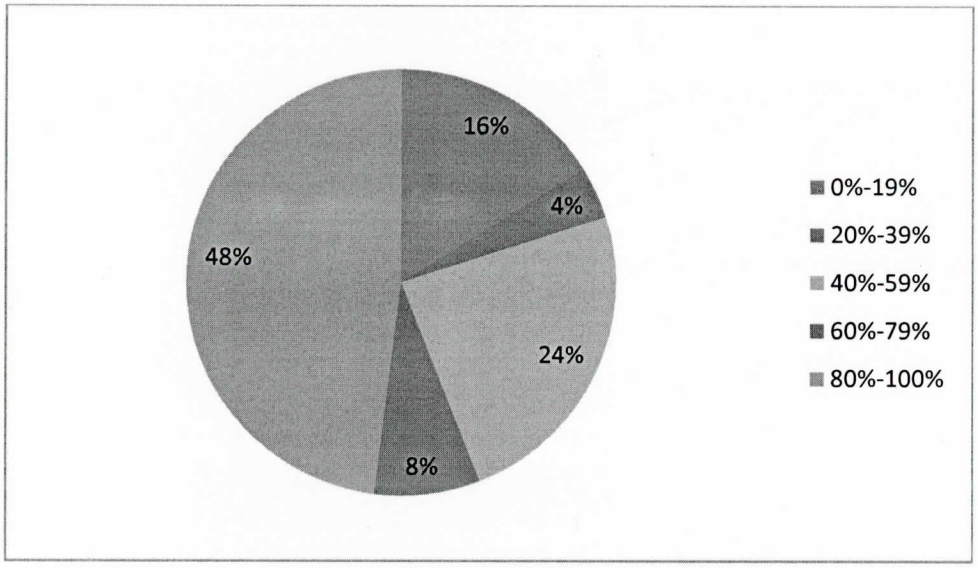

Figure 5: willingness to get premium share from government

Table -3: Amount of premium should be determined

Equal for every public servants	According to number of family member	Should be decided by govt./other
6	16	2

A significant number (65%) of employees considered that premium should be paid according to the number of family members, 24% officers think it should be equal for every employees and 8% are willing to find out any other way to determine premium (Figure-6).

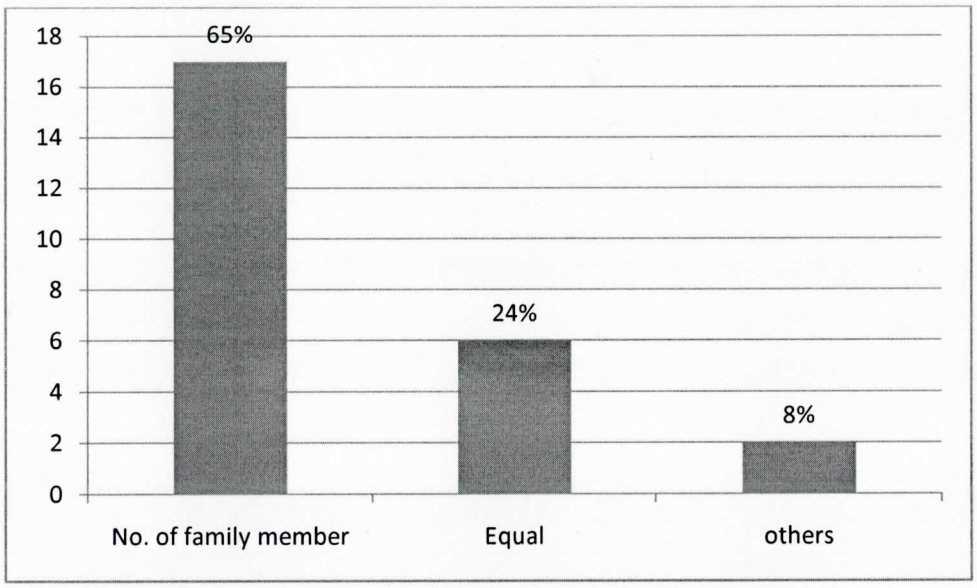

Figure 6: Mode of premium payment

Chapter -3: Result and Discussion

This study reveals that almost every respondent (96%) heard about "Social Health Protection Scheme" except two persons (8%). But cent percent (100%) respondents deemed, they should have Social Health Protection Scheme or social health insurance protecting them from catastrophic health expenditure. They (96%) also believe that every person in the society should be included in social health protection scheme irrespective of their age and socio-economic status. A study revealed that government employees has an incredibly high (about 91%) willingness to join an inpatient social health insurance package and 88 percent of the government employees had the intention to join an inpatient health insurance scheme under government provision paying minimally 75-25 percent of premium (Hamid and Howlader, 2015). But their contribution should be determined according to their income (87%). In another study researchers found, even a large proportion of informal workers (86.7%) were also willing to pay for Community-Based Health Insurance (Sayem *et al.,* 2016). Almost every respondent (94%) opined for Social Health Protection Scheme for government employees. Mode of premium payment should be given by both government and employee is opined by 72% officers. Others opted for sharing 20% from their own. It seems that willingness to join an assumed scheme is highly sensitive to the proportion of premium sharing. This study revealed that 48 percent employees are interested to pay less or equal to 20 percent of premium and 24 percent want to contribute respectively 40 to 60 percent to share of premium (Figure-5).

A significant number (65%) of employees considered that premium should be paid according to the number of family members, 24% officers think it should be equal for every employees and 8% are willing to find out any other way to determine premium (Figure-6). However, each and every respondent wants that each member of family should be included within the bubble of health benefit package.

The study revealed that every public servant is in accord with including retired govt. officials within this insurance policy. Each and every respondent gave their consent without hesitating for a moment even.

In-depth interview:

Personal interview was taken to bring out exact view or opinion on from the beneficiaries. Before asking the willingness to join questions we explained the respondents individually regarding the basic norms of insurance including its concept and functional modalities. All the attributes of the proposed health insurance scheme was also explained before them. It was encouraged for self administering the questionnaire. The interview was taken instantly asking relevant questions regarding this assumed health insurance. Two respondents were interviewed personally and directly by the researcher. Both of them were highly agreed to have such social insurance. They recognized that it's a major concern for our government to ensure health facilities to every citizen of the country. They were willing to surrender their medical allowance from salary provided that government should ensure every kind treatment facility to them. If the health benefit package is limited than were agreed to pay partial amount of the medical allowance. They opined that its very crucial to include all retired public servants within the health coverage.

Prospects:

To ensure health facility for all citizens of Bangladesh with quality and equity (UHC) is the aspiration of government. But health financing is a difficult and sophisticated process. In our country people spent 67% of total health expenditure (THE) by their own (OOP), government's share is only 23% (5% of GDP) and personal life insurance or private health insurance system contributes only 2-3%. And there is no provision of social health insurance in Bangladesh. In that situation, government is committed to institutionalize a Social Health Protection System. In this purview, at first Shastho Suroksha Karmoshuchi (SSK) is piloting in Tangail district for below poverty line (BPL) population. Secondly government is willing to start social health insurance for the population of formal sector like public servants and Garments workers. There are policies and strategies on board, only implementation is delayed.

Many countries of the world like Germany, France, west Europe and some Asian countries like South Korea, Japan are successfully running social insurance. The Republic of Korea is an outstanding example of the successful introduction of a universal health insurance system. It took

just 26 years, once the country had passed its Health Insurance Act in 1963, to achieve universal insurance coverage. The introduction of compulsory health insurance began in 1977 with the Employee Scheme for formal sector employees and SHI schemes for civil servants and educational staff started in 1981 and became important promoters of extending social protection (Aniza, Moshiri H., Radnaa O. & Yondon jamts M. 2010). It is feasible even in the developing world, but has not gotten the attention it deserves. Countries must begin now to craft well-organized schemes, because it takes years to put such a scheme into place (WHO, 2020). Bangladesh has a large informal sector comprising 87.5% of total employment (BBS, 2012). Implementing a contributory scheme for such a large sector will be immensely challenging whereas, it would be easier for small formal sector which is only 8.75% and it will be much easier for public servants the percentage of which is less than 2%.

Social protection programme: SSK covers poor population in a limited number of areas funded from the tax revenue. Autonomous bodies: The teachers of the public universities (autonomous) access health care through a contributory health insurance scheme. Some department of a few public universities also introduced health insurance scheme for the students. Public organizations pools fund to provide health services to their employees either through reimbursement or providing service provision. In the private sector pooling occurs through health insurance specific funds operated by employers for their employees. For example large private companies have insurance schemes. Some NGOs ensure health care to their own staff with contributory health insurance scheme (MOFW 2018).

Challenges:

Health Financing is the foremost challenge for developing countries like Bangladesh to ensure UHC i. e., Social Health Protection. Extent of resource generation and pooling is very limited for inception of social health insurance scheme for the public servants. HCFS set the target of share of budget allocation to health at 10% by 2016 while in 2019 it is still around 5%. This shows that target setting was not realistic. Unfortunately, the recent trend in budget allocation portrayed just the opposite and is concerning as expressed by health experts. Over the last seven fiscal years,

budgetary allocation for health dropped from 6.2% to 4.3% of total government expenditure. (Hassan *et al.,* 2016).

Public sector tax based financing was very low till 2015 (23%) of total health expenditure on health and has been less than 1% of GDP (MOHFW 2018). Despite health being portrayed as an important sector in government policy documents the budget allocation to health has been accorded a low priority (around 5%).Historically household out of pocket payment (OOP) has been the dominant source of health financing. In 2015, OOP accounted for 67%of total health expenditure (THE). Voluntary insurance is negligible, accounting for 2-3% of THE (MOHFW 2018). For Health Sector the HNPSIP presents the indicative budget for the next five years during the programme implementation period. MTBF (Medium Term Budget Framework) presents a 3 year rolling budgets (World Bank 2019).

Though Health care services and systems are fundamental to any society, it cannot be treated as **commodity**. As health status is directly proportional to standard of living, many developed countries faced challenges performing effective health care system. From a comparative study it was revealed that, the United States has structured health care as a commodity, whereas the United Kingdom has considered it a part of the welfare state. Neither model (USA & NHS, UK); however, has fully accomplished the goal of meeting quality, equitable access, and cost effectiveness (Rita, *et al.,* 2004).

Insurance premium may make some difficulties if it would inaccessible or high for the insurer. Despite the Government's initiatives to support health insurance schemes in India, only some 10 % of the population enrolled for health insurance. Indeed, the majority of the population cannot afford premium and contribute to payments. **Health Benefit Package (HBP)** may create another challenge because some diseases and physical distresses like cancer treatment, dialysis, and maternal health services may incur high cost.

Chapter - 4: Conclusion and Recommendations

This study looked for government employees' perception about social health insurance and willingness to join and willingness to contribute to a health insurance provision under government initiative. Social health protection coverage also reduces the indirect costs of disease and disability, such as lost years of income due to death, short and long-term disability, care of family members, lower productivity, and hampered education and social development of children due to sickness. It hence plays a significant role in poverty alleviation. It is very optimistic that 100% government officials are agreed to be included in SHPS and 96% of them are interested to share premium with government. Among them 80 % are agreed to surrender their full medical allowance conditioning that all health care facilities should be covered by SHPS. As the public servants are willing to pay for contributory Social Health Insurance, so it's the time to institutionalize the social health insurance sector. It should not be delayed more to initiate the social insurance scheme for government officials any more. Retired public servants should be benefitted from this proposed insurance policy. A national Institution may be named as National Health Security Office (NHSO) or National Health Security Commission must be established to operate and maintain health security scheme.

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Annexure-1

Questionnaire

Study:

Inception of Social Health Protection Scheme for Public Servants: Perception and Challenges

Section 1: Personal Information		
101	Name	
102	Designation	
103	Date of Birth	
104	Educational Qualification	
105	Gender	1. Male 2. Female 3. Others
Section 2: Health Insurance Related Questions		
201	Do you have any idea about social health Insurance?	1. Yes 2. No
202	If yes, do you think everyone should be brought under the social health insurance coverage?	1. Yes 2. No
203	If no, who do you think to be covered?	1. Children 2. Senior citizens 3. Below Poverty Line People 4. Others
204	If yes, should everyone pay equal premium?	1. Yes 2. No
205	If no, how to set premium?	1. Income wise 2. Profession wise 3. Others
206	Is it necessary to introduce health insurance for public servants as first step to initiate social health insurance for all?	1. Yes 2. No
207	If yes, who will bear the premium?	1. Public servants 2. Government 3. Both 4. Others
208	If both, how will the premium be	1. Government % 2. Public servants %

	shared?	
209	If public servants bear the premium, do you agree to pay your whole treatment allowance as premium?	1. Yes 2. No
210	Should every employee pay equal premium?	1. Yes 2. No
211	If no, how to set premium?	1. Income wise 2. Grade wise 3. Others
212	Should all family members of the employee be covered?	1. Yes 2. No
213	If yes, how to set premium?	1. Equally 2. Family member wise 3. Others
214	Should retired public servants be covered?	1. Yes 2. No