

Factors Affecting Willingness-to-join for Community-based Health Insurance among the Community People of Gaibandha District, Bangladesh

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Abstract

Amid the COVID-19 pandemic, Bangladesh has realized the need for health insurance once again. Changing disease patterns and global economic shocks, such as the Russia-Ukraine war, enhance the cost of living and healthcare expenses, thereby reducing access to healthcare services for many households. Low healthcare coverage from the public sector has resulted in a high burden of out-of-pocket (OOP) expenditures, which account for 68.5% of total healthcare expenditures in Bangladesh. In this context, Community-based health insurance (CBHI) has emerged as a potential alternative for improving financial protection and advancing progress toward Universal Health Coverage (UHC). The study examines the willingness-to-join (WTJ), a hypothetical CBHI scheme, and identifies the determinants influencing enrollment among rural households in the Gaibandha district of Bangladesh. A survey was conducted among 516 randomly sampled respondents. The study found higher acceptance: 90.1% agreed to join, and 86.2% were willing to pay the proposed premium for the hypothetical CBHI scheme, with a mean value of Bangladesh Taka (BDT) 97.34. The study identified several factors significantly associated with WTJ, the scheme, including family size, annual outpatient expenditure, distance from the hospital, choice scheme, and trust in the implementation committee. However, awareness of CBHI was extremely limited, with 97.1% of respondents reporting little or no prior knowledge of the scheme. Furthermore, a large majority (96.7%) expressed a preference for government involvement in managing the scheme. The findings suggest that awareness creation campaigns and institutional support are essential for the successful implementation of such a scheme.

Keywords: CBHI · WTJ · WTP · Gaibandha · Binary logistic regression · Benefit package

Background

Bangladesh has recognized the need for health insurance, even though it has successfully emerged from the COVID-19 pandemic. Moreover, the Russia-

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Ukraine war has disrupted the global supply chain and economic stability, which has driven up prices across the board, including healthcare costs worldwide, resulting in limited access to healthcare in the country. A wide range of economic instability has already been created by the war, both at the micro- and macro-levels. Besides, the types and patterns of disease have been increasing alongside rising healthcare costs and the cost of living.

In addition, low tax revenue, over-dependence on imports, a low export base, the effectiveness of the central bank's monetary policy, interest rate caps, overrun project costs, and the weakness of the banking sector are among the structural problems (The Daily Star, 2022). Those drained the central bank's reserves at an alarming rate, forcing the Bangladesh government to adopt harsh restrictions. Consequently, growth has slowed, the Bangladesh taka (BDT) has depreciated, and reserves have shrunk, prompting the government to approach international financial institutions to raise funds.

The persistent trade deficit and current account imbalances created a huge gap between US dollar (USD) inflows and outflows throughout the fiscal year (FY) 2021-2022, which resulted in an increased exchange rate of the US dollar against the Bangladeshi Taka and further depletion of foreign exchange reserves (Hossain, 2022). Even though depreciation of the BDT has proven an incentive for exporters, it has significantly increased pressure on import payments for medical equipment, pharmaceuticals, and healthcare services. As a result, increased healthcare expenditures create additional financial barriers to accessing healthcare services.

In the United Nations Assembly-2030 agenda, Bangladesh has committed to achieving Universal Health Coverage (UHC) by 2030 under the Sustainable Development Goals (SDGs), which implies that all individuals and communities will receive the health services they need without suffering financial hardship (SDGs, 2030; WHO, 2023). Moreover, a declining trend in budgetary allocations to the health sector was observed over the last decade in Bangladesh. However, the healthcare financing system in Bangladesh remains heavily dependent on OOP payments, which account for approximately 68.5% of total healthcare expenditures, imposing a significant financial pressure on households (Bangladesh National Health Accounts (BNHA), 1997-2020). These high levels of direct payments often lead to catastrophic health expenditures, affecting approximately 15.6% of households in the country (Ahmed et al., 2016).

Community-based Health Insurance (CBHI) has been widely recognized as a potential strategy to enhance financial protection and improve healthcare access in low- and middle-income countries. Evidence from several countries in Africa and Asia suggests that the utilization of healthcare services and health-seeking

behavior has increased through CBHI schemes (Spaan et al., 2012). Hence, CBHI schemes can help improve access to healthcare services and provide financial protection to individuals and families.

Several policy initiatives aimed at strengthening healthcare financing have been undertaken in Bangladesh. A National Health Policy (NHP) was formally approved by the Parliament of Bangladesh in 2000. With the 2011 revisions to NHP, new issues have been introduced, including a health insurance scheme for formal institutions with the provision of health cards for the ultra-poor and deprived parts of society (WHO, 2015). In addition, community clinics and maternal care vouchers provide limited health services under existing reforms (WHO, 2015). Despite those initiatives, the majority of the population, particularly working in the informal sector, have low access to health insurance and social protection (Rockefeller Foundation, 2013). However, limited attempts were made by non-governmental organizations, such as the Bangladesh Rural Advancement Committee (BRAC), through health microfinance schemes for the rural sector (Molla & Chi, 2017), based on individuals' economic capacity. A "pre-payment" national health insurance scheme has been initiated on a pilot basis, named "Shasthaya Shurokkha Karmoshuchi, SSK" on a limited scale to explore potential pathways toward broader health insurance coverage (Ahmed *et al.*, 2018; SSK, 2014).

Although a lack of relevant infrastructure and administrative challenges limits the successful implementation of health insurance schemes in Bangladesh, existing evidence suggests that CBHI initiatives can improve healthcare access, enhance health equity, and promote better health-seeking behavior among rural populations (Hamid, 2015). Moreover, investments in health yield positive outcomes by enhancing productivity, improving working conditions, and improving overall economic well-being (Uddin, n.d.).

Despite the potential benefits of CBHI schemes, empirical research examining community demand for such programs in rural Bangladesh remains limited. In particular, there is a lack of evidence on the willingness of rural populations in Gaibandha district to join CBHI schemes and the factors influencing their enrollment decisions. To address this research gap, the present study aims to assess the willingness to join (WTJ) a hypothetical CBHI scheme among rural households in Gaibandha district and to identify the key factors influencing the decision to participate. Understanding those factors is essential for designing effective CBHI policies and expanding health insurance coverage among underserved populations. The findings of this study are expected to provide policymakers and stakeholders with valuable insights for developing sustainable health financing strategies and leading the way towards achieving UHC in Bangladesh.

Methods

Research Approach

The study employed an exploratory research design that combined quantitative and qualitative approaches. The quantitative component consisted of a structured questionnaire survey to assess respondents' WTJ and willingness to pay (WTP) for a hypothetical CBHI scheme. Qualitative insights were collected through key informant interviews to better understand community perceptions of the scheme's feasibility and implementation.

Pre-survey Work

To determine WTJ and WTP for the proposed CBHI scheme, a questionnaire survey was conducted. Before designing the questionnaire, key informants were interviewed, including community leaders, teachers, health workers, and staff from village-level non-governmental organizations (NGOs). The aim was to identify the factors for implementing the scheme in the research area and the status of perceived healthcare services. Representatives of prospective healthcare providers for the scheme were interviewed to assess their attitudes towards the insured population. Moreover, a reasonable amount of time was spent mapping the locations of the districts and villages, where the survey would be conducted. Some representatives of reputable NGOs were interviewed to assess the WTP of the target population and the starting bid amount. As NGOs implemented many programs, including microcredit and health initiatives, the appropriate WTP for poor people in the study area was well known to them. Before the final survey, a pretest (survey) was carried out on 50 respondents in the rural areas of the district. The key informant interviews (KIIs) were also conducted to obtain supportive information on the scheme's functioning, problems, and prospects.

A Hypothetical CBHI Scheme Scenario

Assuming that people will be willing to pay a premium for a hypothetical CBHI scheme, would be contracted for one year to become a member. A portion of the insured population will fall ill during the period and require healthcare services, which were also assumed. Hence, insured people would have no financial barriers to getting treatment for illnesses. Therefore, access to healthcare services through the scheme would increase. Thus, the insured members do not need to search for credit or sell assets while they are ill. They do not need to delay seeking care; they will recover quickly from their illness and can return to work sooner. Generally, people living in rural areas rely mostly on their labor work for income generation (Jutting, 2003). However, the significant decline in income for insured members can be prevented by protecting productive resources. Income would be stabilized, and consumption would be more stable and sometimes even higher, resulting in positive impacts on health through the CBHI scheme. As a result, improved health will raise

households' gross income. Moreover, as income rises, demand for healthcare increases due to higher opportunity costs. Thus, it will encourage people to extend their membership, which will also induce others to join the scheme. Therefore, the demand for health insurance will increase as well. In this situation, people would be willing to spend more on overcoming barriers to accessing healthcare services than before, which will likely increase the utilization of health facilities and thereby increase the facility's financial resources. Hospitals or health facilities could use financial resources to improve the quality of healthcare, such as by increasing the availability of drugs and purchasing surplus essential medical equipment. Better healthcare quality will raise people's expectations of value from their expenses during illness, thereby increasing demand for health insurance. Risk pooling will therefore increase, and that, in turn, will increase the participation rate, thereby reducing the administrative cost of insurance per member. The premium would be reduced due to "Economies of scale." Lower premiums will once again increase demand for health insurance and population coverage.

Characteristics of the Proposed Benefit Package Included in the CBHI Scheme

A hypothetical scenario outlining the CBHI scheme's benefit package was presented to respondents in the study area to gauge their willingness to participate. The proposed benefit package included both curative and preventive services, with doctors providing consultations and playing an important role in controlling endemic diseases. At the primary stage of the scheme, a low-intensity hospital care component would be included. By raising the pooling fund, the intensity of hospital care will increase as well. Some basic primary healthcare services, such as outpatient care (only a consultation charge), inpatient care (limited at the primary stage), maternal and child health services, etc., as well as secondary care on a referral basis, would be offered at the primary stage of the scheme. A 15-25% discount off the retail price for 14 types of services was included in the benefit package, and a discount for drugs based on the medicine category was also included. The premium of BDT1200 annually or BDT100 monthly per household has been settled to obtain a membership card for the CBHI scheme. Similarities were found between the proposed benefit package and a concept paper for Bangladesh (SSK, 2014), which proposed BDT1000 annually per household. In addition, across population groups, the proposed CBHI scheme will operate on a cross-subsidization model.

Study Area, Study Time and Study Focus

A questionnaire survey was conducted in the rural areas of Gaibandha district. The survey was conducted from February 2019 to March 2019, during which the study focused on the rural people of Gaibandha district.

Sampling

To select the sample size, the Taro Yamane (1967) technique was used. In the study, a simple random sampling technique has been used in two ways. Firstly, a total of 4 (four) Upazilas were selected from 7 (seven) Upazilas in the Gaibandha district: Fulchhari, Gaibandha Sadar, Gobindaganj, and Sundarganj (BBS, 2011). Secondly, 2 (two) villages were selected randomly from each Upazila, and 560 respondents were considered to conduct the survey. Finally, 516 were selected as the study sample, and 44 were excluded because they had no income.

Sources of Data

Primary data were collected through a structured questionnaire survey administered to respondents. Secondary data were obtained from various sources, including government reports, academic journal articles, books, policy documents, and relevant online resources.

Statistical Analysis

Statistical Package for Social Science (SPSS) version 26 was used for the statistical analysis. To describe the data, descriptive statistics (i.e., frequencies, percentages, mean values with standard deviations) were used. To identify factors influencing WTJ in the CBHI scheme, binary logistic regression analysis was employed. Hence, respondents were categorized as willing to join or unwilling to join the CBHI scheme as “YES” or “No.” The results of logistic regression were reported as adjusted odds ratios (AOR), and a p-value less than 0.05 was considered significant (5% level of significance) at a 95% confidence interval (Khatiwada et al., 2017).

Results and Analysis

Demographic and Socioeconomic Characteristics

Of the 516 respondents (Table 1), 65.9% were male and 34.1% were female; any family member aged 18 or older, as well as a permanent resident, was eligible to participate in the interview. Among the sampled respondents, the mean age was 38 years (Mean $\pm$ S.D; 38 ± 12.567), and a total of 38.2% were from the age group lowest up to 30 years, and 38.4% were from 31-45 years, who were very close together in percentages, whereas 23.4% of them were 45 and above years old considered as elderly who need the care the most. On average, families had 5 members, with the majority (73.3%) having 3 or fewer. The largest group of respondents was employed in daily labor (37.8%), followed by service workers (22.7%), although many of them worked as salesmen, waiters, or other informal workers. A very small percentage worked in the formal sector, 21.3% in businesses, and 18.3% in agriculture. 42.8% of respondents had primary-level education, followed by 37.0% who lacked any formal education, 15.5% who had secondary or higher secondary education, and only 4.7% who had graduated or higher degrees. Among the

lowest incomes, the minimum was BDT 18000, and the maximum was BDT 650000. The mean annual income was BDT 112852 (Mean $\pm$ S.D; 112852 $\pm$ 85322.641), where the minimum income was BDT 18000, and the maximum income was BDT 650000 annually.

Table 1. Demographic and Socioeconomic Status of the Study Respondents among the Rural People in the Gaibandha District (n = 516)

Variables	Percentage	Mean	Minimum	Maximum
Gender				
Male	65.9	—	—	—
Female	34.1	—	—	—
Age group				
Lowest up to 30	38.2			
31-45	38.4	38	18	80
45 above	23.4			
Family size				
Lowest up to 3	73.3	5	1	14
4 to 7 >7	25.8			
	1.0			
Education				
No education	37.0			
Primary	42.8			—
Secondary and Higher Secondary	15.5	—	—	
Graduation / Masters	4.7			
Occupation				
Service holder	22.7			
Business	21.3			
Farmer	18.2	—	—	—
Daily labor	37.8			
Annual income				
Lowest up to 100000	64.0			
100001-200000	26.9	112852	18000	650000
200000 above	9.1			

Note: The mean, minimum, and maximum values have been shown only for continuous variables

Knowledge of the CBHI Scheme

The level of knowledge regarding the CBHI scheme (Fig 1) was very poor, at 2.9% in the study area, among those who had heard of it from friends or relatives and the mass media. In contrast, 97.1% had no prior knowledge about the scheme.

WTJ and WTP for the CBHI Scheme

The findings indicated a strong willingness to participate in the CBHI scheme. Respondents with 90.1% were willing to join the hypothetical CBHI scheme (Fig 2 and Fig 3), whereas the WTP of interviewed respondents was 86.2%, and 13.8% refused to pay for such a program. The average WTP was BDT 97.34 (1.148 USD).

Households with Outpatient Care Expenditures

A very small percentage of sampled households (3.6%) incurred outpatient expenditures of BDT 5000 or more in the year preceding the survey (Fig 4). The majority of households (60.5%) had outpatient expenditures of BDT 1001-5000, and 35.9% had expenditures of BDT 1000 or less.

Distance from the Preferred Hospital (km)

Over half of the respondents (53.9%), who were the majority (Fig 5), lived 4-20 km from the hospital; 25% lived up to 3 km, and 21.1% lived over 20 km away.

Choice of the Scheme by Respondents

The majority of respondents (96.7%) preferred that the hypothetical CBHI scheme be managed by government initiatives, while 3.3% preferred private-sector management.

Trust in the Implementation Committee

In this study, 96.7% of respondents (Fig 7) stated they would trust the implementation committee to operate the hypothetical CBHI scheme. On the other hand, only 3.3% of respondents noticed that they would never trust the implementation committee.



Fig-2: Willingness-to-join to the CBHI scheme among respondents

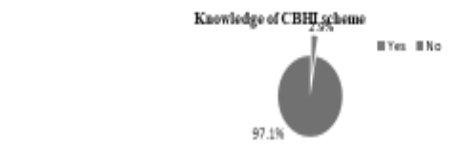


Fig-1: Knowledge of the CBHI scheme among respondents



Fig-3: Willingness-to-pay for CBHI scheme among respondents

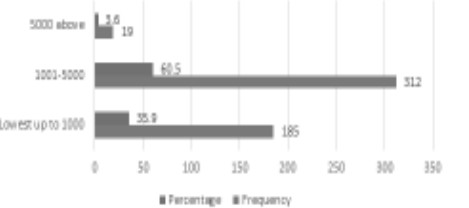


Fig-4: Households with outpatient care expenditures

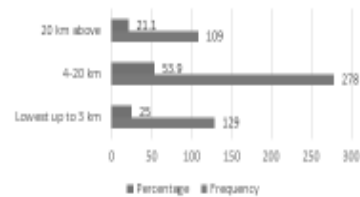


Fig-5: Distance from the preferred hospital (km)



Fig-6: Choice of the scheme by respondents

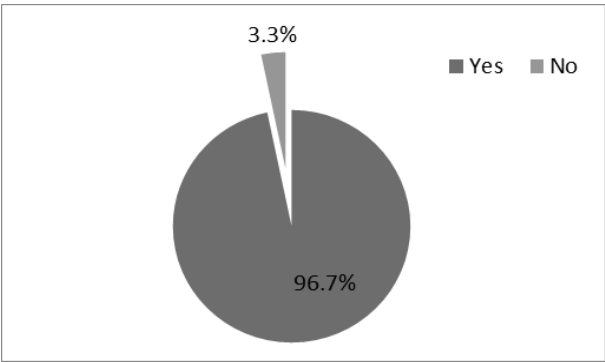


Figure 7. Trust in the Implementation Committee by Respondents

Results and Analysis of Binary Logistic Regression

Table 2. Regression Analysis of Factors Associated with WTJ

Variables	β (S.E.)	Sig.	AOR	95% CI	
				Upper Bound	Lower Bound
Gender					
Male	-.418 (.361)	.247	.659	.325	1.335
Female	Reference				
Age					
Lowest up to 30 years	-.718 (.483)	.137	.488	.189	1.257
31-45 years	-.293(.431)	.496	.746	.321	1.735
45 years above	Reference				
Education					
No education	.230(.381)	.546	1.259	.596	2.658
Primary	-1.137(.733)	.121	.321	.076	1.349
Secondary and Higher Secondary	-.341(.955)	.721	.711	.109	4.627
Graduation/Masters	Reference				
Occupation					
Service holder	-.384(.579)	.507	.681	.219	2.117
Businesses	.226(.423)	.593	1.253	.547	2.873
Farmer	-.557(.520)	.284	.573	.207	1.588
Daily labor	Reference				
Annual Income					
Lowest up to 100000	-.302(.777)	.698	.740	.161	3.393
100001-200000	-1.062(.811)	.190	.346	.071	1.694
200000 above	Reference				
Family size					
Lowest up to 3	2.567(1.133)	.023	13.025	1.414	119.990
4 – 7	1.651(1.087)	.129	5.212	.619	43.924
7 above	Reference				
Annual Outpatient expenditures					
Lowest up to 1000	-1.416(.637)	.026	.243	.070	.846
1001-5000	-1.462(.616)	.018	.232	.069	.776
5000 above	Reference				
Distance from the hospital					
Lowest up to 3	Reference				
4-20	-.827(.373)	.026	.437	.211	.908
20 above	-.058(.487)	.905	.944	.363	2.452
Choice scheme					
Public	-1.422(.707)	.044	.241	.060	.965
Private	Reference				
Trust in the implementation committee					
Yes	-1.705(.651)	.009	.182	.051	.651
No	Reference				

From the Table 2, the adjusted model confirmed that family size (OR = 13.025, 95% CI = 1.414 - 119.990, $p = .023$; when the family size was lowest up to 3 with the reference category was “7 above” numbers), annual outpatient

expenditures (OR = .243, 95% CI = .070 -.846, $p = 0.026$ when the expenditure level was from lowest up to 1000BDT, OR = .232, 95% CI = .069 -.776, $p = 0.018$ when the expenditure level was from 1001-5000BDT with the reference category was “5000 above BDT”), distance of residence from hospital (OR = .437, 95% CI = .211 - .908, $p = .026$; when the distance of residence was 4-20 km away from hospital with the reference category was “lowest up to 3 km”), choice scheme (OR = .241, 95% CI = .060 - .965, $p = .044$; when the respondents wanted to operate the scheme under government (public) initiative with the reference category was “private”) and trust in the implementation committee (OR = .182, 95% CI = .051 - .651, $p = .009$; when the respondents had trust on the implementation committee with the reference category was “no”) were all significantly associated with WTJ.

The Following Model was Run

Logit (WTJ) = f (Family size, annual outpatient expenditure, distance from hospital, choice scheme, trust in the implementation committee)

As shown in Table 2, five independent variables contributed significantly to the model. Binary logistic regression was used to assess the impact of several factors on the WTJ-to-CBHI scheme reported by respondents. The model contained five independent variables (Family size, annual outpatient expenditure, distance from hospital, choice scheme, and trust in the implementation committee). The full model, including all predictors, was statistically significant, with a chi-square value of 46.361 and a p -value of .000 ($<.001$), indicating that the model could distinguish between respondents who reported WTJ and those who did not for the CBHI scheme. The model as a whole explained between 8.6% (Cox and Snell R-square) and 18.1% (Nagelkerke R-square) of the variance in the WTJ-to-CBHI scheme and correctly classified 89.9% of cases. Hosmer and Lemeshow's test indicated that the model had a chi-square value of 9.803 with 8 degrees of freedom and a p -value of .279, indicating a good rather than a poor fit. Thus, the model adequately fits the data.

Results from Table 2 showed that education level was not statistically significant; however, the adjusted model in multivariate analysis (via odds ratios) indicated that respondents with no education were more likely to be willing to join the hypothetical CBHI scheme than those with a graduate or master's degree. Besides, respondents engaged in business were more willing to join the CBHI scheme than daily laborers, though the difference was statistically insignificant.

When the number of family members was lowest, up to 3 and 4-7, those households were significantly more likely to be willing to join the CBHI scheme, compared to the reference category, which was family members of 7 or more. Respondents with annual outpatient expenditures of up to 1000 BDT

and 1001-5000 BDT were significantly less likely to be willing to join the CBHI scheme than households with annual outpatient expenditures of 5000 BDT or above. Respondents living 4-20 km from the hospital were less likely to be willing to join the CBHI scheme than those living up to 3 km away. Respondents who wanted to operate the scheme under government initiatives were less willing to join the CBHI scheme than those who preferred private initiatives. Respondents who had trust in the implementation committee of the hypothetical CBHI scheme were significantly less likely to be willing to join the scheme than households that had never trusted.

Discussion

To facilitate respondents' understanding of the relatively new concept of CBHI in the Gaibandha district, a hypothetical CBHI scheme was presented during the survey. The results revealed that a large proportion of respondents (90.1%) expressed WTJ the scheme, while only 9.9% reported unwillingness to participate. This finding is higher than those reported in previous studies conducted in Ethiopia, where 77.8% of respondents expressed willingness to join the CBHI scheme (Haile et al., 2014), and in Nigeria, where approximately 60% were willing to participate, while 21.7% were unwilling to join (Oriakhi et al., 2012).

The survey also indicated that some poor households expressed interest in joining the scheme, but financial constraints prevented them from paying the required insurance premium. Thus, financial inability was identified as the main reason for non-participation in the scheme. In contrast, a study conducted in Ethiopia reported that some respondents were unwilling to join because they perceived no need for health insurance (Haile et al., 2014).

The study's adjusted estimates indicated that the WTJ-to-CBHI scheme was significantly influenced by family size, annual outpatient expenditure, distance from the hospital, scheme choice, and trust in the implementation committee.

Respondents with smaller family sizes were significantly more likely to join the CBHI scheme compared to those with larger family sizes. This indicates that smaller families are more concerned about health risks and can afford insurance premiums. However, some previous studies have shown the opposite results. A study in Ethiopia reported that WTJ increased with larger household sizes (Haile et al., 2014). Furthermore, a meta-analysis conducted by Dror et al. (2016) found mixed results: Asian studies reported a negative association between family size and CBHI enrollment, whereas studies from Sub-Saharan Africa showed a positive association.

The findings revealed that respondents with lower annual outpatient expenditures were less likely to join the CBHI scheme than those with higher

healthcare expenditures. This suggests that respondents with lower medical expenses may perceive health insurance as less necessary for managing healthcare costs independently.

Trust in the implementation committee was another significant factor in the scheme. Interestingly, the study respondents who reported trust in the implementation committee were less likely to express WTJ. This finding contrasts with previous studies, which identified trust in the management or implementation committee as an important factor in CBHI enrollment (Haile et al., 2014; Dror et al., 2016). In general, trust is considered an important element of social capital that encourages participation in CBHI schemes. Therefore, the unexpected relationship observed in this study may require further investigation.

Education level was not statistically significant in the adjusted model; however, respondents without formal education were more likely to express WTJ the CBHI scheme than those with higher educational levels. A similar finding was reported in Ethiopia (Haile et al., 2014). However, a meta-analysis by Dror et al. (2016) identified that higher education levels were associated with greater participation in CBHI schemes.

Respondents engaged in business activities were more likely to join the CBHI scheme than daily laborers. Daily laborers typically experience irregular income, which may limit their ability to consistently pay insurance premiums. Although business income may fluctuate, it provides relatively more stable cash flow compared to that of daily wage laborers in general. This may exhibit the higher WTJ among business respondents.

Distance from healthcare facilities was also found to influence participation decisions of the CBHI scheme. Respondents living farther from hospitals were less likely to express WTJ toward the CBHI scheme than those living closer. Respondents living closer to healthcare facilities may perceive greater benefits from insurance coverage, as they use healthcare services more frequently when needed.

Although a large majority of respondents (96.7%) preferred government involvement in operating the scheme rather than private initiatives, they were less likely to support the scheme. One possible explanation is that some respondents preferred to observe the scheme's performance and effectiveness before deciding to participate.

Recommendations

The banking sector in Bangladesh is still facing a high number of defaulted loans and scams. Hence, the government should take the initiative to restore

discipline in the macroeconomic zone, as this could affect every sector of the economy, including the health sector. A well-thought-out healthcare financing strategy is important to addressing the problems associated with healthcare utilization. Providing proper healthcare requires coordination between health policymakers and local healthcare providers.

Knowledge of the CBHI scheme was very poor, despite the study area being considered high in acceptance. Thus, marketing strategies are needed to stimulate awareness and knowledge regarding CBHI schemes at the community level. Therefore, the government of Bangladesh should take the initiative to raise awareness among low-income rural communities. Some major challenges in health service utilization in government health facilities include a lack of medicines, poor service delivery, limited diagnostic services, insufficient numbers of skilled health professionals, and a shortage of ambulances. Besides, in Bangladesh, as most of the rural population is informally employed, there is a significant challenge in paying a premium for these vast numbers. Flexible payment mechanisms and subsidized premiums for the low-income population may therefore be necessary to ensure broader participation in CBHI schemes. To address such issues, properly equipping healthcare facilities, developing monitoring systems, and training health personnel to build a skilled health workforce are prerequisites. Besides, exchanging best practices, resources, and expertise with international organizations, NGOs, and neighboring countries can be a great way to address health challenges.

Conclusion

Health insurance plays a significant role in providing financial protection against healthcare costs and reducing the economic burden of illness. The findings of this study indicate that overall acceptance of the hypothetical CBHI was relatively high, with 90.1% of respondents expressing their WTJ for the scheme. The study's findings will be useful to policymakers in identifying the factors influencing WTJ, including family size, annual outpatient expenditure, distance from the hospital, choice of scheme, and trust in the implementation committee. The results provide valuable insights for policymakers and health planners in designing and implementing CBHI schemes successfully in rural Bangladesh. Understanding the determinants of participation decisions can help policymakers develop targeted strategies to increase enrollment and improve the sustainability of CBHI schemes. However, weaknesses within the healthcare system must also be addressed to ensure the success of such initiatives. If these issues are not properly considered during the design and implementation of the scheme, utilization of healthcare services may decline, ultimately hindering progress toward UHC.

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