


RESEARCH ARTICLE

Health insurance for university students in Bangladesh: A novel experiment

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Abstract

Background and Aims: Bangladesh requires some pragmatic initiatives for using its immense potentiality to flourish health insurance. Introducing group health insurance for university students is a groundbreaking idea for stepping toward social health insurance in Bangladesh. This article examined the effect of the health insurance initiative for the university students introduced by the Institute of Health Economics, University of Dhaka, on attitude toward insurance and protecting financial risk against health care expenditure.

Method: We used both management information system (MIS) and primary data obtained through mixed methods. We collected the quantitative data from a baseline survey on 310 students and a year-end survey on 151 students. We used bivariate tools to analyze the data.

Results: The results show that the mean score of attitude toward health insurance in the year-end survey (4.04) was significantly higher than the baseline score (3.21). Results also show that a significantly higher percentage of the students reported insurance as “useful” in the year-end survey (83.74%) than the baseline survey (40.40%). The results also reflect that the scheme has a substantial impact on reducing the out-of-pocket spending for health care, especially for in-patient care, and the anxiety regarding the financing of health care among the students. There is also an indication of sustainability and the feasibility of scaling up such a scheme across the country.

Conclusions: Introducing such health insurance by all the universities may guide the nation toward large-scale group health insurance and social health insurance.

KEYWORDS

attitude, Bangladesh, group health insurance, social health insurance, university students

1 | INTRODUCTION

This article outlines a brief evaluation of a pilot “experiment” that tries out the effectiveness and practicability of a health insurance scheme

for a segment of the student population at the university level in Bangladesh. Although in advanced country settings, such programs are standard, similar systems do not exist in many developing countries. The introduction of this pilot experiment started while

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Bangladesh desperately explores alternative sources of health care financing to cope with fast increasing health care costs and reduce tremendously high out-of-pocket (OOP) payments for health care.

The per capita health care expenditure in Bangladesh is USD 41.91, which is much lower than the World Health Organization (WHO) recommended USD 88.^{1,2} People need to pay about 74% of health outlays from OOP, which is the largest in the region than India with 63% and Sri Lanka with 51%.¹ Existing evidence shows that OOP payments for health care, especially for noncommunicable diseases (NCDs), are a noticeable threat to the poverty reduction initiatives in Bangladesh.³ Massive dependency on OOP payments for health care increases households' financial burden. Significant and unpredictable OOP outlays for health care can expose the households to substantial financial risk and, at their most extreme, may result in impoverishment. Due to OOP payments for health care, about 5 million people fall under the poverty line in Bangladesh.⁴ Therefore, health insurance is argued as an effective vehicle to make modern treatment facilities affordable to all socio-economic classes of people of Bangladesh. Despite colossal potentiality, the development of health insurance is negligible in Bangladesh.

There is a debate whether Bangladesh should adopt a policy for social health insurance covering the entire population. The experts argue that the large informal sector (87.5%) and small tax-gross domestic product (GDP) ratio (8.97%), along with the lack of readiness of health care providers, do not allow introducing social health insurance in Bangladesh for the whole population at present.⁵ However, as argued, Bangladesh should provide continuous efforts to create a pleasant environment to step toward social health insurance with gradual orientation with the informal sector backed by its dwindling nature and thus gain the economy's ability to contribute to the social health insurance fund.

About 9.94 million people work in the formal sector.⁵ Quite a negligible number (about 0.5 million) of formal sector employees are currently under some group health insurance (GHI) coverage by 4 general insurance companies and 15 life insurance companies. There is an enormous potentiality of flourishing GHI in the formal sector, including government, autonomous institutions, for-profit, and not-for-profit private organizations. There is also an opportunity to bring 4.2 million readymade garment workers under GHI coverage. Potentiality also exists for 150 million cell phone users.⁶ The scope also prevails for about 1 million students studying at different public and private universities.⁷ It is necessary to overcome the existing challenges the whole insurance sector faces, including negative attitude toward insurance, lack of insurance education, and absence of innovative insurance products to transform these scopes and opportunities into actions.^{8,9} Negative attitude is the most profound one. Evidence from India and Ghana shows that insurance literacy and perception about insurance schemes play a crucial role in a household's decision to voluntarily enroll and remain enrolled in health insurance schemes.^{10,11} As a demand-side factor, improving attitude toward health insurance requires a longer duration.

Given this backdrop, at the beginning of 2018, the Institute of Health Economics (IHE), University of Dhaka, took a pioneering step

in bringing its students under a GHI scheme, which is the first of its kind at any university in Bangladesh. This initiative emphasizes creating an opportunity for the students to realize that a health insurance mechanism is worthy and useful. This initiative is laudable for its novelty. The positive aspects are many; for one thing, the incidence of NCDs is expected to be much lower here than in the general population because of the age group. Therefore, it should be a low-cost event from the insurer's perspective.

There is evidence that young adults have better health status, especially in terms of NCDs, compared to the general adult population. The incidence of acute illnesses and prevalence of chronic diseases is significantly lower among the younger population (age 20-29 years) compared to 30 years and above. The prevalence of co-morbidity is significantly lower among the population of 25-29 years (36.5 per 1000 population) compared to the population of 30-34 years (54.5 per 1000 population) and above (more than 66 per 1000 population).¹² Therefore, health insurance for such an age group is expected to be more successful than those targeting a more diverse group of individuals.

Moreover, health insurance for the students is likely to ensure access to health care and provide financial risk protection against health care expenditure. Therefore, this insurance scheme is expected to bear an immense potential for the students in reducing their fear that unforeseen health incidents may jeopardize them physically and financially and thus could pose a challenge toward the completion of their academic degrees. This is especially true for those who come from households of modest means and those who relocate to the metropolis from regional towns and villages.

Further, students can be seen and expected to serve as goodwill ambassadors for creating a positive attitude toward health insurance (assuming favorable experience with health care coverage while at university) among the public on the broader society. Hence, its successful scaling up and replication may be a route to stepping toward introducing social health insurance in the country. The existing studies conducted mainly in the US context are limited to explore insurance literacy among the students. Low level of knowledge regarding health insurance and its association with utilization of health care are common findings in the literature.¹³⁻¹⁵ However, there is a paucity of evidence, especially in developing countries, regarding the effectiveness of health insurance interventions on developing a positive attitude toward insurance among university students and their financial risk protection. Hence, the motivating factor of this research is to generate evidence on whether the health insurance scheme for university students plays an effective role in developing a positive attitude toward health insurance as well as financial risk protection.

This study, using mix-methods along with management information system (MIS) data, attempts to examine the progress of the initiative in achieving its objectives: developing a positive attitude about insurance through materializing insurance benefits, protecting the financial risk of the students against health care expenditure, and countrywide scalability of the initiative. This article is important in both academic and policy contexts as it evaluates a novel experiment

of health insurance for university students. The findings are also crucial to improve the design of the scheme for scaling up and replication.

The remaining part of the article is organized as follows. Section 2 provides a brief description of the insurance scheme. Section 3 describes the methodology. Section 4 illustrates the findings. Section 5 offers discussions and conclusions.

2 | DESCRIPTION OF THE INSURANCE SCHEME

Under this unique initiative, IHE is the policyholder, and Pragati Life Insurance Limited (PLIL), the leading life insurance company in Bangladesh, is the insurer. This insurance scheme is compulsory in nature and yearly renewable where insurance coverage is active on the first day of enrollment. The eligible age group for the insurance is between 17 and 27 years at the time of enrollment, with having valid proof of student status. Altogether, 310 regular students of IHE are covered for health insurance (both inpatient and outpatient) and life insurance under this scheme. The annual premium per student is BDT 400 (USD 4.90), half of which is contributed by the student and the remaining half by the institute. The benefit package includes both inpatient department (IPD) care and outpatient department (OPD) care. All types of ailments apart from mental, emotional, or psychiatric disorders, alcoholism, or any other narcotic addiction are covered under the scheme.

Each student is reimbursed annually up to BDT 30000 (USD 367) for IPD care (maximum 10 days a rate of BDT 3000 [USD 37] per day), which includes room rent, hospital services, surgical expenses, consultation fees, diagnostic bills, and medicine during the hospitalization period. A claimant needs to submit treatment-related necessary articles such as a hospital discharge certificate, physician's prescriptions, diagnosis reports, and hospital bills.

For OPD care, the annual reimbursable coverage is BDT 3000 (USD 37), which covers physician consultancy fees and medical investigations. Note that BDT 200 (USD 2.5) was fixed for a prescription as a doctor's consultation fee, and the diagnostic bill was the actual amount up to the maximum limit. However, the reimbursable amount was revised to BDT 5000 after the first year. Moreover, the students can enjoy a 25% discount on pathological and imaging services in more than 200 impaneled hospitals across the country. In addition, if any student dies for any cases except suicide or human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), his or her family gets BDT 50000 (USD 612.22) from the insurance company.

The benefit ceiling was determined upon consultation with the students, while the premium rate was determined based on the competitive bidding. The claimants submit their claims to the IHE desk officer assigned for facilitating the insurance initiative. A designated official of the insurance company collects the claims from IHE once/twice a week and reimburses the claims as per the policy document through the mobile banking system.

3 | METHODS

The data analyzed in the article were obtained from a baseline survey, a year-end survey, MIS of both policyholder (ie, IHE) and insurer (ie, PLIL), and a daily diary of the activities. The baseline survey was conducted on all the 310 students of IHE in January 2018. All the under-graduate (first year–fourth year) and Master's students of this entity were attempted to interview in the baseline survey. The year-end survey was conducted during February and March 2019, while we also attempted to interview all the students of IHE who participated in the baseline survey apart from those who passed out. It is worth mentioning that, in the university, there was a prolonged student movement for “reforming quota system” in the government recruitment policy while the year-end survey was conducted. Many students boycotted the class for a long time as part of their movement, and hence it was not possible to interview the students who were absent in the class while conducting the year-end survey. Therefore, a total of 151 students were interviewed in the year-end survey. In addition, we conducted in-depth interviews (IDIs) with 12 students, of which 7 were insurance benefit claimants.

In addition to a claim form, a prescribed form was required to fill up by the students while submitting an insurance claim at IHE. Thus, data like type of claim (OPD or IPD), amount of claim, amount of medical expenditure by different heads (eg, consultation fees, diagnostic charges, medicine costs, operation costs, bed/cabin charges), and the background information of the claimants were stored at IHE. We also provided a prescribed format to the insurance company to maintain the MIS data. The insurance company provided information like the type of claim and amount of reimbursement. Moreover, we noted down the daily activities and experiences in a diary regularly.

We administered a semi-structured questionnaire in both the baseline as well as the year-end survey. After incorporating the feedbacks of the pretesting, we finalized the questionnaire. The baseline survey elicited socio-demographic attributes, disease profile, health care-seeking behavior, and attitude about health insurance. The year-end survey also elicited information like increasing access to health care, financial risk protection, reduction of anxiety, attitude toward continuing the scheme by IHE, introducing such scheme in other departments and institutes of the university, and willingness to join such scheme after entering the career.

The study received ethical clearance from the institutional review board (IRB) of IHE. Informed consent was sought prior to taking part in the interview. We used bivariate tools for data analysis.

4 | RESULTS

In the baseline survey, a total of 310 (male = 185 and female = 125) students were successfully interviewed. About 45.7% of the students were residing in residential halls of the university. A similar portion (45.8%) were residing with their family. The remaining students were residing in student messes or with their relatives. In the year-end survey, 151 students were interviewed, of which 58% were male, and

42% were female. About 49% of the students were residing in residential halls and 42% with their family. The age of the students in both baseline and year-end surveys ranged from 19 to 25 years. The average monthly household income of the students was about BDT 52000 (USD 636.71) in the baseline survey, while it was about BDT 63500 (USD 777) in the year-end survey. About 24% and 28% of the students had their earnings, mainly from private tuition, resulting from baseline and year-end survey, respectively. Their average monthly earnings were found as BDT 5466 (USD 67) and 7988 (USD 98) in the baseline survey and year-end survey, respectively (Table not shown).

The MIS data of the insurance company show that over 1 year, there were 91 claims by 62 students, of which 87 were OPD and 4 were IPD. More than a quarter of the students (28.61%) submitted OPD claims, while 1.3% submitted IPD claims (Table not shown). The claim rate was significantly (P -value $<.01$) higher (37.5%) among the male students compared to the female students (18.33%).

4.1 | Attitude toward insurance

We asked the students in the baseline survey to rate their attitude toward insurance in a five-point scale (5 = very useful, 4 = useful, 3 = fair, 2 = not useful and 1 = harmful). However, in the year-end survey, we added an additional option named as “no idea about health insurance.” As seen in Table 1, the mean score of the year-end survey (4.04) is significantly higher (P -value $<.01$) compared to the baseline score (3.21). Due to a small number of observations, we classified the responses into three categories (useful, fair, and not useful) by merging “very useful” with “useful” and “harmful” with “not useful.” The results show that insurance was reported as “useful” by a significantly (P -value $<.01$) higher percentage of the students in the year-end survey (80.13%) than the baseline one (45.40%). On the contrary, the percentage of students reporting “fair” was significantly lower (P -value $<.05$) in the year-end survey compared to the baseline survey. Interestingly, no student was found responding to “not useful” option in the year-end survey although it was responded by 17% of the students in the baseline survey.

TABLE 1 Attitude of the university students toward insurance

Attitude toward insurance	Baseline survey ($N_1 = 310$) % (n)	Year-end survey ($N_2 = 151$) % (n)
Useful	45.40 (141)	80.13 (121)
Fair	37.42 (116)	15.23 (23)
Not useful	17.17 (53)	0.00 (0)
No idea about health insurance	-	4.64 (7)
Mean score (in a 5-point scale)	3.21 (SD = 1.12)	4.04 (SD = 0.72)
The difference in mean score between the baseline survey and the year-end survey	0.83 (t -statistic = 9.24, P -value = $<.0001$)	

For further digging down, we asked the students in the year-end survey about their attitude toward GHI to make a comparison between the claimants and the nonclaimants of benefits. It is seen that the percentage of students who rated GHI as “useful” was significantly (P -value $<.01$) higher among the claimants than the nonclaimants of insurance benefit (Table 2). This implies that materialization of the health insurance benefit, as hypothesized, leads to grow more positive attitude toward health insurance among the insured.

Similar findings were also derived from qualitative analyses. We asked the respondents to opine their attitude about the scheme. All the respondents of IDIs acknowledged insurance as a useful tool, although half of them had a negative attitude about health insurance before enrolling in the scheme. One of the respondents mentioned,

“Although I have not claimed any benefit yet, I think that health insurance is a novel idea. Because today I am protecting my friends; tomorrow my friends will protect me from the burden of health care expenditure.”

Another student mentioned,

“I have a severe cold allergy. Due to having health insurance coverage, I am not facing financial hardship for seeking health care. However, I am worried about the expiration of this health insurance coverage in the next year after completing my Master's degree. Hence, health insurance should be made compulsory for all the people in the country.”

4.2 | Accessibility and financial risk protection

We asked the students who claimed insurance benefits in the year-end survey regarding the ease of access to health services and financial risk protection due to enrolment in the GHI scheme. It is seen that 41.67% of the claimants reported that GHI's enrollment made access to health services absolutely easier. The remaining 58.33% also reported that GHI made access to health services moderately easier (Table 3).

TABLE 2 Attitude toward group health insurance of the claimants and the nonclaimants

Indicators	The nonclaimants % (n)	The claimants % (n)
Useful	77.95 (99)	91.67 (22)
Fair	16.54 (21)	8.33 (2)
Not useful	0.00 (0)	0.00 (0)
No idea about health insurance	5.51 (7)	0.00 (0)
Total	100.00 (127)	100.00 (24)

Mitigating the spending for health services has been made absolutely easier for 29.17% of the claimants and moderately easier for the remaining 70.83% (Table 3). We also asked the claimants whether enrolment in GHI reduced the anxiety of mitigating the spending for health care. About 29% of the claimants reported that enrolment in GHI absolutely reduced their anxiety of mitigating the spending for health care, while the remaining 71% reported a moderate reduction of their anxiety for mitigating the health care spending (Table not shown).

Tables 4 and 5 were constituted based on the MIS data of the insurance company and data stored at the IHE office. The results show that the GHI scheme provided 57.57% financial risk protection of consultation and diagnostic services, which stood 33.61% if medicine and day-case were included in the outpatient benefit package. In other words, the copayment for consultation and diagnostic services covered under the scheme constituted 42.43% of OPD expenses, while it became 66.39% after including the expenses for medicines and day cases. On the contrary, there was a negligible co-payment (3.84%) for inpatient benefit package (Table 4).

However, level of financial risk protection of the outpatient benefit package varied among the claimants. About 57% of the claims had more than 70% financial risk protection of the existing benefit package, which declined to 27% while adding medicine in the benefit package (Table 5). This calls for revising the OPD benefit package while scaling up and replicating in the future since the copayment should not exceed 25% of total health expenses.¹⁶ The benefit ceiling needs to be almost doubled for giving 75% financial risk protection to the insured. Although the scheme provides very high financial risk protection (96.16%) for IPD services, there is also importance of increasing

the benefit ceiling while scaling up for all the students at the University of Dhaka. This is because there may arise more severe and expensive IPD cases, especially for critical illness, while a large number of students will be included in the scheme.

Qualitative analyses also show similar results. The respondents were asked about the beneficial aspect of the scheme. Health insurance was reported as a very useful mechanism for financial risk protection by all the respondents of the IDIs. One of the respondents had the following comment,

"I became sick a few months ago, but I was hesitant to seek treatment due to not having enough money. Suddenly, one of my classmates reminded me about the health insurance benefit. Then, I decided to seek treatment using the money which I kept for paying accommodation fees. After my recovery, I received reimbursement of the claimed amount and paid my accommodation fees."

Another student quoted,

"My best friend was mentally upset due to suffering from dengue fever. He had to incur high medical costs. However, reimbursement from health insurance helped him to overcome his mental stress. I have a realization, from this incident that health insurance saves us from sudden financial loss, which relieves us from anxieties."

TABLE 3 Impact of group health insurance on making easy access to health services and mitigating health care expenditure of the claimants who participated in the year-end survey

Indicators	Access to health services % (n)	Mitigating spending for health services % (n)
Absolutely easy	41.67 (10)	29.17 (7)
Moderately easy	58.33 (14)	70.83 (17)
Not easy	0.00 (0)	0.00 (0)
Total	100.00 (24)	100.00 (24)

4.3 | Scope of scalability and sustainability

The students were asked to know their views on whether the GHI scheme should be continued. All the students who took part in the survey strongly urged for continuing the GHI scheme. They also reported that the scheme should be placed in other institutes and departments of the university. An overwhelming majority also intended to avail GHI benefit after entering into the career (Table 6).

It is found from the daily diary that a good number of students came to the insurance corner of IHE to explore the opportunity for

TABLE 4 Level of financial risk protection of outpatient and inpatient benefit packages of all the claimants of the scheme

Type of coverage	Type of benefit	Spending for treatment (in BDT)	Amount of reimbursement (in BDT)	Reimbursement as percentage of health spending	OOP payments as % of total expenses
Outpatient	Consultation fee	34 920	17 000	48.68	51.32
	Diagnostic tests	102 690	62 225	60.59	39.41
	Sub-total	137 610	79 225	57.57	42.43
	Medicine and day case	98 106	0	0	100.00
	Total	235 716	79 225	33.61	66.39
Inpatient	All types of IPD charges ^a	21 838	21 000	96.16	3.84

^aIPD charges include room rent, hospital services, surgical expenses, consultation fees, diagnostic bills, medicine expenses, etc.

including their family members under such a health insurance scheme. The staff of IHE are also interested in being enrolled in such a health insurance scheme, although they had a strong negative attitude initially.

The MIS data of the insurance company show that it reimbursed BDT 100225 (USD 1227) against the premium of BDT 121,600 (USD 1488). In other words, the total reimbursement was 82.42% of the revenue from the premium. More precisely, the insurer had a 17.58% surplus in the premium revenue for its loading costs (administrative expenses and profit margin), which is significantly lower compared to the existing scenario (53%) in Bangladesh.¹⁷ The loading costs range from 6.3% to 32% in most of middle- and low-income countries.¹⁷ Hence, the loading costs seem to be very high in Bangladesh. This implies that the sustainability of the scheme is constrained by scaling up through the enrollment of more students.

The respondents of the IDI were asked to get their views on whether the scheme should be scaled up to all the universities in Bangladesh. A good number of respondents commented on health insurance as a crucial financing alternative for health care, and hence, they suggested for its countrywide scale-up. They added, the university administration should take initiatives to bring all the students under the health insurance mechanism. They also expressed their vows for calling a human chain/rally in the campus, if needed, to push the university administration. A number of them were willing to include their family members and relatives in such a health insurance

mechanism. They were also interested in including themselves in health insurance mechanisms in their working life.

One respondent quoted,

"I like the idea of health insurance so much. I would recommend introducing health insurance in my future workplace wherever I work. When I would become the head of my organization, I will introduce health insurance for all the staff in my office."

Another respondent mentioned,

"I live in the university dormitory. My whole family lives in a village. A few days ago, my younger sister was infected with typhoid. It was difficult for my schoolteacher father to bear the medical expenses. It would have been better if my sister also had insurance coverage like me. Thus, my opinion is that health insurance should be introduced at all levels in our country."

After the insurance initiative rolling out, IHE adopted various measures, including sensitization through banner, festoon, leaflet, organizing seminar, questions and answers sessions, classroom briefing, and setting a health insurance corner for responding to day-to-day questions raised by the students.

IHE took various initiatives, including sending letters to other entities of the University of Dhaka to introduce a similar scheme for their students. As a result, some departments of the University of Dhaka, such as Economics, History, Development Studies, Sanskrit, Anthropology, and Criminology, have already brought their students under the scheme. The central administration (Deans' Committee) of the university took a groundbreaking decision on June 2, 2020, to introduce health insurance for about 37018 students.¹⁸ A technical committee was formed later on to design the benefits package and formulate the modus operandi. The initiative is now under the process of selecting an insurance company through competitive bidding.

The institute also issued a letter to all public universities with a copy to the University Grant Commission and other organizations, including Access to Information (a2i), Planning Commission, Ministry of Health and Family Welfare, and Economic Relations Division, describing the health insurance scheme and its benefits in brief. It is, thus, expected that other universities may adopt similar decision like the University of Dhaka for introducing health insurance for their students in the near future.

TABLE 5 Variations in the level of financial risk protection of outpatient benefit package among all the claimants of the scheme

Level of financial risk protection (in %)	% of claims	
	Existing outpatient benefit package (n = 91)	Outpatient benefit with medicine (n = 91)
≤10	15.38	17.58
11-20	7.69	13.19
21-30	1.1	5.49
31-40	2.2	9.89
41-50	5.49	10.99
51-60	5.49	9.89
61-70	5.49	5.49
71-80	5.49	6.59
81-90	5.49	2.20
91-100	46.15	18.68

Indicators	Continuation of GHI % (n)	Introduction of GHI for the students of other entities of the university % (n)	Willing to avail GHI benefit after entering into the career % (n)
Yes	100.00 (151)	100.00 (151)	98.1 (148)
No	0.00 (0)	0.00 (0)	1.99 (3)
Total	100.00 (151)	100.00 (151)	100.00 (151)

TABLE 6 Views regarding the continuation of group health insurance (GHI), placing it for the students of other entities of the university, and intention to avail GHI benefit after entering into the career

5 | DISCUSSIONS AND CONCLUSIONS

Bangladesh, currently in a transitional stage for graduating to a developing country, is expecting to become a developed country by 2041. Insurance coverage is a key parameter, among others, for a country to be considered as a developed one. Evidence shows that insurance development enhances economic growth.^{19,20} There is an ample contribution of the insurance sector to GDP in most of the developed countries. The contribution of insurance to GDP in 2016 was 9.21% in the United Kingdom, 11.28% in the United States, 7.37% in Sweden, 11.02% in France, 7.97% in Italy, 17.6% in Hong Kong, 12.48% in Korea, 7.7% in Japan, and 4.97% in Australia.²¹ The contribution of insurance to GDP is also quite promising in some south Asian countries, such as Maldives and India, which respectively were 4.7% and 3.07% in 2016. The contribution of the insurance sector to GDP in Bangladesh is only 0.9%, of which 0.7% by life insurance and the rest 0.2% by nonlife insurance or general insurance.

GHI has not been flourished, despite its enormous scope, due to various factors, including massive negative attitudes toward insurance. Traditional insurance promotion is not effective in addressing such a deep-rooted demand-side problem. IHE, thus, came forward to introduce a GHI scheme for the university students aiming at their financial risk protection from treatment expenses and making the students as insurance advocate via developing a positive attitude toward insurance through providing practical experience of the benefits of health insurance. Introducing health insurance for university students, thus, is one step forward in promoting insurance education as well as developing insurance in Bangladesh.

The university students, the most advanced part of the youth population and immediate future of the nation, are highly diversified in terms of the economic, religious, and regional contexts of Bangladesh. The majority of the students, especially in public universities, come from middle and lower-middle-class families. Thus, it is imperative to address financial risk protection with health insurance as an acceptable method across society by reducing the knowledge gap and transforming the positive outlook.

For mobilizing health insurance, it is necessary to disseminate practical knowledge of insurance among the people who are in the mainstream, especially university students who have more influence in their respective communities than any other groups. It is obvious that if the students can realize the benefits of health insurance, they may serve as the insurance promoters and play an important role in scaling up the health insurance mechanism in a higher dimension in their professional life.

There is a clear indication from both quantitative and qualitative findings that the GHI scheme initiated by IHE has been able to increase positive attitudes toward insurance mechanisms among university students. There is also a clear sign of making access to health services easier and mitigating the burden of spending for health care. This is helpful for reducing the anxiety regarding the financing of health care. The scheme is especially useful to provide financial risk protection for IPD care. Similar evidence is found in the literature, especially on social health insurance.^{10,22,23} There is also a strong sign of scaling up of the scheme, which may also lead to making it sustainable.

Hence, introducing health insurance for university students seems to be an important step toward enhancing financial risk protection and reducing the negative attitude toward insurance. Inspirations by the government to all the universities for introducing such health insurance for their students may guide the nation to move toward large-scale group health insurance and eventually social health insurance in the near future.

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All authors have read and approved the final version of the manuscript.

The corresponding author had full access to all the data and took complete responsibility for the integrity of the data and the accuracy of the data analysis.

TRANSPARENCY STATEMENT

The corresponding author of the article affirms that this manuscript is honest, accurate, and transparent, that there is no omission of any important aspects of the study, and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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