Policy Brief

Development of a Framework for Establishing Maternity Insurance in Bangladesh

Key Highlights

The Healthcare Financing Strategy 2012–2032 focuses on improving health financing levels, equity, resource efficiency, and achieving universal health coverage.

The target group for social insurance coverage can be classified into four categories: (a) workers in the formal sector; (b) workers in the informal sector; (c) population below the poverty line, and (d)population not in labour force and unpaid family workers.

The framework proposes premiums of BDT 60–1,015 for coverage up to BDT 41,000, with full government support for the poor. Annual funding of BDT 7,305–9,886 crore would come from the government (63%), employees (23%), and employers (11%), aided by 'sin tax' revenue.

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1. INTRODUCTION

Globally, the primary aim of maternity insurance, as a demand-side financing tool, is to ensure safe pregnancy and childbirth among mothers. In Bangladesh, high cost of maternity care results in few births in medical institutions, thus jeopardising the well-being of mothers and new-borns. Considering this, the government of Bangladesh has committed to introducing maternity insurance as one of the components of its National Social Insurance Scheme (NSIS), under the overall social insurance framework of the National Social Security Strategy (NSSS) by 2026. This maternity insurance component, a major reform under the Health Services Division (MOHFW), aims to provide financial protection and medical support during pregnancy and childbirth. In this backdrop, this policy brief is based on the study *'Development of a Framework for Establishing Maternity Insurance in Bangladesh'*, which aimed to formulate a framework for a maternity insurance scheme with five objectives: (a) review the extent to which maternity insurance can be implemented; (b) which methods of intervention are possible; (c) who will benefit; (d) what will be the outcomes; (e) what types of organisational, operational, and regulatory issues should be considered at the micro-level.

2. MATERNITY SCHEMES: BANGLADESH AND CROSS-COUNTRY EXPERIENCE

2.1 Healthcare Structure in Bangladesh

Legal Framework: The Ministry of Health and Family Welfare (MoHFW) is the central authority implementing healthcare policies and programmes. Key policies aimed at equitable healthcare include the National Health Policy (2000 & 2011) and the National Population Policy (2012). The Healthcare Financing Strategy 2012–2032 focuses on improving health financing levels, equity, resource efficiency, and achieving universal health coverage. Additionally, the Medical Practice, Private Clinics and Laboratories Ordinance of 1982 regulates the private sector. NGOs are regulated through government ordinances and

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the Department of Social Services and Economic Relations Division. Finally, maternity insurance is addressed by the Maternity Benefit Act of 1939 and Section 46 of the Bangladesh Labour Act.

Institutions & Governance: While the government, private sector, and non-government organisations (NGOs) are involved in policymaking, delivering services, financing, and employing healthcare personnel, donors primarily contribute to financing and planning health initiatives.

Financial Flow: Out-of-pocket payments, government revenues from tax and non-tax sources, and funding from development partners to NGOs are the key funding sources of healthcare services.

2.2 Maternity Schemes in Bangladesh

A notable pilot programme run by the MoHFW is the Shasthyo Shuroksha Karmasuchi (SSK) which provides free medical treatment, including maternity care to nearly 4 million people below the poverty line in Tangail. The government pays necessary medical costs for treating 110 diseases categorised by codes and spending limits and covers an insurance premium worth BDT 1000 per family. Each family is allocated a budget of BDT 50,000 for availing healthcare services. The Health Economics Unit hires firms to identify eligible beneficiaries through surveys and interviews and currently, there is no limit on enrolment. Under this scheme, C-sections are pre-planned and not performed on an emergency basis. Codes 61 to 79 represent maternity and gynaecology concerns, and the scheme also houses an Antenatal Care ward. Doctors do not initially consider treatment costs; they provide services first, and adjustments are made at the SSK booth. This scheme does not cover outdoor services, and medication which is typically prescribed for 15 days post-discharge, with occasional extensions to 1-2 months.

Other relevant schemes and provisions are as follows:

Paid Maternity Leave: The Bangladesh Labour Act (2006, amended 2018) mandates four months of paid leave, with benefits based on worker's average daily wage over the last three months before pregnancy notice submission in the industrial sector. As per Bangladesh Bank's directive, government employees receive six months of paid maternity leave.

Voucher Scheme: Offers free maternal services to disadvantaged pregnant women with vouchers. Financial coverage includes BDT 2,000 for general maternal health improvement.

Central Fund: Maternity grant worth BDT 25,000 paid to workers in export-oriented RMG sector, with additional funding of BDT 5,000 – BDT 100,000 for post-delivery complications.

Bangladesh Labour Welfare Foundation Fund (BLWF): Maternity grant worth BDT 25,000 with additional funds for complications paid to formal and informal workers.

Private Insurance: Availed by higher-income urban populations for comprehensive health coverage.

Ensuring equity in healthcare is a common objective that has been observed in the healthcare practices of seven countries including dual public-private healthcare systems (Table 1).

Governance & Monitoring: Government bodies oversee healthcare systems in the studied countries including Thailand's National Health Security Office (NHSO) which monitors the universal coverage scheme, and the Philippines' PhilHealth which monitors health insurance. In China, India, and Vietnam, healthcare delivery is structured hierarchically, with a network of healthcare facilities ranging from national referral hospitals to local health centres.

Funding Mechanisms, Contribution and Premiums: Public funds, employer-employee contributions, revenue from sin taxes, and donations from philanthropic organisations and international donors finance insurance schemes in China, India, Vietnam, Japan and Germany.

Eligibility: Across all countries, eligibility is determined based on compulsory enrolment of citizens according to various categories including duration of residence in Japan and Chile, wage levels in Germany, and social backgrounds in India.

Beneficiaries and Coverage Package: Beneficiaries of healthcare systems in China, India and Vietnam include formal sector workers, indigent populations, retirees, senior citizens, and individuals from low-income households. Coverage packages typically include preventive, curative, and rehabilitative care, along with additional benefits for high-cost medical treatments, emergency care, and essential drugs.

Table 1: Cross-Country Healthcare Practices

Country	Insurance Type	Coverage, Eligibility & Benefit Package	Funding	Governance
China	Social Insurance System	Basic medical insurance coverage with compulsory enrolment for urban employees and residents. Comprehensive medical benefit package	Employer-employee contributions	Administrative ordinances ; Ministry of Health
Chile	Mixed Public-Private Healthcare System	Population enrolled in FONASA, or private insurance through ISAPRE. Compulsory enrolment for citizens and long-term residents	Public funds, employer contributions, and private premiums.	Ministry of Health and the Superintendent of Health. Dual public-private regulation
Japan	Employment-based, NHI, Elderly Health Ins	Compulsory enrolment for residents living for at least three months. Comprehensive benefit package	Funding from premiums, public subsidies, & fiscal adjustments	Government bodies
Germany	Statutory Health Insurance (SHI)	Compulsory enrolment for employees with earnings below a certain threshold. Comprehensive benefit package	Employer-employee contributions; government subsidies	Federal Ministry of Health; Healthcare agencies & associations
India	Ayushman Bharat	Compulsory enrolment for eligible families based on deprivation & occupational criteria. Comprehensive coverage	Government funding with contributions from central & state governments	Ministry of Health and Family Welfare, state-level agencies
Vietnam	Universal Health Coverage (UHC)	Compulsory enrolment & expansion to marginalised groups. Comprehensive healthcare services	Government subsidies, employer contributions, and premiums	Ministry of Health
Thailand	Universal Healthcare Coverage (UHC)	Compulsory enrolment. Comprehensive healthcare services	Tax-financed scheme with additional funding from sin taxes	Government

Source: Authors' accumulation from World Bank (2020); World Health Organisation (WHO) (2021); OECD (2020); National Health Authority (India, 2021); Ministry of Health Vietnam (2019); and country-specific policy documents.

3. CURRENT STATE OF MATERNITY HEALTHCARE: SVRS & DGHS DATA

Background of Mothers: Higher education levels were observed among urban mothers. In terms of age, poor educational attainment was observed among elderly mothers. Thus, relatively young mothers with better educational attainment will likely respond better to a formal maternity healthcare system. Therefore, the framework needs to take into account the maternity services and their reach towards poor and illiterate mothers to ensure their smooth maternity journey. Additionally, given that the majority of mothers are not formally employed (Table 2), the scheme needs to be customised according to the occupation of women.

Place of Delivery: A significant distinction was observed between rural and urban mothers in terms of place of delivery (Table 3) - urban mothers predominantly delivered at formal institutions compared to rural mothers, therefore implying that the target group for the system should be mothers who use formal medical services for delivery. Furthermore, Dhaka and Khulna can

Table 2: Professional engagement of the child's mother (by area)

Mother's Occupation	Rural	Urban	Total
Homemaker	83.3	81.1	82.5
Domestic helping hand	11.2	8.0	10.0
Student	2.3	4.2	3.0
Factory/production worker	0.7	1.1	0.8
Other office employee	0.2	1.1	0.5
Teacher	0.6	1.4	0.9
Engaged to service	0.2	0.7	0.4
Servant/Maid	0.1	0.4	0.2
Looking for work	0.0	0.2	0.1
Unable to work	0.0	0.1	0.1
Others	1.3	1.9	1.5
Total	**100**	**100**	**100**

Source: Author's analysis based on BBS (2021).

be prioritised for piloting the system as giving birth at the household is the lowest among mothers in these divisions. A possible target population for maternity insurance would be mothers aged 18-35 years since they prefer giving birth in formal institutions.

Presence of Skilled Professionals during Childbirth: Mothers in urban areas prefer giving birth in the presence of doctors while those in rural areas rely more on less formally trained professionals. This disparity suggests urban areas are more conducive to piloting

Table 3: Place of childbirth by the mother (by area)

Where was the child born?	Rural	Urban	Total
Within sample area at sample household	40.3	25.0	34.6
Within sample area at other household	3.2	2.4	2.9
Outside sample area	9.8	5.0	8.0
Hospital	23.8	31.6	26.8
Clinics	21.7	32.8	25.8
Maternity clinic	1.0	2.8	1.7
Other	0.2	0.5	0.3
Total	**100**	**100**	**100**

Source: Author's analysis based on BBS (2021).

maternity insurance due to the prevalence of standardised, formal maternity services. Additionally, mothers aged between 26-30 years avail the services of doctors more than other age groups.

Birth and Death Registration: Both urban and rural areas display low registration of childbirth and death which may pose a significant challenge for maternity insurance pilot.

Number of Children per Delivery: In majority of cases, mothers delivered one child per delivery, with the incidence of twin children being relatively high among mothers aged 31-40 years. Thus, the frequency of children per delivery and age of mothers needs to be considered for the framework.

Types of Child Delivery System: C-section deliveries are more prevalent in urban regions while normal deliveries are pervasive in rural settings. Additionally, the rate of C-sections is significantly high in Khulna and Dhaka, while normal delivery rates are highest in Sylhet, Chattogram, and Mymensingh. These trends need to be assessed for drafting the maternity insurance system (Table 4).

Children Delivery by Mother: On average, mothers give birth to 1-2 children in their lifetime, with higher child mortality rates found in rural areas than in urban areas, perhaps due to medical facilities.

Living/Death Status of Children after Birth: Maternal age significantly impacts neonatal survival, with mothers aged 21-25 having the highest probability of live births

Table 4: Types of delivery by area in 2022

(in per cent)

Division	Normal	C-section	Total
Localities			
Rural	61.5	38.5	100
City corporation	41.8	58.2	100
Municipal and other urban areas	49.0	51.0	100
Divisions			
Barishal	65.4	34.6	100
Chattogram	67.9	32.1	100
Dhaka	48.7	51.3	100
Khulna	42.2	57.9	100
Mymensingh	67.7	32.3	100
Rajshahi	55.0	45.0	100
Rangpur	60.3	39.7	100
Sylhet	73.8	26.2	100

Source: Author's analysis based on BBS (2022).

and those under 20 or over 36 facing higher risks. While overall neonatal mortality is relatively low, urban areas exhibit a higher rate of early infant deaths and a greater variability in mortality across maternal age groups compared to rural areas, which consistently show lower mortality rates.

Live Birth/Stillbirth Status: The presence of skilled professionals during delivery reduces the rate of stillbirths, with the incidence being higher in urban areas, especially among mothers aged over 40.

Death Place during Delivery: While the majority of maternal deaths during childbirth occur at home, especially in rural areas, the mortality rate at hospitals in urban areas is twice as high as in rural counterparts. The causes of maternal mortality in rural and urban areas include complex delivery, complicated pregnancy, and excessive post-delivery bleeding.

ANC, Delivery, MMR & PNC: The analysis, based on DGHS data in 2019 (pre-COVID) and in 2023, reveals a concerning decline in maternal delivery rates and a substantial drop in mothers completing all four antenatal care visits (Table 5), alongside a high rate of stillbirths and neonatal mortality within the first minute of birth. Thus, there is an urgent need for targeted policy interventions and maternity insurance frameworks that address these trends, ensure quality healthcare, and provide flexible support options for expectant mothers.

3.1 Issues to be Considered for Maternity Insurance

Factors that must be addressed in maternity insurance include academic qualification of mothers, employment status i.e. formal and informal sectors, local and

Table 5: Maternal health statistics on Antenatal care, delivery, MMR and post-natal care

Maternal health	2019	2023
ANC1	1695891	1511206
ANC2	949472	912776
ANC3	679273	666156
ANC4	647660	627912
Delivery	977145	920696
Normal vaginal delivery (NVD)	496761	512779
Caesarean	468636	399746
Maternal Death	1105	872
Maternal Death Reviewed	2162	807
PNC1	888635	788537
PNC2	585918	526640

Source: Author's compilation from DGHS. (n.d.).

regional variations in opting for formal services, number of children per delivery, coverage of critical pregnancy outcomes, access to skilled professionals during delivery of the children, and supportive infrastructure.

It has been found that younger mothers (21-35 years) in urban areas with better access to skilled professionals and formal services are a key target group. Importantly, poor birth and death registration systems need improvement, and regional variations in healthcare infrastructure must be addressed to ensure equitable and successful implementation, particularly focusing on improving rural healthcare and registration.

4. PROPOSED OPERATIONAL FRAMEWORK FOR MATERNITY INSURANCE

The proposed framework aims to incorporate the strategic approaches suggested by the government: (a) ensuring universal health coverage; (b) reducing Out-of-Pocket Expenses; (c) integrating fragmented government initiatives into a unified scheme and minimising targeting error; (d) exploring more options for financing and co-contributions for better financial viability and sustainability; (e) promoting community-based risk pools via women's cooperatives or NGOs to enhance participation and sustainability of insurance plans for the informal sector.

4.1 Target Population & Beneficiary Category

The target group for insurance coverage can be classified into four categories: (a) workers in the formal sector; (b) workers in the informal sector; (c) population below the poverty line, and (d)population not in labour force and unpaid family workers.

Calculated Number of Beneficiaries: It has been estimated that there are a total of 3.30 million beneficiaries which has been adjusted upwards to approximately 3.70 million per annum considering various pregnancy outcomes. However, this may decrease over time due to the declining fertility rate in the country.

Average OOPE of Maternity Healthcare: Based on the analysis of existing literature on costs, the inflation-adjusted average OOPE were calculated, with the amount ranging between BDT 1,994 to BDT 36,906 across public and private facilities.

Expected Average OOPE of Maternity Healthcare: Expected average OOPE has been calculated to be BDT 34,457.32, assuming that pregnant women have two choices of facility (public/NGO or private) and two equally probable outcomes of pregnancy (normal and C-sections).

4.2 Proposed Framework

Considering the tendency to opt for unnecessary C-sections, three models have been proposed for the insurance framework: (1) 'best-case' model with 15 per cent C-sections; (2) 'middle-case' model with 30 per cent C-sections; (3) 'worst-case' model with 45 per cent C-sections. It has also been assumed that 50 per cent of deliveries will take place in private hospitals where the claims would be reimbursed not more than the average cost of delivery in the NGO facility.

Type, Coverage & Eligibility: The scheme must be a mandatory and cashless universal maternity insurance system with partner hospitals providing services to women aged between 15 to 49 years for all outcomes of pregnancy, given they do not have two living children as

Table 6: Contribution in premiums by sector and group

Models	Per Head Premium (Yearly / BDT)	Formal Sector			Informal Sector			BPL, Dependent or Out of Labour Force		
		Employee	Employer	Govt	Employee	Employer	Govt	Beneficiary	Other Donations	Govt
Model 1	1,500	750	750	0	750	0	750	60	0	1,440
Model 2	1,760	880	880	0	880	0	880	60	0	1,700
Model 3	2,030	1,015	1,015	0	1,015	0	1,015	60	0	1,970

Source: Author's Analysis.

per the National Population Policy. Male employees must also participate in the scheme to avail benefits for their family members. The benefit packages should be activated upon registration to ANC providers and offer coverage for up to 45 days post-delivery. While admission and consultation costs, and hospital charges will be covered, expenses related to non-partner facilities will be excluded from the scheme. The insurer may accommodate excess costs of one component by adjusting it against another, depending on availability

Premium & Contributions: Based on necessary assumptions, the annual premiums for Models 1, 2, and 3 have been calculated to be BDT 1500, BDT 1760, and BDT 2030 respectively (Table 6). Overall, contributions will be accumulated into a pooled fund through which claims will be settled, with the government bearing the administrative costs. Sin taxes on tobacco, SSB taxes, and donor contributions can be potential funding sources to launch this scheme.

Enrolment & Claim Process: The SSK model can be followed for the implementation of the scheme. The proposed process is as follows:

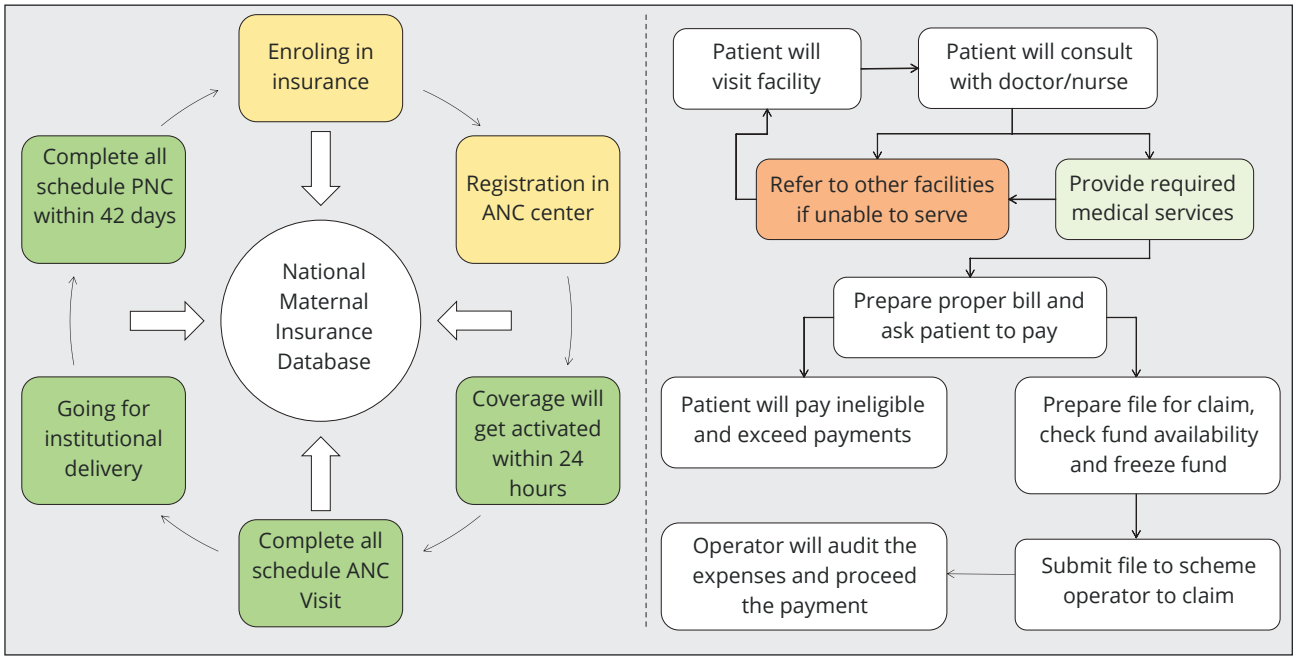
Risk Assessment: Key challenges include collection of premiums from informal sectors, absence of a structured referral system, and creation of incentives for employers. These can be mitigated by different strategies including mandatory implementation, direct and indirect methods of premium collection by employers, implementing strict guidelines for monitoring, and offering tax rebates or subsidies to employers. Other challenges include absence of cap in expenditure components, lack of skilled care providers, absence of administrative and managerial expenditure projections.

Implementation Strategy: The proposed maternal insurance framework can be implemented in phases, starting with a limited number of upazilas. The government can focus on rolling out the framework in government-run institutions and self-administered public entities, while continuing negotiations with private sector representatives. It can collaborate with large Mobile Financial Service (MFS) providers to enhance insurance coverage in the informal sector. In tandem with pilot programmes, supporting systems must be established for monitoring and policymaking.

Institutions & Governance: Multiple stakeholders must be involved in the insurance system including MoHFW for policymaking, HEU and IDRA for monitoring, insurance companies, employers, NGOs, and MFS operators.

Building Awareness: Awareness regarding maternity insurance is essential to dispel myths, increase coverage, sensitise the public about insurance, and promote financial literacy. The primary target audience

Figure 1: A visual illustration of insurance enrolments, coverage, and claim



Source: Author's Analysis.

would be women of childbearing age, their families, and communities. Tools for campaigns include print media, social media, commercials, community outreach initiatives, workshops, and success stories. Collaboration with governmental bodies, insurance providers, and nonprofit groups would be necessary besides effective monitoring and evaluation.

5. RECOMMENDATIONS

Bangladesh lacks a structured maternity insurance scheme, leaving many women financially vulnerable. A well-designed framework is thus crucial for improving healthcare access and reducing financial distress on low-income families. The proposed framework advocates for the creation of an inclusive system with recommendations as follows.

Comprehensive Maternity Services: Provide antenatal care, delivery services, postnatal care, and cover pregnancy-related complications including miscarriage and abortion.

Wide Coverage: Provide services to beneficiaries from diverse backgrounds composed of formal sector employees, informal workers, and disadvantaged women.

Engaging the Informal Sector: It is advised to promote community-based risk pools via women's cooperatives or NGOs to enhance participation and ensure sustainability of insurance plans in the informal sector.

Integration of Initiatives: Fragmented government initiatives must be unified into a national scheme to minimise targeting errors.

Finance: Explore diverse financing and co-contribution options to ensure the financial viability and sustainability of the insurance programme. This may include a combination of employer contributions, government subsidies, individual premiums subject to the level of earning, and donor support. In this way, out-of-pocket expenses must be reduced to protect families from catastrophic healthcare expenses.

Risk Mitigation: Strategies must be adopted to resolve relevant challenges - a tiered reimbursement model must be created to regulate C-sections and control healthcare costs, while transparency must be ensured in premium collection, claim settlements, and administration.

Stakeholder Engagement: Effective collaboration is indispensable between key stakeholders.

- **Ministry of Health & Family Welfare:** Lead policymaking, monitoring, auditing, regulation, and funding.
- **Health Economics Unit:** Develop and monitor insurance frameworks addressing the needs of the Bangladesh market.
- **Insurance Development Authority:** Monitor insurance activities, safeguard the interests of policyholders, resolve claim settlement disputes and reduce insurance-related social stigma.
- **Insurance companies/Scheme Manager:** Provide all insurance-related services and encourage beneficiaries to participate in programme.
- **Employer (formal):** Implement insurance schemes at the workplace and coordinate with the 'Scheme Manager/Handler' for the better execution of the insurance model.
- **NGOs:** Collect premiums and disseminate insurance models among informal sectors. They could also play a significant role in community-driven health workers' training and bridging the gap between government and high-needs populations.
- **Mobile Financial Services or Mobile Network Operators:** Partner in premium collection.
- **Private Settings:** Partner with scheme manager to extend healthcare support for larger population.

Awareness Building: Public awareness and education campaigns must be initiated among possible beneficiaries through potential channels including community events, social media campaigns, workshops, and success stories to dispel myths, enhance knowledge regarding maternity issues and services, boost financial consciousness.