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Masters Dissertation in Public Administration

The healthcare financing for the poor: Prospects of compulsory health insurance for female readymade garment workers in Bangladesh.

Student Name : **Nishat Jahan**

Student ID : **2213982**

Topic Coordinator : **Professor Andrew Parkin**

Supervisor : **Associate Professor Noore Siddiquee**

CONTENTS

ABSTRACT

The Readymade Garment (RMG) industry in Bangladesh is the second biggest across the globe, just behind China, and it is the key driver of the country's economy. Most of the workers in this sector are female, who suffer from health issues and cannot afford treatment with their limited income. This study investigates the possibility of establishing a compulsory health insurance scheme for these workers. In doing so, it employs a qualitative approach and reviews the public health insurance practices of three Asian countries: Thailand, South Korea and Vietnam. This study finds that it is possible for countries with a relatively weak economy and large population to successfully implement health insurance schemes. It shows that successful implementation of health insurance policy in these countries is underpinned by a number of factors including political will, efficient governance structure and strategies; as well as the modest nature of the scheme. The case studies show that Vietnam adopted a gradual approach in covering the population; Thailand introduced means testing, a referral system of gatekeeper and price negotiation working; and in South Korea, there is a two-way relationship among insurer, insured and service providers, together with a review system for claiming long-term care expenses. These three countries have followed different strategies, yet they have achieved considerable success. Bangladesh has opportunities to draw lessons and undertake policy transfer from these international practices. This study concludes that Bangladesh can establish a compulsory health insurance scheme initially for these workers, which could be gradually expanded. The government of Bangladesh should come up with its own scheme that is appropriate to its socio-economic and political contexts. The findings of this study provide significant insights for the government in establishing compulsory health insurance for female RMG workers in Bangladesh as well as in other parts of the world having similar issues.

LIST OF ACRONYMS

BGMEA	Bangladesh Garment Manufacturers and Exporters Association
CHI	Compulsory Health Insurance
CPV	Communist Party of Vietnam
CSMBS	Civil Servant Medical Benefit Scheme
ESHI	Employer-Sponsored Health Insurance
GATT	General Agreement on Tariffs and Trade
GDP	Gross Domestic Product
GNI	Gross National Income
HCFP	Healthcare fund for the poor
HIRA	Health Insurance Review and Assessment
ILO	International Labour Organisation
IOM	Institute of Medicine
MOPH	Ministry of Public Health
MFA	Multifiber Agreement
NHIS	National Health Insurance Service
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket
PHI	Public Health Insurance
RTIs	Reproductive Tract Infections
RMG	Readymade Garment
SDGs	Sustainable Development Goals
STIs	Sexual Transmitted Infections
SHI	Social Health Insurance
THE	Total Health Expenditure
UCS	Universal Coverage Scheme
UHC	Universal Healthcare Coverage
UNICEF	United Nations International Children's Emergency Fund
UTI	Urinary Tract Infection
VHI	Voluntary Health Insurance
WHO	World Health Organisation

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CHAPTER 1

INTRODUCTION AND METHODOLOGY OF THE STUDY

1.1 Background

The Readymade Garment (RMG) industry in Bangladesh is the second largest in the world, just behind China. It is the key driver of Bangladesh's economy (International Labour Organisation 2016a). RMG exported US$ 27.5 billion in the FY18-19, which is about 83.90% of the total export earnings of the country. The total labour force in this sector comprises five million workers of whom 80% are female (Ministry of Finance 2019). In the year 2018, Bangladesh was recommended to be a lower middle-income country by 2024 (The World Bank 2020g). Much of this success comes from RMG sector. As such, the national economy of Bangladesh is very much dependent on these female RMG workers. Moreover, the tag "Made in Bangladesh" is a prestigious brand all over the world, which has brought about great renown for the country (BGMEA 2020a). The female RMG workers, who are behind this renown are being ignored in their every sphere of life.

In addition, there is a little attention paid to these female RMG workers' health and well-being condition by the government (Akhter et al. 2017, p. 572). They endure various health problems, which include reproductive tract infections (RTIs), gastrointestinal and sexually transmitted infections (STIs), blood pressure along with menstrual issue, anaemia as well as family planning related health concerns (Riaduzzaman 2017, p. 23). They also frequently suffer from fever, infections in eyes, jaundices, issues with typhoid, back pain along with skin diseases (Ahamed 2012, pp. 12-3). Besides, they experience urinary tract infection (UTI) (Moran et al. 2020, p. 847), which places a financial burden on them (Rahman et al. 2013, p. 453). As female RMG workers come from the poorer segments of the population, they cannot obtain treatment for their health problems due to their limited income. They also have family responsibilities to fulfil. In addition, as a patriarchal society, females shoulder the brunt of poverty more than males (Riaduzzaman 2017, p. 19).

On the other hand, sick workers cannot put in their full effort, which has negative effects on the economy. Ahmed and Raihan (2014, p. 54) argue that a healthy economy cannot be expected with ill workers. Gupta et al. (2015, p. 90) also claim that the health issues of garment workers reduce their productivity and that this adversely affects the competitiveness of the garment sector in the world market. In addition, dependence on out-of-pocket (OOP) expenditure for

healthcare adds to the burden, which is unbearable for them (Sayem et al. 2016, p. 1). There is hardly any academic literature addressing this issue. The existing literature focuses on the health and wellbeing of workers but pays little attention to the solution to their problems, namely health insurance. Consequently, there is a need for research to investigate the possibility of establishing a compulsory health insurance scheme for female RMG workers. It is expected that a compulsory health insurance scheme would ensure greater provision of healthcare facilities for these workers in Bangladesh, without putting an extra burden on OOP payments. In turn, this will increase their productivity, which would ultimately contribute to the overall economic development of Bangladesh.

Regrettably, in the context of Bangladesh, the establishment of compulsory health insurance is a challenge due to an inadequate budget allocation in the health sector and a vast population. This study seeks an answer to the research question "Is it possible to establish a compulsory health insurance scheme for female readymade garment workers in Bangladesh?". This study argues that even though there is a low budget allocation in comparison to its large population, Bangladesh can introduce a compulsory health insurance scheme initially for female RMG workers, which could be gradually expanded. By investigating the experiences of three countries, namely, Thailand, South Korea and Vietnam, which have already implemented public health insurance schemes, the study provides significant insights into establishing a compulsory health insurance scheme for female RMG workers in Bangladesh.

1.2 Objectives

The general objective of this study is to investigate the possibility of establishing a compulsory health insurance scheme for female RMG workers in Bangladesh. The specific objectives of this study are:

1. To develop essential baseline knowledge on the importance of establishing a compulsory health insurance for female RMG workers in Bangladesh.
2. To examine how countries with a similar and better socio-economic profile have implemented health insurance and investigate their experience in this regard.
3. To explore the possibility of policy learning in the area of health insurance based on the experiences of international practices.

1.3 Methodology

This research project aims to investigate the possibility of establishing a compulsory health insurance scheme for female RMG workers in Bangladesh. To achieve this objective, this study has employed a qualitative approach by reviewing secondary data. Srivastava and Thomson (2009, p. 73) state that qualitative methods are usually utilised for answering 'how' and 'why' type of questions when trying to understand a social phenomenon. The qualitative method is appropriate for this study since it seeks to explore how a health insurance policy would improve female RMG workers' condition as well as to understand why it is necessary for them. In addition, the findings of previous research are essential for gaining a broader understanding in this regard. Toews et al. (2016, p. 1) state that "Qualitative research findings are increasingly used to inform decision-making". Besides, qualitative research is used in social and public policy fields "to understand complex behaviour, needs, systems and cultures" (Ritchie & Spencer 1994, p. 173). Consequently, this method is suitable for examining the possibility for establishing an alternative policy approach, e.g. health insurance for female garments workers in Bangladesh. Yet the qualitative method is not without limitations since it depends on personal perception, belief, views, judgements and mindset, where accurate calculation is not possible (Creswell 2014, pp. 195-6). To address these issues the present study has used multiple sources for cross checking.

In an attempt to find detailed information, this study has undertaken thorough research using relevant electronic databases. These databases include Google Scholar, Findit@Flinders, ProQuest, Emcare (via Ovid), CINAHL, Taylor & Francis, JSTOR, Elsevier as well as Springer Link. The author utilises various sources, such as peer-reviewed journal articles, books, articles from prominent electronic newspapers, conference papers, reports from International Labour Organisation (ILO), World Health Organisation (WHO) and Bangladesh Garment Manufacturers and Exporters Association (BGMEA). In addition, legal documents including relevent laws, acts and constitutions along with relevent policy documents have been gathered from the official websites of relevant ministries of the concerned countries and ILO. Moreover, this study employs descriptive statistics to present data from recent years by means of graphs, pie-charts and tables. This study relies on data available through the WHO, the World Bank, BGMEA and the Ministry of Health and Family Welfare of Bangladesh. The statistics of relevant ministries of Bangladesh including the Ministry of Labour and Employment and the

Ministry of Finance as well as the ILO and the United Nations International Children's Emergency Fund (UNICEF) have also been presented.

Furthermore, case studies have been conducted on the public health insurance (PHI) practices of three Asian countries, namely Thailand, South Korea and Vietnam in order to explore the possibility for undertaking policy learning and policy transfer. This helps us to investigate the practicability of introducing a health insurance policy for female RMG workers in Bangladesh. The case study method is suitable for this study because it allows for deeper understanding through in-depth exploration on a specific subject matter (Thiel 2014, p. 87). Thus, it helps to explore deeply the practices of other countries that have already established health insurance schemes. However, there is an issue with generalisation when using the case study method because every case is unique. What is successful in one country may not be successful in other country because of differences in their respective socio-economic and political contexts (Flyvbjerg 2006, p. 233).

Out of the three countries investigated two (Thailand and Vietnam) are developing countries. Although South Korea is a developed country, when it first introduced a PHI scheme, it was a middle-income economy (The World Bank 2020c, e, f). Furthermore, Thailand has been selected because it attained complete financial protection in healthcare for its citizens in 2002. This country covered 98.5% of its population by 2015 under three PHI schemes. It became successful in utilising the 'Political Economy of Health Financing' framework of the WHO for Universal Healthcare Coverage (UHC) (World Health Organisation 2019). Tangcharoensathien et al. (2019, p. 195) argue that the UHC reform of Thailand provides potential lessons for low as well as middle income countries.

In addition, South Korea has been chosen because in 1977, it initially established compulsory social health insurance (SHI) for industrial workers of big corporations. Then it expanded its coverage incrementally and achieved UHC in 1989. It took only 12 years to achieve UHC, which is the fastest across the globe (Lee et al. 2017, p. 1). It was successful in resource mobilisation for healthcare, quickly expanding coverage for the total population, efficiently collecting public along with private resources for purchasing healthcare for the total population as well as covering healthcare expenses (Kwon 2009, p. 63). Kwon (2009, p. 63) also argues that public health insurance of South Korea could offer significant lessons for low-and middle-income countries that aim to attain UHC.

On the other hand, Vietnam is selected as a case study because it made a long-term roadmap to achieve UHC and wanted to cover 80% of the total population by 2020 (Shillabeer 2016, p. 65). Initially in 1992, it introduced compulsory health insurance (CHI) for poor and formal sector workers. Later, gradually it expanded health insurance coverage to the self-employed as well as to employees in the formal sector. The government of Vietnam enacted the Health Insurance Law in 2008, aiming to attain universal health insurance coverage (Vo & Van 2019, p. 2). As Bangladesh does not have sufficient budget allocation for the health sector, the long-term roadmap of Vietnam could provide potential lessons for Bangladesh to introduce health insurance scheme initially for female RMG workers.

This paper is divided into five chapters. It begins with the introduction and methodology chapter which includes the background of the study, an outline of the projects' objectives together with justifications for the selection of the research methodology. The next chapter is the literature review, which situates my research project within the broader context of the academic literature. Moreover, three case studies have been conducted on the public health insurance practices of Thailand, South Korea and Vietnam, which are shown in the 'Public health insurance: Evidence from international practices' chapter. In the analysis chapter, grounds for Bangladesh to establish a compulsory health insurance scheme for female RMG workers and the potential to undertake policy learning are explored, based on my research findings and other evidence. The final chapter draws some overall conclusions based on the various types of evidence obtained from my research.

CHAPTER 2
LITERATURE REVIEW

In order to offer baseline information, this literature review is divided into three main sections. The first section focuses on the RMG industry and its female workers in Bangladesh. It explores the development of the RMG industry and its contribution to the Bangladesh economy; the current status of the female RMG workers and their health and wellbeing as well as the healthcare financing status of Bangladesh. The second section exclusively reviews health insurance related literature. The policy learning concept is reviewed in the final section of this literature review in order to explore how a policy implemented in one country can be transferred to another. It is very important to review the literature related to these topics because this allows us to identify the grounds for introducing an alternative policy approach, namely a health insurance scheme for female RMG workers in Bangladesh.

2.1 The RMG industry and its female workers in Bangladesh

2.1.1 The RMG industry and Bangladesh economy

In Bangladesh, the RMG industry was established on a small scale in the late 1970s as a modern exporting sector. Then there were only nine export-oriented garment industries and the country earned only US$ 69 thousand in the FY 1978 as the first export earnings through RMG sector (Rahman, Habibullah & Masum 2017, p. 2). There were only 47 RGM industries until the end of 1982 and the number dramatically increased to 587 in 1984-85. By 1999, this number grew exponentially to around 2900 (Chowdhury, Ahmed & Yasmin 2014, p. 105). At present, there are around 4500 RMG factories, of which 40 per cent are knitwear factories and 60% are woven garments manufacturers (BGMEA 2020b).

Both external as well as internal factors played a vital role in producing this phenomenal growth of the RMG sector. The main external factor was the Multifiber Agreement (MFA) which was approved by the General Agreement on Tariffs and Trade (GATT) in 1974. Under the MFA, developed countries like USA and Canada imposed quota restriction on those countries which were exporting garment products at a higher rate than that permitted by bilateral agreements. As a consequence, producers started to look for the countries which were not subject to this quota restriction and which also had cheap labour (Chowdhury, Ahmed & Yasmin 2014, p. 104). As Bangladesh had cheap labour, the MFA acted as a blessing for the country and it

started to receive increased foreign investment. The USA and European Union gave preferential treatment to Bangladesh as a least developed country (BANGLAPEDIA 2020). Although the MFA was abolished in 2004, the RMG products of Bangladesh continued to be competitive globally because of its cheap labour and high production capacity (Younus & Yamagata 2012, p. 1).

The internal factors for the growth of the RMG sector include various kinds of government incentives. These incentives are bonded warehouse, export processing zone, concessionary rate of interest, duty-free import of fabrics, cash export incentive and so on (BANGLAPEDIA 2020). The Industrial Policy 2010 of Bangladesh emphasises the establishment of economic zones and export processing zones along with high tech parks to boost some industries including textiles (Ministry of Industry 2010, p. 5). The Export Policy 2015-18 of Bangladesh also seeks to accelerate the rapid growth of this sector. This policy seeks to enhance women's work force participation in the export-related industries and trade (Ministry of Commerce 2015, p. 1). Alam and Natsuda (2016, p. 316) argue that three factors, namely, the cheap labour market, technological development and the economic transformation policies of the government, greatly facilitated the rapid growth and increased export competitiveness of this sector. Thus, the RMG sector has become the biggest industrial sector of Bangladesh.

Moreover, the contribution of RMG industries to the Bangladesh economy is very significant. It directly employs about five million workers as well as indirectly involves twelve million people with this industry (Rahman, Habibullah & Masum 2017, p. 3). It has allowed about four million women who are unskilled or semi-skilled to enter the workforce. In this way, this sector is playing a central role in women's empowerment by generating job opportunities for them (Islam 2020, p. 2). Besides, in 1973, this country's per capita income (in current price) was only US$120, which reached to US$ 1940 in 2019 (The World Bank 2020a). The GDP of this country had been growing gradually in the last 45 years and the growth rate of GDP was 8.13% in the fiscal year 2018-2019 (Ministry of Finance 2019). The RMG sector has made a remarkable contribution to the GDP of the country, which was 10% in the fiscal year 2018-2019 (Islam 2020, p. 2).

In the fiscal year 2018-19, US$ 34133.27 million was earned from the RMG sector, which was about 84.21% of Bangladesh's total export earnings during that period (BGMEA 2020c). The average contribution of the RMG industry to the Bangladesh national export earnings is

increasing day by day (Hossain 2019, p. 49). **Figure-1** and **Table-1** show the increasing contribution of the RMG industry in the overall export earnings of Bangladesh:

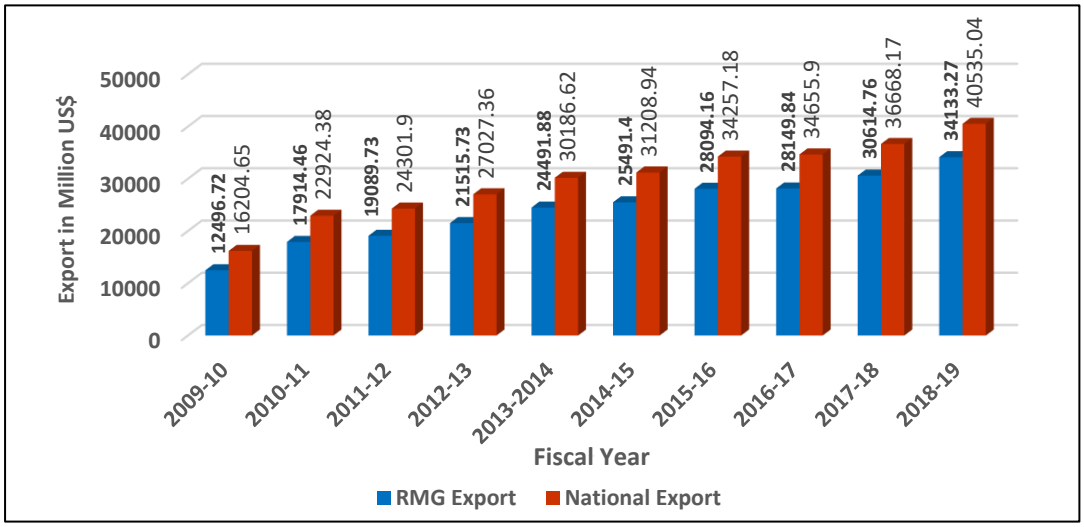

Figure-1: Contribution of RMG industry in the total export earnings of Bangladesh (prepared by the author based on BGMEA 2020c).

FY Year	Total Bangladesh's Export (in million US$)	% of RMG's contribution
2009-10	16204.64	72.12
2010-11	22924.38	78.15
2011-12	24301.90	78.55
2012-13	27027.36	79.61
2013-14	30186.62	81.13
2014-15	31208.94	81.68
2015-16	34257.18	82.01
2016-17	34655.90	81.23
2017-18	36668.17	83.49
2018-19	40535.04	84.21

Table-1: The percentage of RMG's contribution in the total export earnings of Bangladesh (BGMEA 2020c).

In addition, the RMG sector plays a vital role in underpinning the expansion of other allied sectors of the economy, which includes banking, container services of railway, shipping, road transportation, as well as hotel and tourism (Rahman, Habibullah & Masum 2017, p. 3). Now, Bangladesh is on the cusp of graduating from a least developed country to a lower middle-income country and much of this achievement is attributed to the RMG sector (Hossain 2019, p. 48). Thus, the RMG sector has become the backbone of the Bangladesh economy, the major exporter as well as foreign exchange earner, and the biggest labour employer. Therefore, the

workers of the RMG sector require incentives including health insurance because the economy of the country is very much dependent on them.

2.1.2 The female RMG workers and their health condition in Bangladesh

The female RMG workers in Bangladesh come from poor socio-economic backgrounds, and mainly comprise people who migrate from rural to urban areas to avail themselves of the greater employment opportunities. They seek employment in the RMG industries because they have low levels of education and job skills and in order to satisfy the growing demand for dowries during marriage (Riaduzzaman 2017, p. 19). Kibria (1998, p. 2) argues that there are both push factors along with pull factors, which compel women to seek employment in the RMG sector. Push factors include poverty, head of the household's death, unemployment and illness. Pull factors comprise the desire to improve living standard as well as to make savings for dowries at the time of marriage. About 80% of RMG workers are female and among them 50% are adolescent. Their average age is 23.68 years and 92.5% of them are under the age of 30 years. Both married and unmarried female workers are employed there and the percentage of them are 55% and 45% respectively (Sikdar, Sarkar & Sadeka 2014, p. 174).

They mainly live in urban slums, which are overcrowded and in which living spaces are extremely limited. They share kitchens and toilets with many other people living in their residential areas. This is why, the female RMG workers and their family members have to wait for a long time in queues for washing, cooking and using toilets (UNICEF 2015). They get inferior remuneration and other facilities because of their low level of education and job skills. The legal minimum monthly wage of an RMG worker is BDT 8000 (US$ 94.37[1]). In practice, they are getting less than the prescribed amount (Butler 2019). As they get low wages, very often they have to overlook their health problems. Thus, the low wages of female RMG workers undermine their ability to access healthcare facilities (UNICEF 2015). Riaduzzaman (2017, p. 27) argues that even though the female workers of this sector are the key drivers of the Bangladesh economy, they are neglected in every sphere of their lives including that of health. They are disadvantaged in getting both the basic amenities of life and healthcare.

According to the World Health Organization (2020), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". It emphasises both the absence of diseases together with other factors, which include peoples' economic,

[1] As of 9 October 2020, <www.currencyconvertor.com >.

social, and living environments and the strategies that can address these issues. In Bangladesh, the health and nutrition level of female RMG workers is extremely low. About 50% of these workers suffer from malnutrition and anaemia (UNICEF 2015). Moreover, as they live in slums, there is a lack of safe and sufficient water for drinking and bathing. As a result, they suffer from diarrhoeal diseases (UNICEF 2015). A study reports that more than 40% of female garment workers suffer from various chronic diseases, which include reproductive tract infections, gastrointestinal and sexual transmitted infections, blood pressure along with menstrual issues, anaemia as well as family planning related health concerns. Adolescent female RMG workers have high vitamin A deficiency (Riaduzzaman 2017, p. 23).

Another study of 310 garments workers (Moran et al. 2020, p. 847) found that 31.94% of them can take only three toilet breaks per day due to a lack of toilet facilities in their work places and residences. From the urine samples 7.45% of the respondents were diagnosed with urinary tract infection. This study also claims that UTI issue also triggers absenteeism, exhaustion, lack of concentration and low productivity (Moran et al. 2020, p. 855). UTI causes an excessive financial burden for women from low socio-economic status and limits their involvement in income-generating activities (Rahman et al. 2013, p. 453). Ahamed (2012, pp. 12-3) claims that female RMG workers frequently suffer from fever, infections in eyes, jaundices, issues with typhoid, anaemia, back pain along with skin diseases. The use of masks is not a common practice among workers within these industries. Consequently, there is a prevalence of another serious disease, namely tuberculosis (Kibria 2009, p. 55). In addition, most of these female workers' children live with their grandparents in rural areas, due to the working conditions and the lack of facilities for childcare. As a result, they suffer from depression due to their inability to manage work stress and the stresses of their family life (Akhter et al. 2017, p. 571).

In the RMG sector, 90% of industries have their assigned doctors, while they only deal with preliminary aids. 10% of these industries still do not have any doctors for workers (Sikdar, Sarkar & Sadeka 2014, p. 177). Akhter et al. (2017, p. 575) claim that the clinics of the RMG factories usually give basic painkillers and oral salines to the workers as medicines, when they become sick. These factory's clinics do not have the management system to refer the workers to the government hospitals, if needed. Thus, the female RMG workers have to fight with their illness by their own means and most of the time they have to ignore their sickness because of their financial situation.

2.1.3 Healthcare financing in Bangladesh

Bangladesh has substantially widened essential public health interventions coverage, e.g. through immunization that reduced the rate of maternal and child mortality. Yet, the secondary and the tertiary healthcare services are extremely inadequate for the lower income people as well as for the vulnerable groups of the society (Ministry of Health and Family Welfare 2012). OOP expenditure is considered to be the key means of securing healthcare financing in most of the low-and middle-income countries including Bangladesh. The total health expenditure (THE) is only 2.3% of the GDP in Bangladesh, while government's health spending compared to its GDP is only 0.40% in 2017 (World Health Organisation 2020a), as shown in **Figure-3** and **Figure-4**. This situation places Bangladesh among the lowest spending countries in the South & South-East Asia Region for its health sector (World Health Organisation 2017). In addition, the per capita health expenditure is BDT 2887 (US$ 34.05[2]), of which 67% is OOP expenditure, the government's healthcare financing is only 23% and remaining 10% comes from NGOs and donor agencies (Ministry of Health and Family Welfare 2018). The Healthcare financing of Bangladesh is shown in **Figure-2** below:

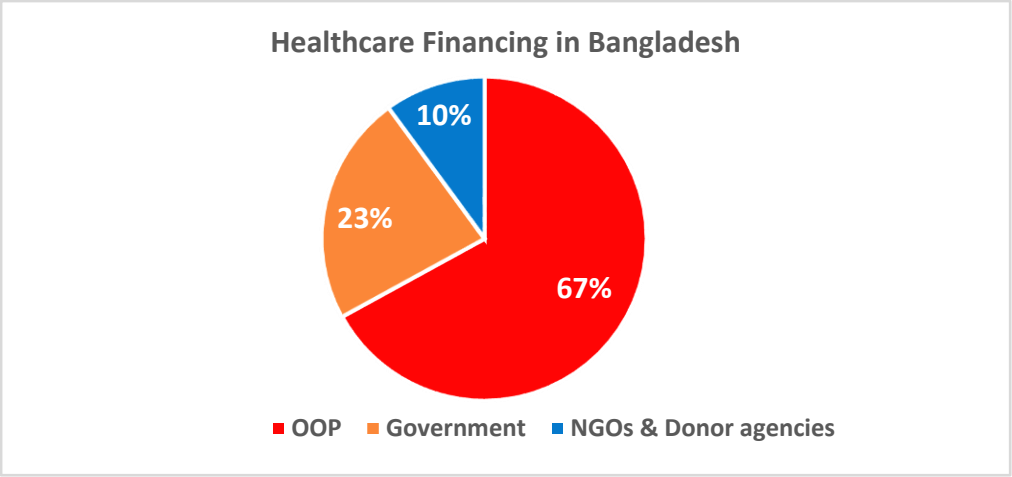

Figure-2: Healthcare financing of Bangladesh (prepared by the author based on Ministry of Health and Family Welfare 2018).

[2] As of 9 October 2020, <www.currencyconvertor.com>.

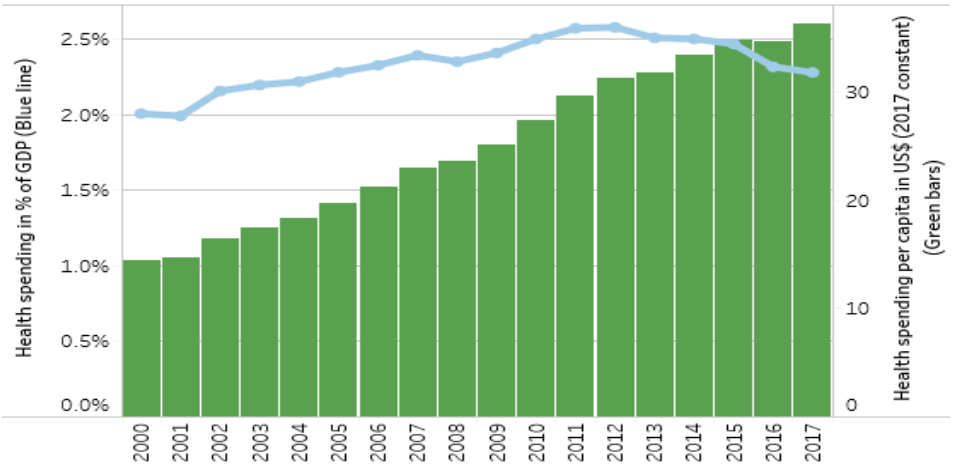

Figure-3: Health spending in percentage of GDP and health spending per capita in Bangladesh (World Health Organisation 2020a).

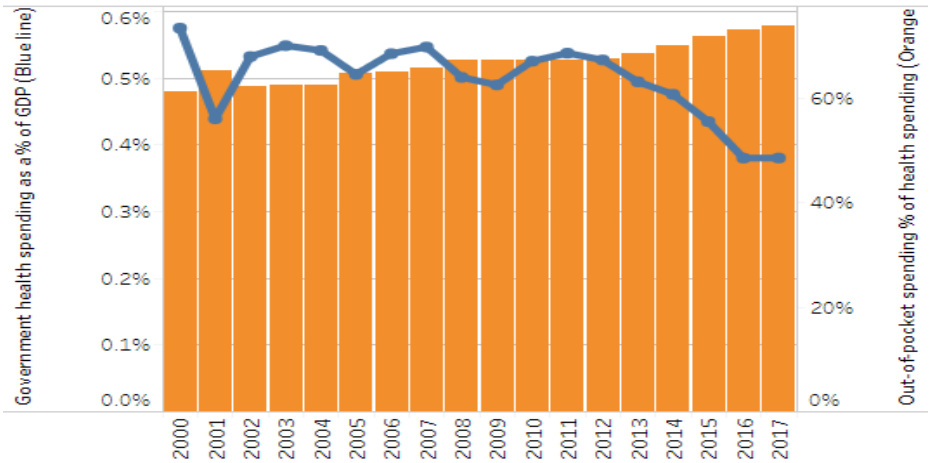

Figure-4: Government health spending and out-of-pocket spending in Bangladesh (World Health Organisation 2020a).

According to the World Health Organisation, reliance on OOP spending in the current health expenditure of Bangladesh was 74% in the year 2017 (World Health Organisation 2020a) as shown in **Figure-4**. Dependence on OOP expenditure for healthcare places a financial burden on households and causes their impoverishment (Sarker et al. 2017, p. 2). Ahmed, Begum and Cotlear (2019, p. 6) also claim that 4.5% people in Bangladesh were impoverished for health care, which was calculated on the basis of purchasing power parity US$ 1.90 per day in 2011.

There is a combination of various mechanisms in the healthcare financing of Bangladesh. Every part of this system has a different financing source. For example, private providers depend on household OOP expenditure; NGO providers rely on international funding and OOP expenditure; and the government provides services based on the government budget incorporating international funds. Tax revenues are used to subsidise the healthcare costs of citizens as well as to pay the salaries of the health sectors' workforce. The contribution to the Total Health Expenditure of the private sector is significantly higher than that of public sector in Bangladesh, which is shown in **Figure-5** below:

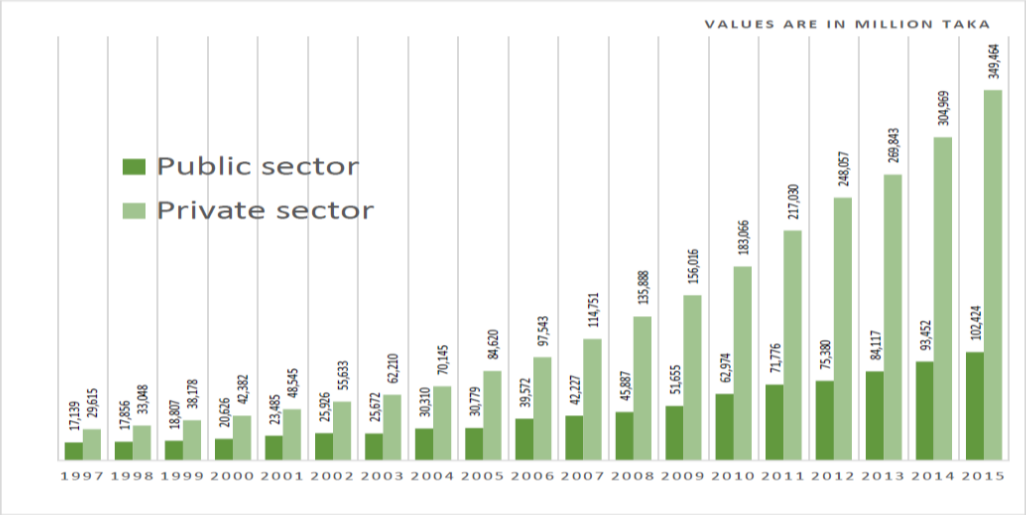

Figure-5: The Total Health Expenditure (THE) by Public and Private Sector in Bangladesh (Ministry of Health and Family Welfare 2018).

On the other hand, the concept of health insurance is a very recent idea in Bangladesh. Some private insurance companies are offering health insurance schemes on a very limited scale. Their contribution to the total healthcare financing is negligible, less than 1%. The reasons for this low coverage include high premium costs and the fact that it is available only for the urban population. As such, private insurance is out of the reach of the poor and low-income population because of its high cost (Health Economics Unit 2020). There are some community-based schemes operated by NGOs along with local hospitals. Yet, these schemes are also available in a very limited area, their success is doubtful and their contribution to the overall national health financing is negligible (Health Economics Unit 2020). Joarder, Chaudhury and Mannan (2019, p. 2) argue that the public and private health insurances in Bangladesh are almost non-existent and that the allocation for health financing remains inadequate.

The Healthcare Financing Strategy 2012-2032 was approved to attain Universal Healthcare Coverage by 2032. A pilot program named 'Health Insurance Scheme' is currently underway towards achieving UHC in three upazilas out of 492 in the country and these three upazilas are from the same district (Tangail). The households under the poverty-line are the beneficiaries of this scheme (Ministry of Finance 2019). In this scheme, every enrolled household receives healthcare service coverage equivalent to BDT 50,000 (US$ 589.77[3]) yearly. The government finances the premium for this coverage, which is BDT 1000 (US$ 11.80[4]) per year. There are some issues with this program that include decreased motivation of service providers, delay in scheme activities, low service utilisation and difficulties in the registration of targeted population (Ahmed et al. 2018, p. 1). Despite these issues, the beneficiaries of this scheme receive outpatient consultation and inpatient care, referral care from District Hospital together with essential medicines for inpatient care at the Upazila Health Complex and the District Hospital free of charge (Ahmed et al. 2018, p. 2).

In addition, a pilot project of Social Health Insurance scheme is being implemented for 20,000 garment workers for the period from 2017 to 2021 by Gonoshasthaya Kedra, a Bangladeshi non-government organisation and healthcare service provider. It obtains the funds for this project from Weave our Future (WoF), which is an Auchan's foundation in France. The general objective of this pilot project is to improve the garment workers' health status and to enhance their productivity. The beneficiaries of this scheme obtain assistance for healthcare up to BDT 25000 (US$ 294.90[5]) per year and they have to pay BDT 600 (US$ 7.08[6]) as an annual premium. This scheme provides some essential health services, which include access to 24-hour hospital services, ambulance service along with pharmacy facilities (SNV Netherlands Development Organisation 2020). However, there is no special focus on the female RMG workers who are the key drivers of the Bangladesh economy by the government.

2.2 Health insurance related literature

Generally, health insurance refers to an insurance, which covers the entirety or a part of the financial expenses that are incurred in connection with the provision of healthcare to a person. Felman (2018) argues that the insurance, which covers medical as well as surgical expenditures of an insured individual, is recognised as health insurance. Here, the term 'insured' pertains to

[3] As of 9 October 2020, <www.currencyconvertor.com>.
[4] As of 9 October 2020, <www.currencyconvertor.com>.
[5] As of 9 October 2020, <www.currencyconvertor.com>.
[6] As of 9 October 2020, <www.currencyconvertor.com>.

the person who has health insurance coverage or to the owner of this health insurance policy. The word 'provider' is used to refer to a doctor, clinic, laboratory, hospital, pharmacy, as well as to the healthcare practitioner who provides treatment to a person. In this instance the insured can pay out of pocket and later obtain reimbursement. Conversely, insurers can directly pay to the providers, which depends on the type of coverage that is provided. In those countries that do not have Universal Healthcare Coverage, e.g. the USA, health insurance is usually included in the benefit packages provided by employers (Felman 2018). According to Encyclopaedia Britannica (2006, p. 851),

> Health Insurance System for the advance financing of medical expenses through contributions or taxes paid into a common fund to pay for all or part of health services specified in an insurance policy or law. The key elements are advance payment of premiums or taxes, pooling of funds, and eligibility for benefits on the basis of contributions or employment without an income or assets test. Health insurance may apply to a limited or comprehensive range of medical services and may provide for full or partial payment of the costs of specific services. Benefits may consist of the right to certain medical services or reimbursement of the insured for specified medical costs. Private health insurance is organized and administered by an insurance company or other private agency; public health insurance is run by the government.

Thus, there are mainly two types of health insurance: public health insurance and private health insurance. For example, the Australian government implements a health insurance policy by means of a program named Medicare. It covers most of the residents of Australia for their health care. Yet everything is not covered by this policy. The residents can take out a private health insurance policy in order to get wide-ranging healthcare (Canstar 2020). Private health insurance is of two categories, such as hospital cover and extras cover. Hospital cover supports in covering in-hospital costs and extras cover non-medical health services including optical, chiropractic and dental treatment (Canstar 2020). There are schemes, which fall broadly under these two categories, although it is difficult to classify them under one category or the other.

There is the Social Health Insurance (SHI) scheme, which is one kind of financing as well as way of managing healthcare system through risk pooling. According to the Organisation for Economic Co-operation and Development (OECD), "a social health insurance scheme is one where the policy-holder is obliged or encouraged to insure by the intervention of a third party" (OECD 2003). Here there are various options: the government could accommodate all of its

employees in this scheme; the employer might impose a condition for the participation in this scheme during employment; the employer could encourage their employees to join the scheme by paying contributions on their behalf; or a trade union might organise beneficial health insurance coverage accessible only for its members. In this scheme, contributions are generally made on behalf of employees (OECD 2003). Several governments like Thailand and South Korea have implemented this scheme for attaining UHC, which is one of the SDGs of the United Nations (UN).

In addition, there is the Voluntary Health Insurance (VHI) scheme found in several countries in the world. In VHI, the decisions to join and to make payments for the premium are voluntary. There are different forms of VHI that include employer-based for-profit schemes along with small non-profit schemes, e.g. Community-based Health Insurance (World Health Organisation 2020e). VHI schemes are used to complement or supplement the publicly-funded benefits in higher-income countries for healthcare services and expenses. VHI can be seen in the shape of Community-based Health Insurance in lower-income countries, as the publicly-funded healthcare structures are usually weaker there. Low-and middle-income countries around the globe have a growing number of middle-class people. These middle-class people have an expectation of receiving better healthcare services, which they are not getting from the publicly-funded health system. In these cases, VHI schemes frequently play an alternative role (World Health Organisation 2020e). Yet, the contribution of VHI in the healthcare financing of the world is marginal, which is less than 5%. No country is reported to attain advancement towards UHC by depending mainly on VHI (World Health Organisation 2020g).

Developed countries are implementing 'Employer-Sponsored Health Insurance' (ESHI) schemes for the industry-based workers to enable them to obtain access to quality healthcare and to protect them from financial risk. This type of scheme is recommended for developing countries as well. Generally, organisations provide these schemes for their workers as a part of benefit and compensation packages (Ahmed et al. 2020, p. 2). The Bangladesh Diabetic Samiti (BADAS) implemented a pilot ESHI scheme for one year (March 2014 to February 2015) as a means of increasing access to healthcare for RMG workers in Bangladesh. This pilot project was implemented for six factories of the New Asian Group, which is situated at Gazipur, Bangladesh. This scheme provided mandatory healthcare services for the 8000 workers of these six factories (Ahmed et al. 2020, p. 2). Ahmed et al. did a study of 1924 of these workers and found that the ESHI scheme had a substantial impact on the workers' utilisation of healthcare.

This study also found that the ESHI scheme had an insignificant impact on reducing OOP expenditure for healthcare. The study recommended that the awareness building for the utilisation of designated providers for healthcare under this scheme could reduce OOP spending. It concluded that employers within the RMG sector should introduce ESHE schemes for their workers in order to improve their health and wellbeing and to deal with the challenges that stand in the way of achieving UHC in Bangladesh (Ahmed et al. 2020, p. 10).

The Institute of Medicine (IOM) states that health insurance allows for the better provision of healthcare services and leads to improved health outcomes (Institute of Medicine 2002, p. 47). It significantly reduces the prevalence of early death among adults and vulnerable sectors of the population in comparison to their uninsured counterparts. Health insurance also reduces the gender disparity in obtaining access to healthcare services (Institute of Medicine 2002, pp. 77-80). Bovbjerg and Hadley (2007, p. 1) argue that the 'bottom line' is that poor people who are uninsured are sicker and have a greater probability of premature death than their insured counterparts. Conversely, health insurance improves the health of vulnerable subgroups of the population such as infants, children and the poor (Levy & Meltzer 2008, p. 406).

Giedion and Díaz (2010, pp. 13-9) reviewed 49 quantitative studies on low-and middle-income countries and found that health insurance has a positive impact on the levels of access to and use of healthcare services. It reduces OOP payments as well as the incidence of catastrophic payments, specifically for the poor. Another panel data study on the effect of public health insurance in China found that PHI has a positive impact on health. This study also revealed that PHI much improved the health of people in middle age, the elderly and poorer groups (Fan et al. 2019, p. 9). Expansion of health insurance coverage leads to improved health outcomes, lengthens lives and increases labour force productivity (Bovbjerg & Hadley 2007, p. 2). As expanding health insurance coverage has positive effects, governments around the world especially from low-and middle-income countries have sought to ensure that wider sections of their populations are covered so as to achieve UHC (Erlangga et al. 2019, p. 13).

Although several lower-and middle-income countries have introduced health insurance schemes, they face substantial challenges in doing so. Vilcu et al. (2016, p. 2) state that lower-and middle -income countries face challenges in covering the population in the informal sector as well as poorer groups. These groups of people do not have the income needed. To address this issue, governments have to subsidise the contributions of these groups by transferring

general revenue to the fund for health insurance. Substitute terms are used, which consist of "premium subsidisation" or "exemption from contribution". The key issue here is that this subsidisation of contributions interrupts or diminishes the linkage between the insured being capable of making contributions by themselves and being eligible for benefit packages. This is why, the low-and middle-income countries are rethinking how these issues can be resolved or minimised (Mathauer 2015, p. 13).

Health insurance is a major policy reform. Reform is a change from current situation to a better situation (Collin 1998, p. 239). Health insurance is intended to bring about major positive changes in people's lives in the area of healthcare as discussed above. Scholars have shown that 'political will' is the critical variable in the success of any kind of policy or governmental reform. Richmond and Cook (2016, p. 6) state that Canada's failure in implementing a national policy for Aboriginal health equity reflects the lack of 'political will'. Quah and Yu (2015, p. 157) in a comparative analysis argue that Singapore has been successful in anti-corruption reform because of the political will of the government, whereas Japan, Philippines, China and Taiwan lack the necessary political will to tackle the causes of corruption. Ankamah and Khoda (2018, p. 3) argue anti-corruption reform and development policy implementation are influenced by political will. Likewise, Brinkerhoff and Cosby (2002, p. 6) state that political will as well as pragmatic leadership are vital ingredients for securing and implementing policy reform. Therefore, political will is the major factor that underpins the introduction of health insurance schemes and allows for their successful implementation.

Now the question is why political leaders should commit to introduce this kind of policy reform? There is evidence, which indicates that this kind of reform enables governments to earn greater legitimacy and thereby to stay in power for a longer time. For example, the former prime minister of Malaysia Mahathir Mohamad during his tenure (1981-2003) introduced several administrative and policy reforms, which included a new administrative capital, an international airport and reform in education policy, foreign policy and health policy. His visionary policy 'Look east' greatly helped the development of Malaysia (Reza & Yasmin 2019, pp. 501-3). These reforms ultimately helped him to earn legitimacy and in so doing enabled him to stay in power for a long time. This is one reason why the government of Bangladesh should consider introducing a health insurance policy for the RMG female workers. Another reason is that such workers make a significant contribution to the Bangladesh economy. If they are not in good health that will adversely affect the economy of the country.

This research project focuses on the public health insurance scheme for these workers because the government is already implementing a pilot program named 'Health Insurance Scheme' for poor people in a small scale as a first step for achieving UHC (Ministry of Finance 2019). This study seeks to ascertain if a PHI scheme can be introduced in Bangladesh without putting an excessive burden on the government's budget. In order to do so it uses the policy learning concept to draw lessons from international practices.

2.3 The concept of policy learning

Although Bangladesh is the eighth most populous country in the world (Worldometer 2020) and has a limited budgetary allocation for the health sector, it can learn useful lessons from other countries, which have already implemented a health insurance policy.

Many academics have discussed the policy learning concept, even though they refer to it using different names. Two concepts are prominent in discussions of policy learning, namely, "lesson drawing" established by Rose (1991) and "policy transfer" developed by Dolowitz and Marsh (2000). Policy learning or lesson drawing is a process in which policy actors seek to learn from the experiences of a particular policy initiative or practice in order to see if it can be adopted in another jurisdiction (Rose 1991, p. 3). This process entails making judgements regarding the practicability as well as the desirability of shifting the founding policy paradigm. Koch and Oksanen (2003, p. 56) argue that policy learning brings about a change in activities within political organisations. These include changes in the specification of a policy, in its orientation and management structures and in its instruments and content. Lessons can be drawn from the performance of a policy or program. Negative lessons happen when the specific policy or program under observation is regarded as being unsatisfactory and therefore requires modification (Rose 1991, p. 19).

The second aspect of policy learning is what Dolowitz and Marsh (2000, p. 5) call "policy transfer". This is a process in which existing policies are used to develop new policies in a different jurisdiction. Policy transfer only occurs when a policy is considered to be have been successful. In the recent decades "lesson drawing" and "policy transfer" have increased in popularity in the policy arena regardless of time and space (Rose 1991; Dolowitz and Marsh 2000). The advancement of technologies as well as communication networks have made it

simpler and quicker to exchange new ideas and information on program and policy designs among policymakers (Dolowitz & Marsh 2000, p. 6).

The possibility of lesson drawing and transfer however does not mean that a policy that is successful in one country will work in another. There is the possibility of policy failure due to the fact that each country has its own specific characteristics and context. Rose (1991, p. 6) recommends that modifications are required to minimize these risks considering the historical, cultural and institutional contexts of the country which is the intended recipient of the policy transfer. Even though policy learning can be a valuable approach, it is necessary to consider its practicability. Both "lesson drawing" and "policy transfer" pose significant challenges. It may therefore be necessary to modify these concepts in order to adapt them to the contexts of a specific country.

As Bangladesh has not yet adopted a health insurance policy for female RMG workers, the practicalities of such a policy remain to be discovered. Consequently, investigating the practice in other countries, which have already established this policy reform (e.g. Thailand, South Korea and Vietnam) offers useful insights into such practicalities.

To sum up, this literature review has gathered essential baseline information regarding the health condition of RMG female workers in Bangladesh and has sought to justify the introduction of an alternative policy approach, namely a health insurance policy. It has explored the development of RMG industries and their contribution to the Bangladesh economy. Both external as well as internal factors have played a vital role in facilitating the phenomenal growth of the RMG sector. The RMG sector has become the backbone of the Bangladesh economy by becoming the major export and foreign exchange earner. It is also the biggest labour employer in the country. This literature review has examined the female RMG workers' social status and health condition and found that they suffer disadvantage in obtaining access to both the basic amenities of life and healthcare. Moreover, in the healthcare financing of Bangladesh, there is no special attention paid to female RMG workers. As a result, these workers have to depend on OOP expenditure for their treatment and very often have to ignore their sickness because of their weak financial condition. The health insurance related literature is also reviewed. This literature shows that health insurance improves people's health and wellbeing, lengthens their lives, increases their productivity and decreases the gender disparity in access to healthcare services. It reduces OOP expenditures and health vulnerability particularly for the poor and

vulnerable section of the population. This review has also shown that there are issues that must be addressed when establishing health insurance schemes for the poor in lower-and middle-income countries. The poor do not have the income needed, which places an additional burden on the government's budget. Political will is an essential prerequisite for undertaking a major policy reform like health insurance. Political leaders should commit to this sort of policy reform because it supports to earn greater legitimacy. Finally, the policy learning concept has been reviewed, which helps us to examine the practices of other countries that have already established health insurance schemes. The next chapter accordingly reviews the public health insurance practices of Thailand, South Kore and Vietnam.

CHAPTER 3

PUBLIC HEALTH INSURANCE: EVIDENCE FROM INTERNATIONAL PRACTICES

There is a proverb, which goes “health is the root of all happiness”. Virtually every country in the world is committed to achieving universal health coverage (UHC) by 2030, which is one of the SDGs declared by United Nations. For this reason, to address health issues and to support their citizens, many countries around the world have introduced health insurance schemes to attain UHC. This chapter explores the public health insurance practices of three Asian countries: Thailand, South Korea and Vietnam. In particular, it provides an overview of the PHI schemes, which include when and in what aspects they have been introduced and how they have been implemented. In addition, the strengths and limitations of this policy are also explored to examine the possibility of establishing a compulsory health insurance scheme initially for female RMG workers in Bangladesh.

3.1 Thailand

Thailand is a developing country which is located in Southeast Asia and which is categorised as an upper-middle income country. In 2019, its GNI per capita was US$ 7260, its GDP was US$ 543.65 billion and GDP growth rate was 2.4%. The total population of Thailand was about 69.63 million in the year 2019 (The World Bank 2020e). The country is ranked 20th in population in the world (Worldometer 2020). Life expectancy was 76.93 years in the year 2018 and was 61.99 years in 1975 when Thailand first introduced health insurance scheme for low-income groups. The poverty head count ratio at national poverty was 9.9 in 2018 (The World Bank 2020e). Health expenditure per capita was US$ 247 in 2017 and health spending was 3.7% of the GDP in the same year (World Health Organisation 2020c). **Figure-6** shows the Health expenditure in percentage of GDP in Thailand below:

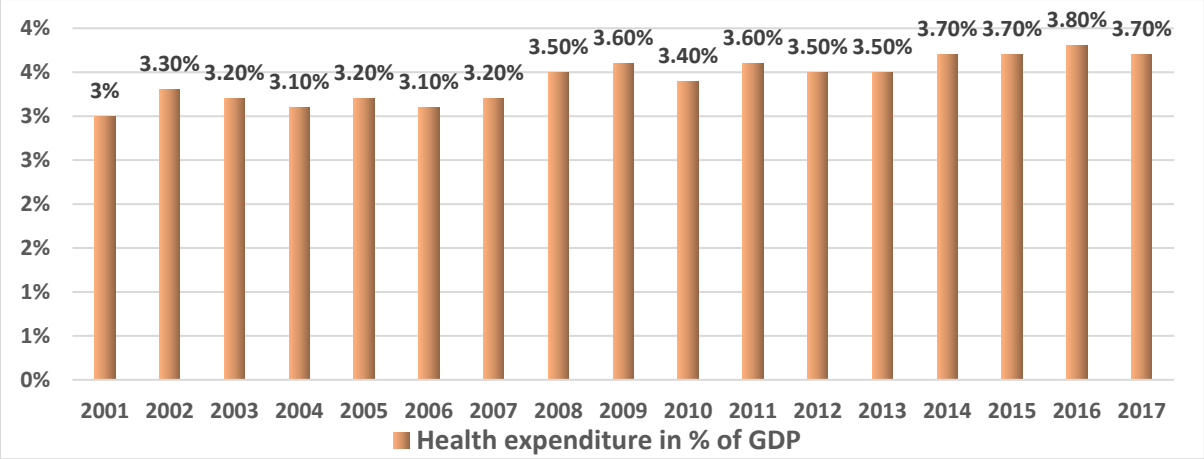

Figure-6: Health expenditure in percentage of GDP in Thailand (prepared by the author based on World Health Organisation 2020c).

3.1.1 The overview of public health insurance in Thailand

In 1975, the Thai government initially introduced the Low-income Scheme to provide healthcare service for the poor at no cost. The income of households was assessed on the basis of the Ministry of Public Health (MOPH)'s benchmark, which was not the same as the national poverty line because that was too low. Cards were provided to the entitled households for healthcare with no co-payments. Non-poor households were not provided with cards because of means testing, while some of the poor households could not be covered by this scheme. Later, this scheme was expanded to include aged people, persons with a disability and children below 12 years of age. This scheme was tax-financed where budget was allocated annually. The benefit package of this scheme covered outpatient, inpatient and dental services along with medicines, while it excluded some high-cost services (Tangcharoensathien et al. 2018, p. 1210).

Then the government established the Civil Servant Medical Benefit Scheme (CSMBS) under the Royal Decree 1980. This non-contributory scheme is still ongoing for civil servants and their dependents, the latter of which includes the employee's parents, spouse as well as children under 18 years (Chaiyakunapruk et al. 2016, p. 5). From the very beginning of this scheme there is a reimbursement model of fee-for-service that is applicable for outpatient and diagnosis related inpatient care. Here the services are compensated by general tax revenue due to the low salaries of the civil servants. This scheme has an open-ended payment method, which is being operated by the Comptroller General's Department under the Ministry of Finance. Here

healthcare providers are mostly public hospitals along with a few private hospitals (Damrongplasit & Melnick 2015, p. 158).

Moreover, the MOPH introduced the Voluntary Community-based Health Insurance in 1983 under the Health Card Project. In this scheme, households with five members had to pay an annual premium of 500 THB (US$ 15.77[7]) (Paek, Meemon & Wan 2016, p. 2). The number of enrolments in the scheme was low because of adverse selection process. Then the MOPH started to subsidise 500 THB per card to raise the enrolment for this scheme. This scheme was financially non-viable because of exceeding revenue expenditure (Tangcharoensathien et al. 2018, p. 1211). In 1990, the government introduced the Social Health Insurance scheme for the employees of the private sector under the Social Security Act 1990. SHI is one of the components of the social security system, which is being administered by the Social Security Office under Ministry of Labour. In this scheme, the source of finance is equal tripartite contribution by the government, employer as well as employee. The benefit package includes expenses for medical examination and treatment of outpatient, inpatients expenses, medicine and transportation expenditure along with other essential expenses (Section 63, Social Security Act 1990 (Thailand), p. 27).

By 2001, in spite of the aforementioned schemes, 30% of the entire population were still uninsured. The Universal Coverage Scheme (UCS) was one of the political manifestos in the Thai general election of 2001. The winning Thai Rak party led the government and introduced UCS in 2001 initially in six provinces (Tangcharoensathien et al. 2018, p. 1211). USC has been implemented all over the country since 2002 under the National Health Security Act 2002. This scheme has been introduced to cover the participants in the schemes of Low-income and Voluntary Community-based Health Insurance along with the rest of the 30% uninsured population. This scheme is operated by the National Security Office. Initially, each person insured under this scheme had to make a co-payment of 30 THB (US$ 0.95[8]), which was the political slogan of Rak party “30 Baht treats all diseases”. In 2006 this co-payment provision was eliminated and it was re-established in 2012 (Damrongplasit & Melnick 2015, p. 158). The benefit package includes the services of prevention, diagnosis, therapeutic, ante-natal, rehabilitation of both physical and mental along with transportation or ambulance facilities (Section 3, National Health Security Act 2002 (Thailand), pp. 1-2). **Figure-7** shows the

[7] As of 28 September 2020, <www.currencyconvertor.com>.
[8] As of 28 September 2020, <www.currencyconvertor.com>.

evolution of health insurance schemes in Thailand and its positive impact on the reduction of child mortality:

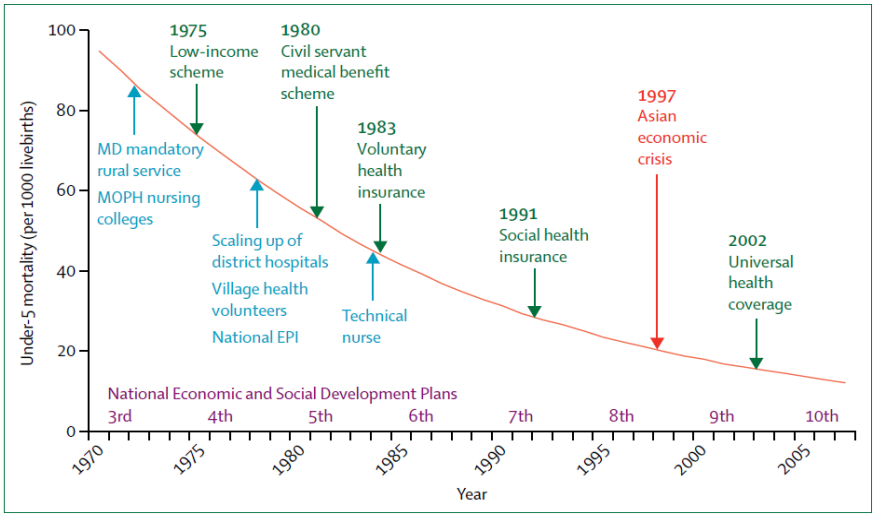

Figure-7: The evolution of health insurance schemes in Thailand and its positive impact on the reduction of under-5 child mortality (Tangcharoensathien et al. 2018, p. 1210).

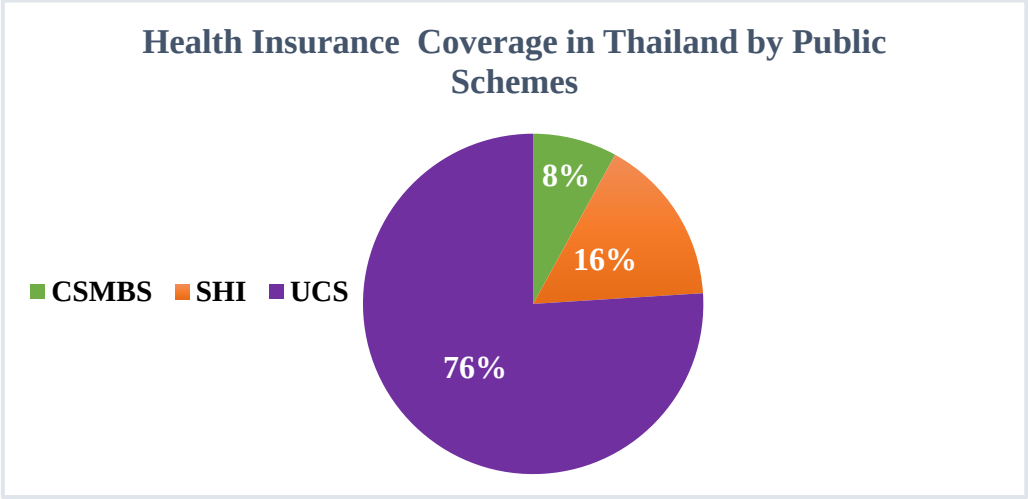

Figure-8: The health insurance coverage in Thailand by three public schemes (prepared by the author based on Sakha, Bahmanziari & Takian 2019, p. 1158).

In 2002, Thailand attained Universal Health Coverage by the three public schemes, namely UCS, CSMBS as well as SHI (Patcharanarumol et al. 2018, p. 2), as shown in **Figure-8**. These schemes serve different population segments, which do not overlap. Yet, there are some differences in the design features of these schemes (Damrongplasit & Melnick 2015, p. 158).

3.1.2 Strong and weak points

The main strength of the PHI system of Thailand lies in the strategies that were adopted by the government. According to Tangcharoensathien et al. (2018, p. 1212), the Civil Registration and Vital statistics system have helped the introduction and faster implementation of the three schemes of the country. These systems involve a unique ID card that enables the provision of continuous health coverage to citizens, while transferring members among the existing three PHI schemes. Besides, as the PHI system is mainly tax-based, the government has adopted a number of strategies for reducing excessive expenditure on healthcare without compromising the quality of care. These strategies include the formation of a price negotiation working group which has succeeded in reducing the prices of some expensive medicines and essential medical instruments and which saved US$ 257 million of spending on the healthcare sector in 2016 (Sumriddetchkajorn et al. 2019, p. 416). Moreover, the referral system of gatekeeper as well as the close-ended payment system of SHI and UCS schemes kept the healthcare expenditure within the reach of government (Sumriddetchkajorn et al. 2019, p. 416). Dao and Nichter (2016, p. 124) claimed that as Thailand transformed its financing system to one of progressive taxation where the rich contribute a larger share of the plan than the poor, this has helped to decrease the occurrence of unexpected health expenditures and OOP spending.

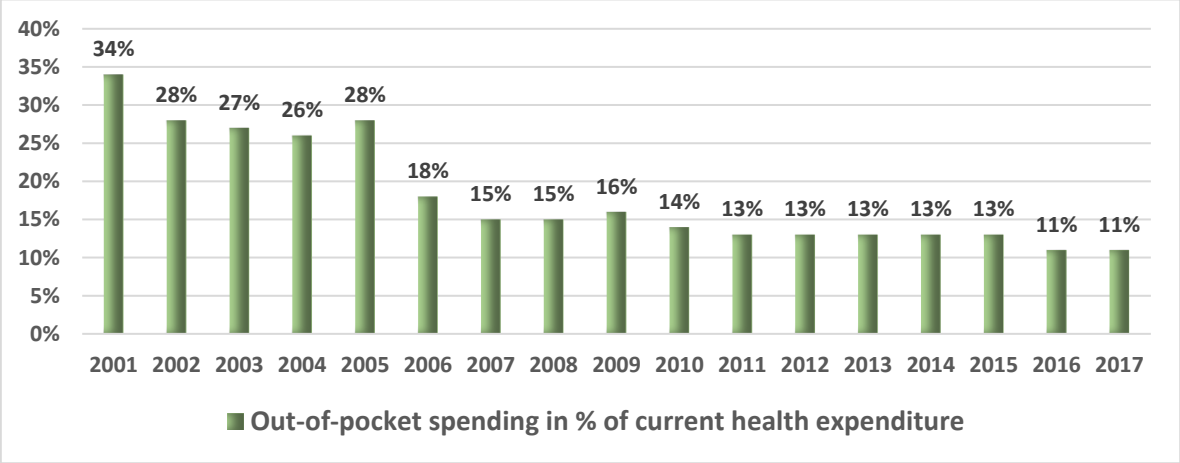

Figure-9: Out-of-pocket spending in percentage of current health expenditure in Thailand (prepared by the author based on World Health Organisation 2020c).

The **Figure-9** shows the declining trend of OOP spending over the years from 2001 to 2017. The only exceptions to this trend were the years 2005 and 2009 when these percentages slightly increased by 2% and 1% over that of previous years. It can be easily assumed that the

government has attained UHC through the introduction of UCS scheme in 2002 and the OOP spending started to decline from that date. Moreover, **Figure-7** indicates the positive impact that PHI schemes have had in reducing under-5 child mortality. Therefore, the PHI schemes have had a positive impact in reducing OOP spending as well as in improving healthcare facilities, especially for the vulnerable groups in Thailand.

On the other hand, there are some weaknesses in the PHI system of Thailand. As the CSMBS scheme has the open-ended payment method, this program frequently faces the issue of escalating expenditures for medical services along with drugs (Damrongplasit & Melnick 2015, p. 158). In addition, Sumriddetchkajorn et al. (2019, p. 415) also mentioned that there are some disparities in the existing PHI schemes, especially in the benefit packages. Moreover, a mainly tax-financed health insurance system of the country, where a large proportion of the population lives in poverty will have to always struggle to cover the rising costs of healthcare services.

To sum up, in 1975, the Thai government initially established the Low-income Scheme to provide healthcare services to the poor at no cost. At that time, the economy of Thailand was not as well-developed as it is now. The per capita income of the country was only US$ 380 in 1975 (The World Bank 2020e). The country gradually attained UHC through its PHI schemes. The political commitment and leadership of the government as well as its pragmatic strategies are the key factors that have underpinned the efficient implementation of this policy reform in Thailand (Tangcharoensathien et al. 2018, p. 1212). Yet, a mainly tax-financed health insurance system might not be a good model for those countries who are still struggling to provide basic amenities for their citizens.

3.2 South Korea

South Korea is officially known as the “Republic of Korea” and it is a developed country. It is situated in East Asia and is grouped in the high-income countries. In 2019, its GNI per capita was US$ 33,720 and its GDP was US$ 1.64 trillion. With a population of 51.71 million in the year 2019 (The World Bank 2020c), South Korea is ranked 28th among the most populous countries in the world (Worldometer 2020). Life expectancy was 82.83 years in the year of 2018, while it was 64.90 years in 1977 when South Korea first introduced health insurance scheme for industrial workers. Health expenditure per capita was US$ 2,283 in 2017 and health

spending was 7.6% of the GDP in the same year (World Health Organisation 2020b). **Figure-10** shows the Health expenditure in percentage of GDP in South Korea below:

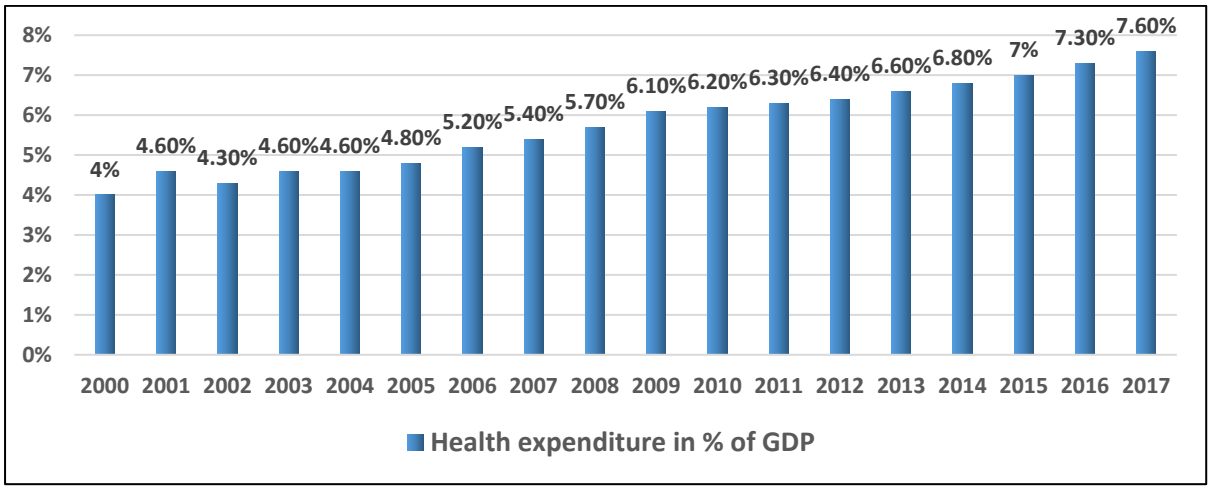

Figure-10: Health expenditure in percentage of GDP in South Korea (prepared by the author based on World Health Organisation 2020b).

3.2.1 The overview of public Health Insurance in South Korea

The public health insurance in South Korea is compulsory by law, which covers the total population of the country. Initially, South Korea enacted the Health Insurance Law in 1963 under which a number of VHI schemes were piloted up to 1977. Then compulsory SHI was introduced in 1977 for industrial workers of large corporations having employees over 500 and for their dependents (Kim & Lee 2010, pp. 142-4). Then this insurance was expanded in 1979 to cover government employees along with teachers and the employees of private schools. In the same year, this scheme was also extended to industrial workplaces that have more than 300 employees. In 1981, it started to cover those working within industries that had more than 100 employees. In the same year, the regional health insurance was implemented in three rural areas of the country. In 1988, regional health insurance was introduced for all the rural residents of the country. Then this was expanded to include the urban residents in 1989, by which stage the country had attained universal health insurance coverage within only 12 years of the introduction of compulsory health insurance (Lee 2003, p. 49). This compulsory health insurance was managed through 409 society-based insurers. As there were disparities in financial status, the regional health insurance societies, the health insurance societies for government employees and those for teachers and the employees of private schools were merged organisationally into the National Health Insurance Service (NHIS) in 1997 (Kim & Lee 2010, p. 144). Then a unified 'National Health Insurance Act 1999' was passed. Its purpose

was to provide citizens "with insurance benefits for the prevention, the medical examination, the medical treatment, and the rehabilitation in case of the disease and the injury, the childbirth, the death, and the improvement of health" (Article 1, National Health Insurance Act 1999 (South Korea), p. 1). Health related policy reform of South Korea is generally formulated on the basis of the citizens' needs. Yet, it is influenced by political desires (World Health Organisation 2015, p. 19). **Figure-11** shows the South Korean public health insurance structure below:

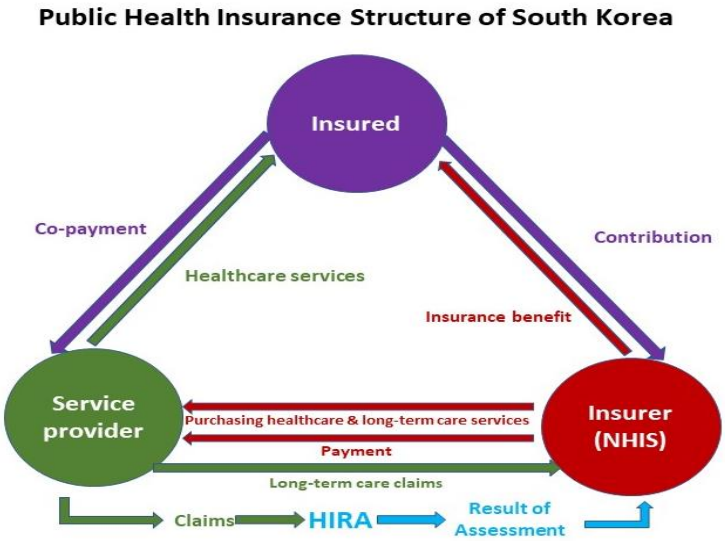

Figure-11: The public health insurance structure of South Korea (prepared by the author based on National Health Insurance Act 1999 (South Korea); Ha et al. 2011; NHIS 2020).

In the PHI system, there are variations in the rate of contributions paid by the insureds. In respect of the employee insured, contributions are calculated by the multiplication of the average monthly salary with the contribution rate (average monthly salary × contribution rate). In the case of government and corporate employees, the employee pays 50% of the contribution and another 50% is paid by the employer. In the case of private school employees, the employee pays 50% of the contribution while the owner of the private school and the government pay 30% and 20% respectively (Kim & Lee 2010, p. 150). Besides, self-employed insured have to pay 100% contribution by themselves on a monthly basis.

According to the National Health Insurance Act 1999, healthcare benefits are "provided for the treatment of diseases and injuries, and childbirths, etc. of the insured and his dependent" (Article 39, National Health Insurance Act 1999 (South Korea), p. 10). There are mainly two types of benefits in the PHI scheme of South Korea, namely service benefits and cash benefits.

There is another benefit provided under the lease program for care aids and appliances. These benefits are provided by the NHIS for the prevention, diagnosis, treatment or rehabilitation of diseases or injuries of the insured and their dependents (NHIS 2020).

A. Service benefits include healthcare benefits as well as health check-ups.

B. Cash benefits include care expenditures, ceiling system of co-payment, compensations on extreme co-payments, expenditures on appliances for persons with a disability along with examination expenses for pregnancy and childbirth (NHIS 2020).

1. If the appliance cost is under the highest amount of subsidy that is permitted, then NHIS pays 90% of the cost of the product. If the appliance cost is above the highest amount of subsidy that is permitted, then NHIS pays 90% of the highest amount of subsidy.

2. NHIS pays KRW 250,000 (US$ 217.59[9]) for childbirth. This benefit will be suspended if the insured gives birth in a foreign country.

3. In the cases of consumables for diabetics and self-catheterisation, NHIS reimburses KRW 900-2500 (US$ 0.79-2.18[10]) and KRW 9000 (US$ 7.87[11]) respectively to the insured.

4. The monthly amount that NHIS reimburses for home oxygen is KRW 120,000 (US$ 104.92[12]) and for portable oxygen is KRW 200,000 (US$ 174.87[13]).

5. NHIS reimburses a part of the expenditure for renting a respirator and buying consumables with a prescription from a doctor. This amount varies according to the types of consumables that are used.

C. Under the lease program, NHIS purchases appliances and leases them to the insured person who needs to use them temporarily at the time of their treatment and rehabilitation. These appliances include wheelchair, walker, stick as well as crutches (NHIS 2020).

[9] As of 10 October 2020, <www.currencyconvertor.com>.
[10] As of 10 October 2020, <www.currencyconvertor.com>.
[11] As of 10 October 2020, <www.currencyconvertor.com>.
[12] As of 10 October 2020, <www.currencyconvertor.com>.
[13] As of 10 October 2020, < www.currencyconvertor.com>.

3.2.2 Strong and weak points

The key strength of the PHI scheme of South Korea is its institutional design. This design works as a chain, which has the two-way relation among insurer (NHIS), insured and service provider, as shown in **Figure-11.** More importantly, service providers cannot directly claim long-term care expenses of healthcare services and drugs to the NHIS. At first, these claims are being reviewed by Health Insurance Review and Assessment (HIRA) service, after the review NHIS provides expenditures to the service providers (Ha et al. 2011, pp. 927-8). Moreover, NHIS is successful in mobilising public along with private resources covering healthcare expenses as well as expanding coverage to the total population quickly (Kwon 2009, p. 63). Besides, there is a declining trend in OOP expenditure, which can be attributed to the impact of the PHI scheme.

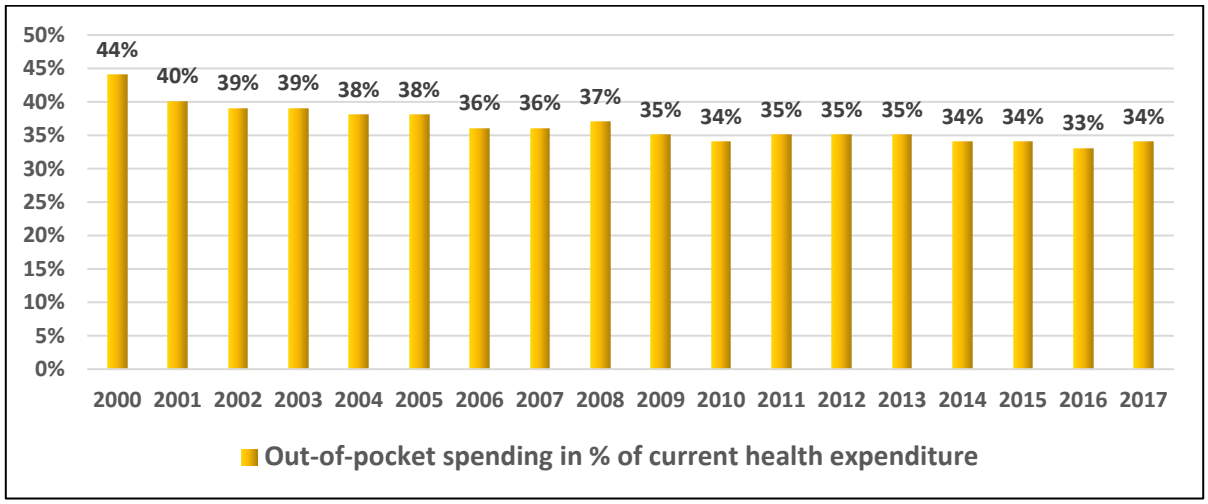

Figure-12: Out-of-pocket spending in percentage of current health expenditure in South Korea (prepared by the author based on World Health Organisation 2020b).

The **Figure-12** shows the declining trend of OOP spending from 2000 to 2017 in South Korea, which is declined by 10% over these 17 years. There are little fluctuations in this declining trend. The positive thing is that there is a declining trend of OOP expenditure even though it is not so significant.

Despite the above, there are some limitations in the PHI scheme of South Korea. Kim et al. (2016, p. 1) claim that although the entire population of the country is covered by the PHI scheme, the benefit coverage is low. This scheme does not cover services with high-cost health technology (Lee & Shaw 2014, p. 7306). Another weak point of this scheme is claimed by

Kwon (2009, p. 63), which is the challenge of fee-for-services caused by the dominance of private healthcare providers because most of the healthcare providers are from the private sector. In addition, there is the issue of the rapidly growing percentage of aged people. It is assumed that this growing parentage of elderly population is the impact of the PHI scheme and it is also a challenge for the country to deal with.

Briefly summarised, in 1977, the economy of South Korea was not as strong as it is today and the per capita income was only US$ 970. (The World Bank 2020c). Yet, the government of South Korea introduced a compulsory SHI for industrial workers and their dependents to ensure that they received healthcare services. The country attained its universal health insurance coverage within only 12 years of the introduction of compulsory health insurance in 1989. The factors that underlie this achievement are efficient institutional design as well as political desire. According to the World Health Organisation (2015, p. 19), health related policy reform within South Korea has been influenced by the political desire. In addition, this scheme does not put an excessive burden on the state budget because there are provisions for co-payments and contributions. Moreover, NHIS efficiently mobilised resources from both public and private sources in order to cover healthcare expenses (Kwon 2009, p. 63). According to the National Health Insurance Law, a person who receives healthcare benefits has to pay a part of that cost as co-payment (Article 41, National Health Insurance Act 1999 (South Korea), p. 11). However, the benefit coverage of this scheme is low and there is the challenge of fee-for-services caused by the dominance of private healthcare providers.

3.3 Vietnam

Vietnam is situated in the South-eastern Asian region and is a lower-middle income country. In 2019, its GNI per capita was US$ 2540 and its GDP growth rate was 7%. The total population of Vietnam was about 96.46 million in 2019 (The World Bank 2020f). The country is ranked 15th among the most populous countries in the world (Worldometer 2020). Life expectancy was 75.32 years in 2018 and was 71.12 years in 1975 when Vietnam first introduced a Social Health Insurance scheme for workers in the formal sector and pensioners. The poverty head count ratio at national poverty was 6.7 in 2018 (The World Bank 2020f). Health expenditure per capita was US$ 129.58 in 2017 and health spending was 5.5% of the GDP in the same year (World Health Organisation 2020d). **Figure-13** shows the Health expenditure in percentage of GDP in Vietnam below:

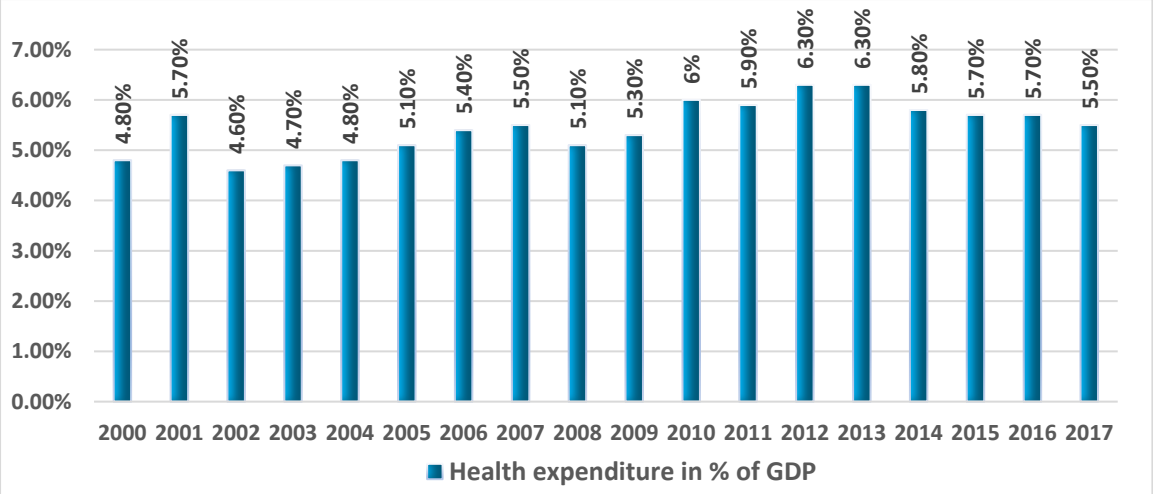

Figure-13: Health expenditure of Vietnam in the percentage of GDP (prepared by the author based on World Health Organisation 2020d).

3.3.1 The overview of public health insurance in Vietnam

The public health insurance system in Vietnam is a single payer system. In 1989, the government implemented pilot projects in some provinces for health insurance. Then the SHI scheme was introduced in 1992. It initially covered formal sector workers and pensioners as a form of compulsory insurance (Shillabeer 2016, p. 63; Vo & Van 2019, p. 2). As the program did not cover minorities or the poorer sections of the population, the government provided health cards for the poor on a small scale in 1995. It created another additional fund for them in 2002 which was known as the healthcare fund for the poor (HCFP). This program offered free or low-cost services to the entire population. In 2005, SHI and HCEP were combined together and a Voluntary Health Insurance scheme was introduced for the self-employed, informal sector workers and the dependants of those who are in the compulsory program. In November 2008, the health insurance law was passed, which was effective from July 2009 (Vo & Van 2019, p. 2). The government devised a long-term roadmap for attaining Universal Health Insurance Coverage with a target of covering 80% of the population by 2020 (Shillabeer 2016, p. 65). However, the government is ahead of its target, 87% of the total population was covered under the SHI scheme in 2018. The poorer section of the population, ethnic minorities, children under the age of six, elderly people over 80 along with socially disadvantaged groups are totally covered under the government's fully subsidised premium. Near poor, students as well as households are partly subsidised, which varies from 30% to 70% according to their economic status. Almost 70% of the health insurance fund is expended for the secondary and

tertiary levels (World Health Organisation 2020f). **Figure-14** shows the evolution of Social Health Insurance and **Figure-15** indicates the public health insurance structure of Vietnam:

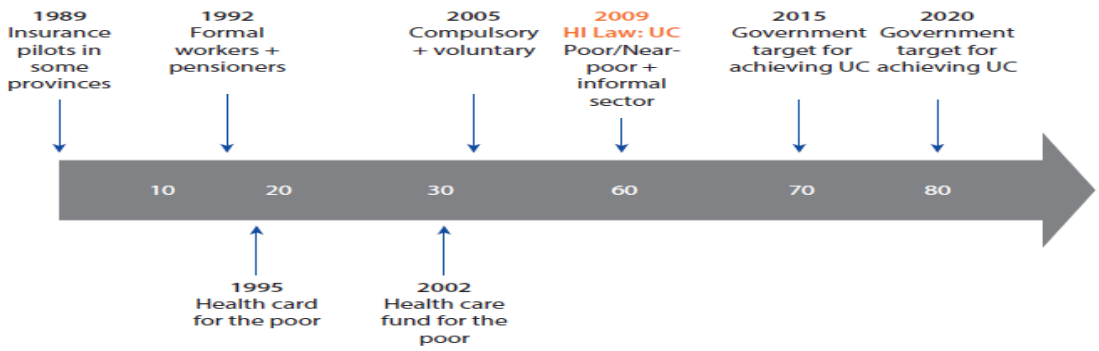

Figure-14: The Evolution of Social Health Insurance in Vietnam (Somanathan et al. 2014, p. 13).

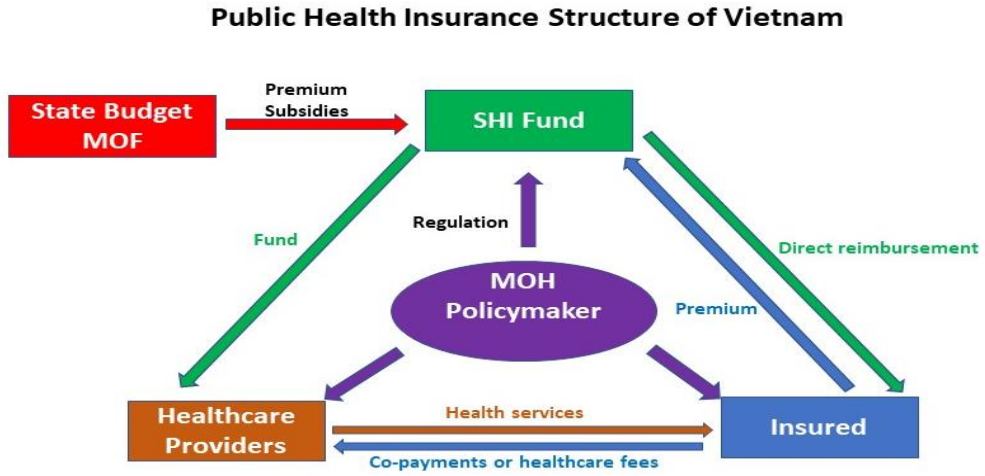

Figure-15: The public health insurance structure of Vietnam (prepared by the author based on Law on Health Insurance 2008 (Vietnam); Vo & Van 2019; Teo et al. 2019).

There are 25 groups of insured population. These groups are divided into four broad groups on the basis of contribution of payment: a) premiums are paid by salary along with social allowances, b) premiums are provided by the government, c) premiums are provided jointly by the government and the individual d) premiums are solely provided by the individual (Do, Oh & Lee 2014, p. 920). The eligibility rules and the percentage of subsidy are as follows:

1. The poor, ethnic minorities, children under the age of six, elderly people over 80 along with socially disadvantaged groups of people are covered through the government's 100% subsidised premium.

2. Near poor (below 130% poverty line) get a 70% subsidy.
3. School going children and other students receive a 30% subsidy.
4. Workers in the informal sector, households related with agriculture, cooperatives members as well as household enterprises also receive a 30% subsidy (Vilcu et al. 2016, p. 7).

The monthly premium for the workers is 6% of their minimum monthly salary or remuneration, where the employer has to pay two-thirds and the employee has to pay one-third of the amount. If a worker is on maternity leave or adopts a child under four months during this period, none of the workers or employers are required to pay a premium for their health insurance. However, the worker will be entitled to health insurance benefits as consecutive health insurance participation time (Article 13, Law on Health Insurance 2008 (Vietnam), p. 10).

There are provisions for co-payments and reimbursement of payments in the PHI system of Vietnam. Co-payments are applied for all of the insured members, while there are exemptions for the groups who are fully subsidised by the government. The percentage for co-payments varies between groups. It is 5% for pensioners and for the members having social protection allowances; while the other groups have to pay 20% of co-payment. A higher co-payment rate is applied for the insured who bypass facilities of lower referral. It depends on their healthcare access level, which is 30% at the hospitals of district level, 50% at the provincial level hospitals percent and 70% at the central and tertiary hospitals percent. The insured get reimbursed for some specific medicines, which are mentioned in the essential medicine list of the country (Tien et al. 2011, p. 25). The SHI benefit package includes the following services:

1. All kinds of ambulatory along with hospital basic service.
2. Referral for higher level of service if required as well as the transportation cost of referral is covered for the poor.
3. Drugs that are included in the reimbursement list (Article 21 & 22, Law on Health Insurance 2008 (Vietnam), p. 13-4; Vilcu et al. 2016, p. 7).

There are some rights of the insured in the existing Vietnamese Health Insurance law, which includes the right to have a health insurance card if they are paying premiums for health insurance and to choose a primary healthcare provider (Article 36, Law on Health Insurance 2008 (Vietnam), p. 17). However, the health insurance fund mainly depends on the government's general budget transfer for covering contributions for the groups who have

eligibility entitlement (Teo et al. 2019, p. 33). The sources of funds for health insurance in Vietnam include premiums, profits through investments from the fund, domestic along with foreign aid and revenues (Article 33, Law on Health Insurance 2008 (Vietnam), p. 17).

3.3.2 Strong and weak points

The increase in PHI expenditure has had a positive impact on healthcare in Vietnam. Vo and Van did a survey in 2019 on the impact of health insurance upon household vulnerability. The study found that the expansion of access, reduction of costs as well as the improvement in healthcare had a positive impact in decreasing healthcare vulnerability, especially for the poor (Vo & Van 2019, p. 11). It was possible to increase coverage of the population rapidly under the SHI scheme because of the government's pragmatic institutional design together with the increased budget transfer for fully subsidised payments of insurance for the poor, children along with aged people, as well as partial subsidised payments for near poor and other vulnerable groups. This coverage had increased from 5% in 1993, which was the year of the scheme's inception to 87% in 2018 (Teo et al. 2019, pp. 33-4). This success is not attributable to the increase of investment in healthcare per year but rather to the institutional design for healthcare. The government has decentralised its healthcare facilities from central and provincial level to district and community level, which made healthcare facilities more accessible for their citizens (Reinhardt 2019; Teo et al. 2019, p. 39). Vietnam has successfully mobilised domestic resources along with foreign aid to lessen the burden on the government for covering health insurance expenses (Article 33, Law on Health Insurance 2008 (Vietnam), p. 17).

The government has prioritised expanding health insurance coverage for the population as opposed to focusing on the provision of high-level health facilities and decreasing the level of OOP spending. Somanathan et al. (2014, p. 13) argue that not only is the service coverage of the PHI limited but also the quality of service is poor. Tien et al. (2011, p. 24) also state that occupational diseases, rehabilitation or home care, treatment for drug addiction, medical aid devices, glasses, teeth as well as instruments as hearing aids are not covered by the scheme. Do, Oh and Lee (2014, p. 920) also claimed that health insurance provides low quality of healthcare and involves a long waiting time. For this reason, people who have the ability take high quality of services on their own. This has had a negative impact on the reduction of OOP expenditure. Lee et al. did a study in 2019 utilising the data from the health system community survey and also found that health insurance of Vietnam makes little provision for the utilisation

of high-level healthcare services. The detoriation in the quality of primary care compels people to seek a high quality of services on their own, bypassing primary services.

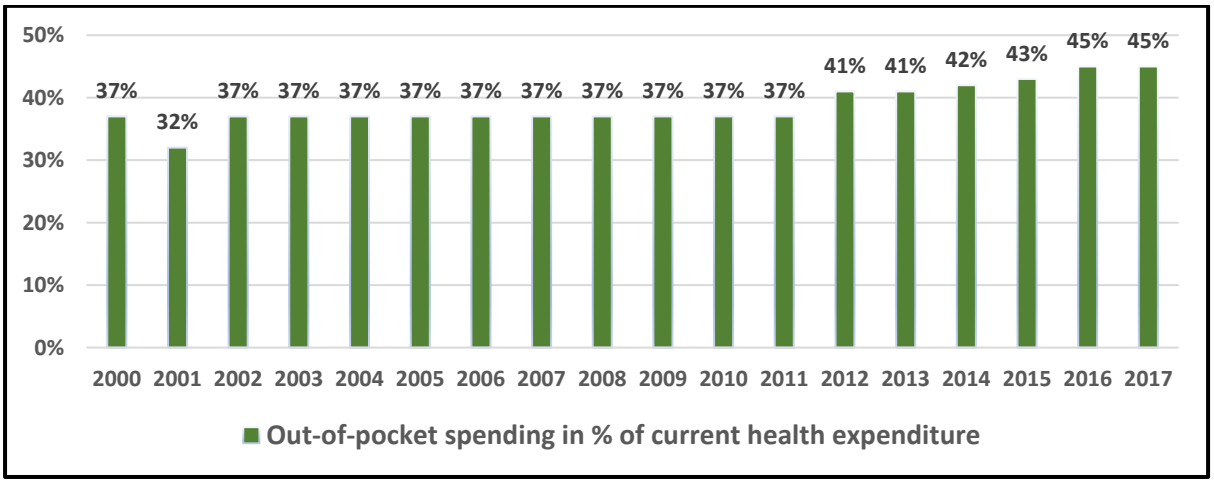

Figure-16: Out-of-pocket spending in percentage of current health expenditure in Vietnam (prepared by the author based on World Health Organisation 2020d).

Figure-16 shows the rising trend of OOP spending of Vietnam, which declined by 5% in 2001. The following year it increased by 5% making the percentage 37 again and remained constant up to 2011. Then the percentage started to increase, up to 42% in 2012 and 45% in 2017. Therefore, the expectation from health insurance in Vietnam is financial protection as well as a reduction of OOP and unexpected expenditure on health (Lee et al. 2019, pp. 10-1). Do, Oh and Lee (2014, p. 920) mention another limitation, namely, the expensive premium or contribution of the insured. This contribution is calculated on the basis of the minimum salary of an employee, where ability-to-pay is not considered. In addition, the health insurance fund still mainly depends on the government's general budget transfer (Teo et al. 2019, p. 33).

In brief, in 1992, when Vietnam introduced compulsory health insurance initially for the poor and workers in the formal sector, their economy was weaker than it is now, with a per capita income of US$ 130 only (The World Bank 2020f). In spite of its economic weakness, the country introduced health insurance and devised a long-term road map for expanding its coverage and gradually it became successful. It is obvious that the main reason for establishing public health insurance in Vietnam is the commitment of the government to ensure health rights to their citizens. Vietnam is a one party state, the president as the head of the government has changed ten times up to present (Sawe 2019), yet, they are continuing with PHI, which indicates their strong political commitment to this kind of policy reform. In addition, this scheme does not place an excessive burden on the state budget because there are provisions for

co-payments by some sections of the population. Yet, the informal sector workers are still not covered by the PHI scheme. They are in the voluntary scheme and the government provides 30% subsidies for their healthcare service. Perhaps, covering these groups of workers fully may put an additional burden on the government budget. **Table-2** below shows the features of Thailand, South Korea and Vietnam at a glance:

Features	Thailand	South Korea	Vietnam
Economic group	Upper-middle income	High income	Lower-middle income
GNI per capita (2019)	US$ 7260	US$ 33,720	US$ 2540
Health expenditure per capita (2017)	US$ 247	US$ 2,283	US$ 129.58
Rank among the most populous countries	20th	28th	15th
Enrolment procedure	Automatic enrolment by authorities	Active enrolment by beneficiaries	Active enrolment by beneficiaries
Level of subsidisation	Full	1. Partial (30%-50% for government, corporate and private school employees) 2. No subsidisation (self-employed)	1. Full (poor & disadvantaged people) 2. Partial (near poor, school going children & informal sector employees)
Benefit package	Inpatient and outpatient care; reimbursement for drugs included in the national list.	Healthcare service benefits, cash benefits, appliances as lease for concerned insureds	Inpatient and outpatient care; reimbursement for drugs included in the national list.
Fund	Multiple	Single	Single
Source of fund	Mainly tax-based and contributions of insured	Tax revenue, contributions of insured & private resources	Revenues, premiums, profits through investments from the fund, domestic & foreign aids
Population coverage (%)	100%	100%	87% (2018)

Table-3: Features of Thailand, South Korea and Vietnam at a glance (prepared by the author based on The World Bank 2020c,e,f; World Health Organisation 2020b,c,d; Social Security Act 1990 (Thailand); National Health Security Act 2002 (Thailand); National Health Insurance Act 1999 (South Korea); Law on Health Insurance 2008 (Vietnam); Vilcu et al. 2016; NHIS 2020).

3.4 Key findings from the three country cases

This research project has found some of the common factors that have underpinned the implementation of public health insurance schemes in Thailand, South Korea and Vietnam. These factors are political will; an efficient governance structure together with pragmatic strategies; and the modest design of the scheme.

First of all, political will or commitment is the most important driving factor, which influenced the establishment of health insurance schemes in the selected three country cases. When these schemes were introduced, the economies of these countries were not as developed as they are today. Besides, Vietnam, Thailand and South Korea are ranked 15th, 20th and 28th among the most populous countries in the world (Worldometer 2020). The noteworthy reason behind this kind of policy reform is the governments' will to provide healthcare service for their citizens at an affordable cost as well as to improve their health and wellbeing. In the case of Thailand, the UCS was part of the political manifestos in the general election of 2001. The winning Thai Rak Thai (TRT) party was in government and established the UCS in 2001 (Tangcharoensathien et al. 2018, p. 1211). Vietnam has also shown a clear political commitment to the advancement of healthcare facilities and the attainment of Universal Health Insurance Coverage (Tien et al. 2011, p. 38). In South Korea, the commitment to citizens as well as the commitment to international organisations, ensured that the government introduced a health insurance scheme. Although health related policy reform of South Korea is usually formulated based on the citizens' need, it is influenced by the political desire (World Health Organisation 2015, p. 19). In this way, political commitment has been a prerequisite for establishing PHI schemes in these three countries.

Secondly, efficient governance structures and pragmatic strategies are a common feature of all three countries that have enabled them s to introduce and implement their health insurance schemes efficiently. In Thailand, the strategies of means testing and 'Civil Registration' along with the 'Vital statistics' system, have helped with the identification, introduction and faster implementation of the three public schemes of the country (Tangcharoensathien et al. 2018, pp. 1210-2). Moreover, the referral system of gatekeeper and formation of price negotiation working, which helps to keep healthcare expenditure within the reach of the government (Sumriddetchkajorn et al. 2019, p. 416). In South Korea, there is a two-way relationship among insurer, insured and service providers, together with a review system for claiming long-term

care expenses (Ha et al. 2011, pp. 927-8) as shown in **Figure-11**. The South Korean government has centralised its regional health insurance societies into a National Health Insurance Service, as there were some disparities in regional health insurance societies (Kim & Lee 2010, p. 144). In Vietnam, the government adopted a gradual approach, which was a long-term roadmap to achieve Universal Health Insurance Coverage for their citizens (Yamada & Vu 2018, p. 3). In addition, the government has decentralised its healthcare facilities to make them more easily accessible for their citizens. Those countries which are struggling to move forward can learn from Vietnam's progress (Reinhardt 2019; Teo et al. 2019, p. 39).

Moreover, PHI schemes are modest in nature in all three countries reviewed. The governments of these countries are not the sole sources of finance for these schemes. There is a close-ended payment system for SHI and UCS in Thailand. For these two schemes, there is provision for contribution, even though the contribution for UCS is not significant. In the South Korean health insurance system, there are provisions for contribution and co-payment. In the case of insured employees, irrespective of whether they work for the public or corporate sectors, this contribution is to be paid by the employee and employer equally. Self-employed insured have to pay 100% of the contribution by themselves. Other insureds have to pay according to the predefined percentages. As in the case of the Vietnamese Health insurance system, there is also provision for premiums and co-payments. In respect of premiums, the insureds have to pay contributions as per the category they belong to. NHIS of Thailand efficiently mobilised both public and private resources for the purpose of purchasing healthcare services to cover of healthcare expenses (Kwon 2009, p. 63). Likewise, Vietnam has mobilised domestic resources along with foreign aid to lessen the burden on the government for covering health insurance expenses (Article 33, Law on Health Insurance 2008 (Vietnam), p. 17). Thus, health insurance does not put an excessive burden on the government's budget in all three countries.

Furthermore, Thailand's case indicates the positive impact of PHI in reducing OOP spending as well as in improving access to healthcare facilities, especially for the vulnerable groups. South Korea also has a declining trend in OOP spending even though it is not as significant. PHI in Vietnam has reduced households' health vulnerability particularly for the poor(Vo & Van 2019, p. 1). However, the study has found some problems in health insurance schemes in the three country cases. In South Korea and Vietnam, the benefit coverage of the health insurance scheme is low. There is also the challenge of fee-for-services caused by the dominance of private healthcare providers in the South Korean PHI system. There is expensive

premium or contribution of insureds in Vietnam, where contribution is calculated based on the minimum salary of an employee, where their ability-to-pay is not considered. The high priority that the Vietnamese government has accorded to expanding health insurance coverage and their relative inattention to providing high-level healthcare facilities, has had a negative impact on reducing OOP expenditure (Lee et al. 2019, pp. 10-1). In Thailand there are disparities in the benefit packages provided by the three existing PHI schemes. Each of these problems can be overcome with strategies that address the specific context of each country.

To sum up, what the foregoing cases reveal is that it is not only economically advanced countries that can implement public health insurance schemes but also less developed countries. All of the three countries reviewed have introduced PHI schemes at a time when their economies were not as developed as they are presently. Furthermore, the population of these countries is not small. Three key factors that contributed to the successful introduction and implementation of PHI schemes in these cases include political will, efficient governance structure and the modest nature of the scheme design. Pragmatic strategies help to lessen the burden on the government budget. Even though the schemes introduced by these countries are not without their shortcomings, nonetheless, health insurance scheme seems to be a policy, which provides healthcare services to their citizens and improves their health and wellbeing. It also reduces health vulnerability and the level of OOP expenditure, especially among the poor, if it is been appropriately designed and implemented according to the specific country's context. Thus, Bangladesh has ample opportunities to learn from these international practices when establishing a compulsory health insurance scheme initially for the female RMG workers. The next chapter analyses the grounds for Bangladesh to establish a compulsory health insurance scheme for these workers and identifies the lessons that Bangladesh can draw from the international practices.

CHAPTER 4
ANALYSIS

Chapter 3 examined the experience of public health insurance schemes in three Asian countries. What we have discovered is that the three key factors which contributed to the successful implementation of PHI schemes are political will; efficient governance structure and strategies and the modest nature of the scheme. These three factors are also likely to underpin the success or failure of this policy alternative for female RMG workers in Bangladesh. Fundamentally, the choice of a suitable scheme design is the most vital element in ensuring the effectiveness of this novel PHI scheme in Bangladesh. The aim of this chapter is to analyse the findings in the light of the information presented in the previous chapters and additional literature. This chapter is organised into two sections: the first section examines the grounds for Bangladesh to introduce a health insurance scheme for female RMG workers while the second section focuses on the potential for policy learning, and discusses the practical lessons that Bangladesh can draw from these international practices.

4.1 Grounds for Bangladesh to establish health insurance scheme for female RMG workers

There are a number of grounds for Bangladesh to establish a compulsory health insurance scheme for female RMG workers. Several studies (Fan et al. 2019, p. 9; Giedion and Díaz 2010, pp. 13-9; Levy and Meltzer 2008, p. 406; Bovbjerg and Hadley 2007, p. 1) have argued that health insurance can improve people's health and wellbeing by increasing their access to and use of health services. It is more effective for the vulnerable subgroups of the population, which include infants, children and lower income people. Furthermore, even though Rwanda is categorised as a low income country (The World Bank 2020d), it has covered 98% of its population through health insurance schemes (McNeil Jr 2013). Since 2000, the rate of maternal mortality has decreased by 60% and the child mortality rate under the age of 5 years has dropped by 70% (Twahirwa 2008, p. 824). The Philippines as a lower-middle income country (The world Bank 2020b), has brought 85% of the total population under government-subsidised health insurance, where 100% formal and nonformal employees are covered (Bredenkamp & Buisman 2015, p. 3). This health insurance coverage has had a positive impact on vulnerable and poor groups of the population. The three country cases are consistent with

this evidence and all of them initially introduced health insurance schemes for the poorer and vulnerable groups, which includes workers. The case of Thailand shows a sharp decline in child mortality as shown in **Figure-7.** A report shows that health insurance has increased the utilisation of healthcare facilities among poorer beneficiaries in Vietnam (Vilcu et al. 2016, p. 19), which has ultimately had a positive impact on their health. In South Korea, health insurance increases the frequency of using inpatient and outpatient healthcare services among lower income Koreans (Sohn & Jung 2016, p. 9). As female RMG workers of Bangladesh suffer from health complications and come from the poorer segments of the population, they cannot pay for their medical expenses with their limited income. Therefore, a compulsory health insurance for female RMG workers would increase their access to healthcare facilities and thereby improve their health and wellbeing.

Moreover, the literature shows that health insurance increases people's longevity and the productivity of the labour force (Bovbjerg & Hadley 2007, p. 2). All three case studies have shown that after the implementation of health insurance, the average life expectancy of those countries has increased **(see page-22, 27, 32)**. Thus, health insurance has a positive impact on increasing the lifespan of citizens. In addition, health issues cause a lack of concentration as well as low productivity amongst workers, while health insurance enhances the performance and productivity of an industry. Yamada and Vu (2018, p. 13) claim that employers could be encouraged to introduce health insurance schemes for their workers as such schemes can increase the profitability of their companies and enhance the productivity of their workers. Therefore, establishing a compulsory health insurance scheme for female RMG workers of Bangladesh would be beneficial not only for the garments industry but also for the overall economic development of the country.

Furthermore, in regards of OOP spending, the existing literature indicates that PHI reduces OOP as well as unexpected payments frequency for healthcare, particularly for the poorer section of the population (Giedion & Díaz 2010, pp. 13-9). The case of Thailand shows how PHI can have a positive impact in reducing OOP spending as well as in improving healthcare facilities, especially for the poor. South Korea has also experienced a decline in OOP spending although it is not so significant, amounting to only 10% in the 17 years from 2000 to 2017. The Vietnamese government has placed a high priority on expanding health insurance coverage, while placing a lesser priority on providing high-level healthcare facilities and on reducing OOP spending. This has compelled their citizens to take high quality of healthcare services on

their own. This has had a negative impact on the reduction of OOP expenditure (Lee et al. 2019, pp. 10-1). Yet, PHI reduces households' vulnerability particularly for the poor in Vietnam (Vo & Van 2019, p. 1). These issues raised by the experience of Vietnam could be addressed with the appropriate strategies in accordance with the specific context of Bangladesh. Therefore, the establishment of a compulsory health insurance scheme for female RMG workers would reduce their OOP expenditures and the unexpected payments frequency and thereby lessen their health vulnerability.

In addition, although there is no specific data on the extent to which PHI reduces gender inequality in access to healthcare in the three countries reviewed, the evidence from elsewhere shows that health insurance reduces gender disparity in accessing healthcare services (Institute of Medicine 2002, p. 80). Bangladesh is also committed to reducing gender inequality in all spheres of life including health facilities. According to part-3, section 28 of the 'Constitution of the People's Republic of Bangladesh', "Nothing […] shall prevent the state from making special provision in favour of women or children or for the advancement of any backward section of citizens" (Laws of Bangladesh 2020). Moreover, section 11 of the 'National Health policy 2011' of Bangladesh states that the right of women to having better physical and mental health will be ensured at all stages of their life cycle to establish gender equity. In addition, according to section 31 of this policy, special provisions will be made for the backward and vulnerable population to ensure health facilities for them (Ministry of Health and Family Welfare 2011). Likewise, section 10.00 of the 'National Labour Policy 2012' of Bangladesh asserts that as workers play a vital role in the production process, their physical and mental health are very important to enhance the national productivity. For this reason, the government will take necessary steps to introduce a health insurance scheme as well as to ensure the supply of necessary items for treatment (Ministry of Labour and Employment 2012). Thus, it seems that the establishment of a health insurance scheme for female RMG workers is consistent with the government's ideology. A pilot program named 'Health Insurance Scheme' is currently underway in a small scale for the households under the poverty-line in Bangladesh (Ministry of Finance 2019). Yet, the policy response of the government is not visible in terms of introducing health insurance for female RMG workers in Bangladesh. This is thought to be attributable to the lack of sufficient budget allocation as well to the fact that Bangladesh has the burden of a vast population. Above all, it is due to a lack of political will. Therefore, Bangladesh has the opportunity to learn from these foreign practices to introduce this novel policy alternative for its female RMG workers.

However, the evidence shows that there are issues associated with health insurance in lower- and middle-income countries. They confront challenges in implementing PHI schemes, especially to cover the workers in the informal sector and the poorer segments of the population. As these groups of the population do not meet the income threshold, the governments have to subsidise or exempt them from contributions (Vilcu et al. 2016, p. 2; Mathauer 2015, p. 13). Despite these issues, this policy reform could be established in a country like Bangladesh if there is political will; an efficient governance structure and suitable strategies; and a rational scheme design. As we can see in the three countries reviewed, they also confronted some challenges and limitations in introducing and implementing this policy. In South Korea and Vietnam, the benefit coverage of PHI schemes is low. In South Korea, there is also the challenge of fee-for-services caused by the dominance of private healthcare providers. There are expensive premiums or contributions from the insured in Vietnam, where the contribution is being calculated on the basis of the minimum salary of an employee, not on the basis of ability-to-pay. Whereas, in Thailand, there are disparities in the benefit package of the three existing schemes. Yet, as they do have political commitment; efficient institutional design along with pragmatic strategies; and moderate design of scheme, they have achieved considerable success in implementing this policy in their countries. Thus, there are opportunities for Bangladesh to learn from international practices in establishing a compulsory health insurance scheme initially for the female RMG workers.

4.2 Potential Policy Learning

In this section of the study, the concept of "lesson drawing" advanced by Rose (1991) together with that of "policy transfer" advanced by Dolowitz and Marsh (2000) have been used to understand Thailand, South Korea and Vietnam's health insurance practices. In the context of Bangladesh, there are rationales for "lesson drawing" for the purpose of establishing a compulsory health insurance scheme initially for female RMG workers. The current policy response for introducing health insurance remains poor, despite the presence of an opportunity for creating an efficient governance structure and for designing a scheme that suits the specific socio-economic and political context of Bangladesh.

It is high time for Bangladesh to draw lessons from international practices on public health insurance. The three countries introduced PHI schemes for workers and the poorer section of the population at a time when their country's economic conditions were not as prosperous as

they are currently. At the time these schemes were introduced, the per capita incomes of Thailand, South Korea and Vietnam were significantly lower **(see page-27, 32, 37)** than they are today. In 2019 the per capita income of Bangladesh was US$ 1940 (The World Bank 2020a). As capita income indicates the economic strength of a country, Bangladesh is in a better economic position to these three countries when they first introduced their health insurance schemes. Notwithstanding the economic challenges that they faced, these countries went ahead and successfully implemented these policies, which essentially shows that the economic challenge is not an insurmountable barrier. It can be overcome with the right kind of strategies. These countries started on a small scale and gradually expanded the scheme so that it became nationwide, which can be an important lesson for Bangladesh. Economic challenges can be seen in developed countries as well and that should not prevent the government from experimenting with new policies for the betterment of their citizens. All three of the countries reviewed have large populations. Vietnam, Thailand and South Korea are ranked respectively 15th, 20th and 28th among the most populous countries in the world, while Bangladesh is ranked 8th (Worldometer 2020). Therefore, Bangladesh can draw lessons from the countries reviewed by examining how and in what ways they have implemented their PHI schemes.

With respect to strategies and institutional design, the Vietnamese government adopted a gradual approach, which was a long-term roadmap for attaining Universal Health Insurance Coverage and covering 80% of the population by 2020 (Shillabeer 2016, p. 65). However, the government is ahead of its target and has covered 87% of the total population under SHI in 2018 (World Health Organisation 2020f). Initially in 1992, it introduced a compulsory SHI scheme for poor and formal sector workers. Later, it gradually expanded health insurance coverage to the self-employed as well as to employees in the formal sector (Vo & Van 2019, p. 2). As Vietnam and Bangladesh have socio-economic similarities, the long-term roadmap of Vietnam could be a practical and transferable lesson for Bangladesh. It is not possible for the government of Bangladesh to ensure coverage of the total population overnight because of the low budget allocation in the health sector relative to other countries and because of its huge population. Yet, it is possible to start in a small scale initially for the female RMG workers, which could then be gradually expanded.

Moreover, the South Korean government has centralised its regional health insurance societies into the National Health Insurance Service, as there were some disparities in regional health insurance societies (Kim & Lee 2010, p. 144). Conversely, the Vietnamese government has

decentralised its healthcare facilities from central and provincial levels to district and community levels, which made healthcare facilities easily accessible for their citizens (Reinhardt 2019; Teo et al. 2019, p. 39). It was possible for Vietnam to cover the population rapidly under their SHI scheme because of the government's pragmatic institutional design and strategic approach (Reinhardt 2019). In Bangladesh, initially health insurance system could be centralised because most of the garments industries are in the Gazipur district, which is very close to the capital city Dhaka, a few are in the district of Chittagong. When the scheme would cover the total population of the country, at that time the health insurance system could be decentralised for better implementation.

Furthermore, the strategy of 'means testing' for the identification of insureds in Thailand would be a very good lesson for Bangladesh because this will enable the government to find the eligible insureds among the vast population. The system of 'Civil Registration' along with the 'Vital Statistics System' in Thailand have helped faster implementation of the three public schemes, namely CSMBS, SHI and UCS. These systems provide a unique ID for each citizen, which helps to identify members of the scheme and to register them with a network of healthcare service providers according to their preference. This lesson is also feasible and transferable to Bangladesh because the country already has a unique National ID card, namely a 'Smart Card' for each of its citizens, which they can use to obtain any kind of services from the government (Bangladesh Election Commission 2020). This ID card can easily be used for introducing health insurance in Bangladesh.

In addition, the government of Thailand has adopted several strategies to lessen the excessive expenditure for healthcare, which include the formation of a price negotiation working group as well as the referral system of gatekeeper. These strategies help to keep the healthcare expenditure within the reach of government. This is why, Thailand spends in its health sector around 4.1% of the GDP, which is lower than that of several middle and higher-income countries that expend about 7-11% of their GDPs (Sakha, Bahmanziari & Takian 2019, p. 1158). These strategies of Thailand could benefit Bangladesh by enabling it to reduce the financial burden of health insurance on the government. In South Korea, there is a two-way relation between insurer (NHIS), insured and service provider as shown in **Figure-11**. Here service providers cannot directly claim long-term care expenses of healthcare services and drugs from the NHIS. After being reviewed by HIRA service, NHIS provides these expenditures to them (Ha et al. 2011, pp. 927-8). Moreover, NHIS efficiently mobilised both

public and private resources for purchasing healthcare services for citizens and for covering healthcare expenses (Kwon 2009, p. 63). Vietnam has successfully mobilised domestic resources along with foreign aid to lessen the financial burden on the government of covering health insurance expenses (Article 33, Law on Health Insurance 2008 (Vietnam), p. 17). As we can also see Rwanda has successfully mobilised funds from domestic and external sources to cover the expense of health insurance (Abbott, Sapsford & Binagwaho 2017, p. 111). Bangladesh can draw lessons from South Korea, Vietnam and Rwanda as the allocation of funds for the health sector remains low in the country and it carries the burden of a vast population. The government also needs to take the necessary steps to collect funds from public, private and international donor agencies to cover the expense for health insurance.

Likewise, in all of the three countries reviewed, health insurance schemes do not place an excessive burden on the government budget because of the modest design of the schemes. The governments of these countries do not entirely finance these schemes. In the case of Thailand, there is a close-ended payment system for SHI and UCS. For these two schemes, there is provision for contribution, although the contribution for UCS is not significant. In the South Korean PHI system, there is provision for contribution and co-payment. In the case of the employee insured, regardless of whether they are located in the public or corporate sectors, this contribution is to be paid by employee and employer 50% each. Self-employed insured have to pay 100% of the contribution by themselves. Other insureds have to pay according to the predefined percentages. In the Vietnamese PHI system, there is also provision for premiums and co-payments. In case of workers in Vietnam, the premium is 6% of their minimum monthly salary or remuneration, where the employer has to pay two-thirds and the employee has to pay one-third of the amount (Article 13, Law on Health Insurance 2008 (Vietnam), p. 10). Thus, the PHI schemes do not place an excessive burden on the government's budget in these three countries. In Bangladesh, none of the mentioned practices can be fully copied and pasted because every country has distinctive features which derive from its unique socio-economic and political contexts. As the RMG female workers in Bangladesh are paid low salaries, any contribution for premiums would be a financial burden for them. This is why, they could be either exempted from paying such premiums or required to pay only a negligible amount. Indeed, employers and the government could pay the contributions for these groups of workers. As these workers are the key drivers of the Bangladesh economy, investment in their health would be economically beneficial for both employers and the government. Such investments would increase their productivity, as several studies have shown.

Above all, political will is necessary for establishing a compulsory health insurance scheme for female garments workers in Bangladesh. Although Rwanda is a low income country (The World Bank 2020d), it has covered 98% of its population through health insurance schemes (McNeil Jr 2013). This has been possible because of strong political commitment and pragmatic strategies (International Labour Organisation 2016b). Rwanda is therefore a role model for other economically weak countries in the world due to its universal healthcare coverage (Twahirwa 2008, p. 824). As we can also see, while the governments of these countries have changed, they have nonetheless continued with their PHI schemes, which is a manifestation of their political commitment to this policy reform. In Thailand, the Thai Rak Thai party was in power when the Thai government established the UCS in 2001 as a part of their political manifesto (Tangcharoensathien et al. 2018, p. 1211). This policy agenda did not suddenly arise in their political manifesto; the support base of this party is the rural Thais and urban poor, rather than the elite or middle class. They came to power because they were supported by these groups of ordinary people and masses (Huang & Thananithichot 2018, p. 215). The party itself has an inherent inclination to favour the poor and ordinary Thais. The UCS scheme as a policy commitment came from this political ideology, which is reflected in their election manifesto. They implemented this policy when they came to the power.

Vietnam is a socialist country, which is led by the 'Communist Party of Vietnam (CPV)' (Vietnamese Embassy in Australia 2020). In spite of criticisms of the socialist system, a positive aspect of this system is that they care about the ordinary people, the welfare of the people. The communist philosophy itself talks about equality, equity, uniformity and distribution system (Hardt 2010, pp. 134-5). Therefore, the Vietnamese government is expected to have a greater commitment to these kinds of policies, which include health insurance. In addition, the fact that the government is committed to attaining Universal Health Coverage as a part of SDGs, enabled it to devise a long-term roadmap for reaching Universal Health Insurance Coverage for their citizens (Yamada & Vu 2018, p. 3).

On the other hand, South Korea is a democratic republic with a presidential system (Library of Congress 2020). Although in 1961, Park Chung-Hee came to power through a military coup, he re-established the Korean republic adopting a presidential system in 1963 (Britannica 2020). Despite some controversies in his 18 years regime, he played a predominant role in shaping the country (Podoler 2016, p. 271). During his tenure, this country experienced radical industrial

development and economic growth (HISTORY 2018). As he wanted to stay in power for a long time, he undertook many policy reforms for the benefit of the country as well as for its citizens. One of those reforms was the establishment of a compulsory health insurance scheme for industrial workers and their dependents.

If any government cares for the people and wants to win their hearts and minds, these kinds of policy reform can be expected to earn them greater legitimacy, which is valid for Bangladesh as well. In Bangladesh, a democratic government is in power and the basis of the government should be the people. As stated by Abraham Lincoln, the sixteenth president of the United States of America, democracy is the "government of the people, by the people, and for the people" (Minkenberg 2014, p. 53). The government of Bangladesh has to address the concerns of the people. As the female RMG workers are making an enormous contribution to the economy, any responsible government should pay attention to their welfare in terms of health and wellbeing. Therefore, the Bangladesh government should introduce policies to address their needs, which would eventually help the government to earn greater legitimacy.

However, there is no one specific formula for expanding health insurance coverage which suits every political setting. Consequently, countries must adapt policies and necessary measures according to their own contexts (Sakha, Bahmanziari & Takian 2019, p. 1158). Due to the poor policy response of the Bangladesh government to the health issues confronted by female RMG workers and to the task of establishing a compulsory health insurance scheme for them, Bangladesh should seek to draw lessons from international practices and to undertake policy transfer. Policy transfer from other political settings is easier for policymakers than making a new policy because proven solutions can be easily obtained (Dolowitz & Marsh 2000, p. 14). Moreover, the practicability of a policy is considered to be a motivation, which should not be ignored in the process of policy transfer. Rose (1991, p. 24) argues that "the ideal programme is both practical and desirable". Considering the overall literature and the experiences of the three country cases, it seems that the introduction of a compulsory health insurance scheme as a policy alternative for female garments workers is a practical idea that is transferable to Bangladesh. Rose (1991, p. 6) recommends that modifications are required to minimise risks considering the historical, cultural as well as institutional contexts of a country, which is going to receive the idea. This is why, policy actors need to engage in the process of rational policy transfer by drawing upon the best international practice that suits the Bangladeshi socio-economic and political contexts. Therefore, a thorough assessment is required to avoid adverse

consequences of the policy and to set a modest design of scheme, which would not put an excessive burden on the government's budget and which would improve the health and well-being of this group of workers.

To sum up, health insurance can improve the health and wellbeing of the poor and vulnerable groups of the population by increasing their access to and use of health services. It can increase peoples' lifespans and improve the productivity of the labour force. It can also reduce OOP expenditures and lessen the gender disparity in accessing healthcare services. Economic development is not a major prerequisite for the introduction and implementation of public health insurance schemes because the three countries introduced these schemes when their economies were weaker than they are today. Likewise, a huge population is not a major barrier. The three factors that contribute to the successful implementation of this type of policy include political will; efficient governance structure and strategies; and the modest nature of the scheme design. Considering the constitution, health policy and labour policy, it seems that the establishment of a scheme for female RMG workers is consistent with the government's ideology. Yet, as per poor policy response to the health issues of these workers, the government of Bangladesh has opportunities to draw lessons and undertake policy transfer from international practices. Considering the overall literature and the experiences of the three case studies, it seems that the establishment of a health insurance scheme for female RMG workers is a practical idea that could be transferred to Bangladesh. The government of Bangladesh needs to take the necessary steps that are in accord with the country's context. Therefore, Bangladesh can establish a compulsory health insurance scheme initially for female RMG workers even though the country has a low budget allocation for its health sector in comparison to its large population.

CHAPTER 5
CONCLUSIONS

In this research project, it has been argued that despite a low budget allocation for the health sector and the burden of a vast population, Bangladesh can establish a compulsory health insurance scheme initially for female RMG workers, which could then be gradually expanded. This scheme would improve these workers' health and wellbeing without putting an additional burden on out-of-pocket expenditures, and would ultimately contribute to the overall economic development of Bangladesh.

The RMG sector is the key driver of the Bangladesh economy. Most of its workers are female and the national economy very much dependent on them. They suffer from various diseases and cannot afford medical treatment on their limited income. Yet, there is a little attention paid to these female RMG workers' health and well-being by the government. This study has considered health insurance as a potential policy alternative to address the health problems confronted by these workers. It has investigated the possibility of establishing a compulsory health insurance scheme for them. The present study has adopted a qualitative approach through a review of secondary data. Case studies have been conducted on the public health insurance practices of the three Asian countries: Thailand, South Korea and Vietnam.

From the three country cases, the study has found that it is not necessarily the case that only economically advanced countries can implement a PHI scheme. All of these countries introduced PHI schemes when they were not as economically advanced as they are today. Furthermore, their population is not small, since Vietnam, Thailand and South Korea are ranked respectively 15th, 20th and 28th among the most populous countries in the world, while Bangladesh is ranked 8th. Some of the common factors that have contributed to the successful implementation of PHI in these instances are political will, efficient institutional structure and the modest nature of the scheme design. Despite their economic challenges and a large population, these countries have pursued these policy reforms and in so doing have achieved considerable success, which essentially shows that economic challenges and a large population are not insurmountable barriers. They can be overcome with the right kind of strategies. These countries started in a small scale and gradually expanded the scheme so that it extended nationwide, which can be an important lesson for Bangladesh. In Thailand, the strategies of means testing, 'Civil Registration' along with 'Vital statistics' system, have helped with faster implementation of PHI schemes. Moreover, the referral system of gatekeeper and formation of

price negotiation working helps to keep healthcare expenditure within the government's reach. In South Korea, there is a two-way relationship among insurer, insured and service providers, together with a review system for claiming long-term care expense. The South Korean government has centralised its regional health insurance societies into a National Health Insurance Service, as there were some disparities in regional health insurance societies. In Vietnam, the government adopted a gradual approach, which was a long-term roadmap for attaining Universal Health Insurance Coverage for its citizens. Furthermore, the government has decentralised its healthcare facilities thereby making them more accessible for their citizens. These three countries have followed different strategies, yet they have achieved significant success. In these countries, PHI schemes do not place an excessive burden on the government budget because of their modest nature. The governments are not the sole providers of finance for these schemes and there are provisions for contributions and co-payments. Yet, the scheme design of these three countries has its shortcomings, which could be overcome with the right kind of strategies.

In the Bangladesh context, there are a number of grounds for establishing a compulsory health insurance scheme for female RMG workers. Health insurance can improve their health and wellbeing by increasing their access to and use of health services. It thereby lengthens their lives and increases their productivity. It also reduces OOP expenditures and lessens health vulnerability particularly of the poor. Furthermore, health insurance reduces the gender disparity in access to healthcare services. Therefore, a compulsory health insurance scheme for female RMG workers would ensure that they have greater access to healthcare facilities and would improve their health and wellbeing. This would be beneficial not only for the garments industries but also for the overall economic development of Bangladesh. Thus, the establishment of a compulsory health insurance scheme for these workers is an economically sensible policy option for Bangladesh.

This study has examined the possibility of establishing a compulsory health insurance scheme in Bangladesh based on the concepts of policy learning and policy transfer. The Vietnamese government's long-term road map would be a practical and a transferable lesson for Bangladesh because it is not possible for the government to cover the total population overnight due to the low budget allocation in the health sector and a huge population. The health insurance system in Bangladesh initially could be centralised as it is in South Korea because most of the garments industries are located in the Gazipur district, which is very close to the capital city Dhaka. When the scheme would cover the total population of the country, at that

time the health insurance system could be decentralised as in the case of Vietnam for better implementation. In addition, the formation of a price negotiation working group and the referral system of gatekeeper strategies adopted by Thailand could be beneficial for Bangladesh by enabling it to reduce the financial burden of health insurance on the government. South Korea, Vietnam and Rwanda have successfully mobilised domestic resources along with foreign aid to reduce the burden on the government budget of covering health insurance expenses, which would be another feasible lesson for Bangladesh as the budget allocation for the health sector remains low in the country. Thus, Bangladesh has ample opportunities to learn from these international practices in order to establish a compulsory health insurance scheme initially for the female RMG workers.

Although there are provisions for contributions and co-payments in the PHI schemes of the three country cases, as the RMG female workers in Bangladesh get a low salary, making contributions for premiums would be a financial burden for them. This is why, they could be either exempted from paying premiums or required to pay only a negligible amount. Employers and the government could pay the contributions for these groups of workers. As these workers are key drivers of the Bangladesh economy, investment in their health would be economically beneficial for both employers and the government since this would increase their productivity. The government of Bangladesh needs to devise its own scheme that is appropriate to its socio-economic and political contexts, because there is no single formula that can be copied and pasted from one country to another. Policymakers should seek to engage in a rational policy transfer process in order to address the health issues of these workers. Here international practices need to be carefully examined and assessed so that policymakers can avoid any adverse consequences when undertaking this policy reform and set modest ambitions when designing the scheme. Therefore, Bangladesh can establish a compulsory health insurance scheme initially for female RMG workers, which could then be gradually expanded nationwide. As Bangladesh has not adopted a health insurance policy for female RMG workers, the implications of implementing this policy are yet to be seen. The findings of this study provide significant insights for the government in establishing compulsory health insurance for female RMG workers in Bangladesh as well as in other parts of the world that have similar issues.

Despite these findings, there are some limitations with the present study, which should be noted. This is a new area of research. As such, there is inadequate literature on the topic from the Bangladesh perspective. Likewise, there is a scarcity of data suitable for cross-country

comparison. Besides, for this study, empirical research and statistical testing have not been undertaken. This research project is limited to a qualitative approach based on a review of the secondary data. This study has not been able to undertake survey/interviews in order to capture stakeholders' perspectives (e.g. female RMG workers and policymakers). It has not been able to address the other factors that are related to female RMG workers' life and livelihood and that would determine the success or failure of a health insurance policy. This study has covered the social and economic benefits of establishing a compulsory health insurance policy in accordance with the socio-economic and political context of Bangladesh. A quantitative approach based on statistical analysis of primary data may provide more accurate result. Therefore, a long-term empirical study is recommended, which can overcome these limitations by using primary data and statistical tests for making the result more robust.

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