COMMUNITY BASED HEALTH INSURANCE SCHEMES: A COMPARATIVE REVIEW

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CERTIFICATE

This dissertation entitled, "**COMMUNITY BASED HEALTH INSURANCE SCHEMES: A COMPARATIVE REVIEW**" is submitted in partial fulfillment of the requirements for award of the degree of Masters of Philosophy, of Jawaharlal Nehru University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work

(Kaushik Saikia)

We recommend that this dissertation be placed before the examiners for evaluation.

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To Emon and Maina...

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List of Abbreviations

AHA	American Hospital Association
AIDS	Acquired Immuno Deficiency Syndrome
AMA	American Medical Association
CBHI	Community Based Health insurance
CBO	Community Based Organization
DFID	Department for International Development
GDP	Gross Domestic Product
Govt.	Government
GTZ	German Technical Assistance
HIV	Human Immune Virus
HR	Human Resources
HSS	Health Service System
ILO	International Labour Office
NGO	Non Government Organization
NHI	National Health Insurance
NHS	National Health Service
OECD	Organization for Economic Cooperation and Development
SEWA	Self Employed Women's Association
SHI	Social Health Insurance

TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United State Agency for International Development
WHO	World Health Organization

INTRODUCTION

INTRODUCTION

Health of people has been determined by the interaction of many factors, the socio economic context of people's lives and the environment they live in. According to Health Canada [1] the health determinants are a complex network or web of interchangeable variables that facilitate depiction of the health of an individual or a population. The recognition to social relationship also influenced the issue of rights of choices and provisioning of choices by appropriate authority. The recognition of interdependence of individuals and community was a big step forward to understand health in a holistic way. The impact of poverty, livelihood, employment, social discrimination on individual life and health can be seen as Social Determinants of Health Report.[2]

Organization of health services is a crucial aspect of ensuring health to all. The health service system consists of different sub systems with the primary aim of promoting, restoring or maintaining health of individuals and communities through systematic interaction of people, organization and actions done by different partners and stakeholders.[3] A health service system is therefore more than a structure of publicly or privately owned facilities that deliver personal and public health services. The organization and operation of health service system is influenced by certain core values like equity, social justice, universality, people-centredness, community protection, scientific soundness, self-determination, and self-reliance etc.[4] These underpinning factors make the health service system responsive, efficient and effective. The goal of

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[1] What Determine Health?, As Available in http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php as accessed in 02 Jan, 2010

[2] CSDH, 2008, '*Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*'. Final Report of the Commission on Social Determinants of Health, Geneva, World Health Organization

[3] WHO, 2007, '*Everybody Business: Strengthening Health Systems to Improve Health Outcomes : WHO's Framework*. Geneva, WHO Press

[4] Drouin, A. 2007, '*Methods of Financing Health Care: A Rational Use of Financing Mechanisms to Achieve Universal Coverage*', Technical Commission on Statistical, Actuarial and Financial Studies, World Social Security Forum, Moscow.

the health service system as described by WHO[5] is to deliver effective, safe, quality personal and non-personal health interventions to the people whenever and wherever required ensuring equity in distribution and access. It is also supposed to make provision for adequate resources so that people are protected from any kind of financial catastrophe because of health reason and can have access to assured quality of medicine, curative care and diagnostic facilities which are safe, efficient, cost effective and appropriate technology. The health service system also thrives to maintain and develop a competent pool of human resource which will provide, manage and strewed the health service system with available information, effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system-design, and accountability to achieve the stated objective of the system. The objective health service is achieved through the selection of methods of financing, structure for health services delivery and payment for health care providers.

One of the major subsystems of the health service system is health financing system. The World Health Report 2000[6] states that the purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care. This means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so. The health financing system is crucial to delivery of health service system as the entire provisioning and management of health service system depends upon effective financing. The provisioning of health care services, ensuring proper functioning of health care, availability of medicine and diagnostic facilities and human resources are directly related to health care finance. To ensure that every individual has access to health care

[5] WHO, 2007, *op cit*

[6] WHO, 2000, '*The World Health Report 2000 - Health Systems: Improving Performance*'. Geneva. pp 24-25

services and provisioning, the health financing system carries out three major functions of revenue collection, pooling of resources and purchasing of health care services.[7]

The method of health financing considerably influences health status of poor especially in the developing countries. Among developing countries the level of spending in health is significantly low to ensure equitable access to health services and interventions for all. The non availability of sufficient resources for operating the health service system increases out of pocket expenditure pushing many people into medical poverty trap. Governments in most countries constantly struggle to raise sufficient funds to purchase health services to meet increasing demands of quality health services for its population. It always remains a tough decision for government, policy makers and health economists to decide how to raise sufficient funds for health, spread the financial burden, pool the risk and use the resources effectively, efficiently, and equitably. Countries make different decisions in each of these areas, so the resulting financing systems vary in areas such as the mix between taxes and insurance, and between public and private funding and provision.[8]

The approaches to mobilize resources typically include a mixture of general taxation and contributions to public health service systems and private health insurance schemes. The main methods of financing for health care include the national health insurance system, general revenue, private insurance, community-based insurance and out-of-pocket payments. The choice of method will impact on who bears the financial burden, the amount of resources available and who manages the allocation of resources.[9]

According to the WHO National Health Accounts 2004, at global level the government shares 33%, social health insurance contributes around 25%, private health insurance accounts for 20% and out of pocket health expenditure accounts for 22% of the global health expenditure. In low and middle income countries high out of pocket expenditure

[7] Schieber, G. et.al. 'Financing Health Systems in the 21st Century' in Jamison T. Dean et. al. (eds). 2006. *Disease Control Priorities in Developing Countries*; Oxford University Press, New York. ch.12

[8] *ibid*

[9] Drouin, A. 2007, '*op cit*

is the biggest problem for accessing health facilities. Out-of-pocket expenditure ranges between 50 to 80% of total health expenditure in a number of countries of Africa and Asia. WHO National Health Accounts of 2006 indicate that out-of-pocket expenses were 77% of total health expenditure in Burundi, 82% in Congo, 58% in Bangladesh, and 70% in Cambodia.[10]

The methods of health financings are methods of risk pooling and spreading the financial burden. Although the conceptualization of the methods are different, the main task of all the methods is to raise the resources to fund the health services delivery, purchase and distribute the services and pay incentives for the providers. These models are not exclusive; in most countries a mixture of various models are used. The health finance systems are either based on the tax revenue and social insurance (Like National Health System of UK and Social Health Insurance of Western Europe), private insurance schemes like in the United States, private source and out of pocket expenditure in most of the low and middle income country, grants and other source of financing which can be seen in mainly in the poorest of the poor countries where the health service systems are completely dependent on external assistance and community based health insurance which is one of the emerging methods of health care financing.[11,12]

The problem with the health care delivery is that even with the existing methods which are implemented and experimented in different countries still people's access to health service remains a challenge. The global experiment with the market led system of health financing also could not ensure equitable health access, affordable treatment, universal coverage and comprehensive health care to all.[13] While the world determined to achieve the health for all by 2000, in many low and middle income countries more than 50% of

[10] Drouin, A. 2007, *op cit*

[11] Green, A. 1999, '*An Introduction to Health Planning In Developing Countries*'.Oxford University Press. New York

[12] Mills, A. and Ranson, K. 'The Design of Health System' in Merson , M et.al (eds),2005. *International Public Health : Diseases, Programs, System and Policies*, Massachusetts, Jones and Bartlett Publishers,

[13] Ghosh, B. 2008, 'Rich Doctors and Poor Patients: Market Failure and Health Care Systems in Developing Countries'; *Journal of Contemporary Asia*, 38(2), pp 259 – 276

the population are still beyond health safety net. The Millennium Development Goals also fails to achieve its targets related to health in most of the countries. The dysfunction of the health care becomes a social problem forcing many countries to rethink their health service system.

Rationale of the Study

The study tries to look at the question of health care financing in the context of globalization and liberalization over the last three decades. Most of the countries are limiting or reducing national budget on the healthcare, reducing public health care service provisioning. The evidence across the world shows that the public spending on health and education are either stagnating or reducing in low, middle and high income countries[14].With this stagnation and shedding of public responsibility a greater space, role and responsibility for the private sector emerges with the argument of efficient and the better service provisioning. The OECD data shows that in the countries where social health insurance or comprehensive health insurance exists, even there is a duality of private and public health care system and the private health care is receiving increasing importance.[15] Although the market was supposed to provide efficient- effective and affordable health care services but in reality increased role of market has produced inequalities in access. The expensive private health care especially in the low and middle income countries and often urban centric concentration of the market led health care provisioning is most of the time not accessible for the rural and poor people. This is a clear mark of market failure. With limited state health coverage and unaffordable private health care people from the low and middle income group suffered most resulting in a differential pattern of health care service utilization. Because of the failure in part of both public and market led services and the changing global economic and health policies, the government across the globe started looking at alternative health financing methods to protect the interest of the poor and ensuring health services

[14] Bonila Chachin, M. et.al. 2003, '*Health Care During Transition And Health Systems Reform*', Lucerne Conference of the CIS-7 Initiative, January 20-22, Switzerland

[15] Tuohy, C. et. al. 2004, 'How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD Nations' ;*Journal of Health Politics, Policy and Law 29 (3)*, pp 359-396

accessibility to a certain level. Community Based Health Insurance is one such mechanism promoted to mitigate the effect of the rapid change in the health sector and has been seen as a tool to ensure equity, universality in the health care provisioning which is sustainable and can be replicated. The concept of the CBHI has found takers in the World Bank and WHO as the one of the viable methods of alternative health care financing. The question remains how effective is CBHI as an alternative to health care financing, how effectively it address the question of equity, universality and sustainability of health care services, meets gaps between the demand and supply of the services and how viable it is to replicate and scale up in larger way and not remain as an adhoc mechanism. Also the nature of the evidences generated over the years need to be analyzed carefully to examine whether these examples are promoting some specific model of CBHI.

Research Objective

The broad objective of the study is to understand the working of the CBHI models and the historical development of CBHI.

The specific objective of the study is to understand –

1. The working of Community Based Health Insurance across low and middle income countries.
2. The extent of achievement of the principle of equity and universality by the CBHI.

Methodology

The study is descriptive and analytical in nature where the published material (articles, books and working and discussion papers) both physical and online are reviewed and analyzed to find out the objective defined. The study is based on secondary data source

and the data selection is done through both published and online literature using physical and online search mechanism limited to English language.

Relevant websites and the online resources of relevant international organizations, electronic database and academic and research centers were also searched. A screening of the reference list of relevant papers and reviews was undertaken.

The electronic search was done in two stages. Firstly the key word based search of the database. The main keywords used are Community Based Health Insurance, CBHI, Social Health Insurance, Out of Pocket Expenditure, Review of CBHI, Evidence of CBHI, Review of CBHI Evidence, Health Insurance, and Community Initiative in Health Financing. The search was done on the title level at the database. Secondly the search was done to include only the low and middle income countries from Asia and Africa. The evidences from the developed countries and countries from Latin America are not included.

For physical search the journals and books available on the CSMCH documentation centre and University Central library was used. The same key concepts were used to do the physical search and more over the reference checking of the published work are used to find the books and articles.

Electronic database used:

1. Jstor
2. Pubmed
3. Oxford University Journals
4. SAGE Online Journals with Back files
5. Science direct (Elsevier) with back files
6. Springer Link
7. Taylor and Francis
8. Wiley Inter-science with back files
9. Google and Google Scholar

Chapterization

The study has four chapters. Chapter 1: Health Service System and Health Care Financing tries to looks into the different health service system and health care financing system currently been in operation and the evolution of the same from the philosophical undercurrent. Chapter 2: Health Insurance and History of development tries to find out the historical development of three major forms of health insurance i.e. the Social/ national health Insurance, The Private Health Insurance and the Community Based Health Insurance. The Chapter 3: Community Based Health Insurance: Modalities and models describe and analyze how CBHI works, its typology and the popular models of CBHI their linkages and operational details. The final Chapter .i.e. Chapter 4: Community Based Health Insurance: reviews of schemes reviews the CBHI schemes from Africa and Asia and also includes the concluding inferences and observations.

CHAPTER - 1

HEALTH SERVICE SYSTEM AND HEALTH CARE FINANCING

HEALTH SERVICE SYSTEM AND HEALTH CARE FINANCING

Defining Health Service System

Conceptualizing the term "health" has been complex and difficult. The term has been defined from many perspectives. Initially the term health had a very organic definition, which was limited to body, its organs and bodily function and abilities. This organic definition of health ignored the entire range of socio economic and political issues which play a major role in determining health outcomes and provisioning of health services. WHO in 1946 for the first time tried to define health in a holistic way by adopting the definition of "A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".[16] In 1984 WHO extended the definition to include "The extent to which an individual or a group is able to realize aspirations and satisfy needs, and to change or cope with the environment; health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capabilities"[17] in the exiting definition of health. The idea of including social relationship, individual aspiration and political aspect of life to the existing definition would have created a holistic perspective of health and its scope. The concept of health is thus influenced by the interplay of macro, meso and micro level socio economic, political and other factors or determinants of health.[18]

1.1. Determinants of Health

Health of people both at community level and individual level has been determined by the interaction of many factors, the socio economic context of people's lives and the

[16] Preamble to the Constitution of the World Health Organization, 1946, as available on http://www.who.int/about/definition/en/print.html as accessed on 18th December 2009

[17] Wanke, M. et.al. 1995, '*Building A Stronger Foundation: A Framework For Planning And Evaluating Community-Based Health Services In Canada*', Health Canada, Ottawa, p 8

[18] *ibid*

environment they live in. According to Health Canada[19] the health determinants are a complex network or web of interchangeable variables that facilitate depiction of the health of an individual or a population. Most of these factors are beyond control of individuals or communities and involve macro level factors. WHO recognized the following factors as determinants of health but it is not limited to those discussed below.[20] The determinants of health cover a much wider range of issues and these include socio economic, physical, environmental, individuals characteristics and behavioural aspects –

1.2.1. The Social and Economic Environment Determinants

Income and social status are significantly linked to quality of health. People with high income level have proportionately better and safer living environments, access to education, and control over their livelihood and food security. The right to property, better governance, level of corruption, power structure and social inclusion and exclusion, political stability and political system impacts upon the health. Factors like access to finance, education, transportation and communication facilities, level of industrialization and urbanization also influence the health outcomes and status of individuals and communities.[21,22,23]

1.2.2. The Physical Environment Determinants

The physical environmental factors such as quality of air, safety of drinking water, source of energy for household activity, regulations on food and food production, composition of soil, safe houses, roads, employment and working conditions, waste

[19] What Determine Health?, *op cit*

[20] The Determinants of Health. as available http://www.who.int/hia/evidence/doh/en/ as accessed on 02-02-2010

[21] Stevens, P. 2005, 'The Real Determinants of Health', International Policy Network, London UK

[22] What Determine Health? *op cit*

[23] The Determinants of Health. *op cit*

disposal facilities that are available to us, all are vital to the health and well-being of a population.[24,25]

1.2.3. Individual Characteristics and Behavior Determinants

Genetic inheritance has a direct impact on predisposing people to specific ailments and certain diseases. Health related behavior and self care strategies also determine the health status of community and individuals.[26,27]

1.2.4. Social Support Network Determinants

Health outcome of the individuals and community are also determined by the availability of social support networks and the cohesiveness of society. Existence of meaningful relationships at individual and community level, recognizing and appreciating diversity enables people of various backgrounds to develop a sense of belongingness and feeling supported. Simultaneously access to social support, participation in community organizations enhance health outcome of individual and community, by giving an increased sense of self worth and heightens stability which impacts positively in case of a health emergency or challenge.[28,29]

1.2.5. Gender and Cultural Determinants

Gender determines societal roles, personal characteristics, ways of thinking and being. These differentiations lead to the differential disease pattern among man and women in different stage of life. Differential access to health services, its utilization and health seeking behavior due to gender effects the quality of life due to existing male hegemony and patriarchy. The same holds true for culture. The customs, tradition and common practices greatly influence the health of community and individuals as well as their quality of life. Every culture defines disease and treatment in its own evolutionary

[24] What Determine Health? *op cit*

[25] The Determinants of Health. *op cit*

[26] What Determine Health? *op cit*

[27] The Determinants of Health. *op cit*

[28] What Determine Health? *op cit*

[29] The Determinants of Health. *op cit*

context which influences health care seeking behavior, lifestyle and reaction to health challenges.[30,31]

1.2.6. Health Services as Determinants

Among all the determinants of health, health service system plays a key role in reducing mortality and morbidity among population. The structure of health functioning and provisioning of health services has direct bearing on people's lives by ensuring the accessibility and availability of the required services, responsiveness of the system to emergency, occurrence of acute diseases and epidemics and other health related events.[32]

It is of immense importance that people have the access to health care facilities for treatment and care when necessary and to promote good health in general. Health service system determines the structure of health organization, the provisioning and management of the services, level of care to be provided at various service delivery points, standard operating protocols and policy decision related to health accessibility, regulation and control of medical care, diagnostics and pharmaceuticals etc. The health service system determinants also includes health financing, convergence with other system, preventive and promotive health, and peoples participation in decision making and planning.

1.3. Defining Health Service System

WHO defines health service system[33] as "consisting of all organizations, people and actions whose primary intent is to promote, restore or maintain health". This includes efforts to influence determinants of health as well as more direct health-improving activities. A health service system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring

[30] What Determine Health? *op cit*

[31] The Determinants of Health. *op cit*

[32] What Determine Health? *op cit*

[33] WHO, 2007, *op cit* pp 5

for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well known determinant of better health".

Health service system consists of preventive, curative and rehabilitative services. It is a complex system that consists of several sub systems that are interrelated. These sub-systems include health service provisioning, health care financing, health care management etc.

1.3.1. The Objective, Goal and Determining Factors for Health Service System

The Health Service System has certain functions, objectives and goals. World Health Report 2000 elaborates on some key objective and function of the HSS. These include the following[34],[35] -

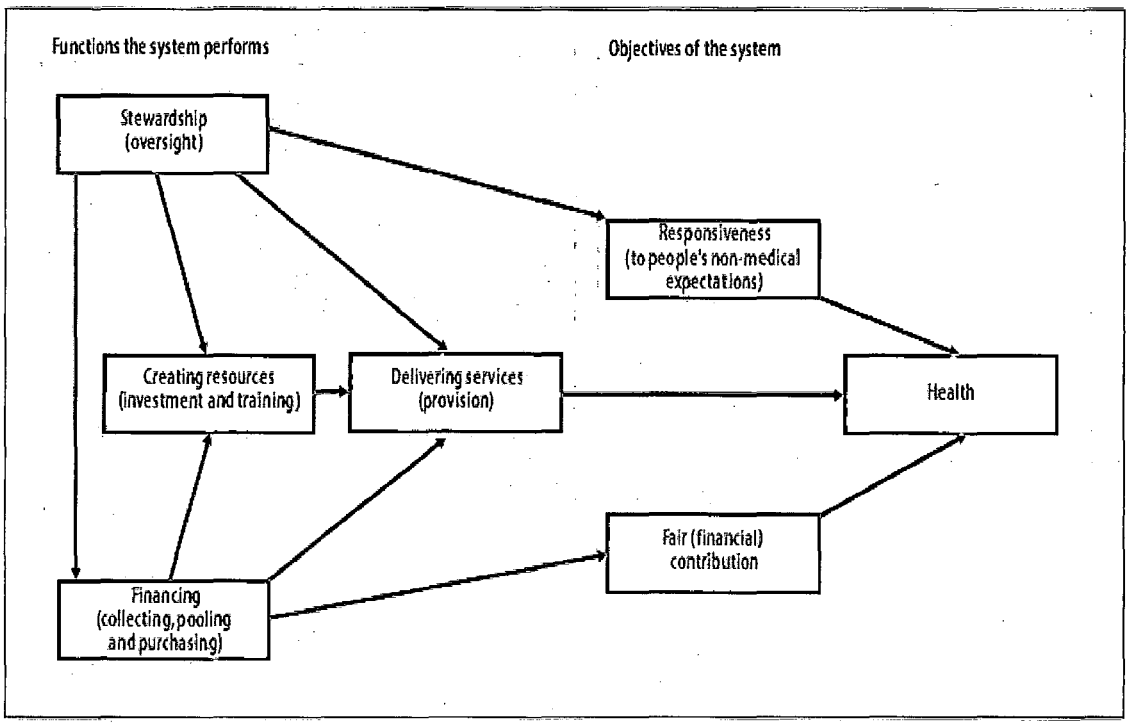
- Deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources.
- A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances.
- A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health service systems performance and health status.
- Equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness and scientifically sound and cost-effective use of the same.

[34] WHO, 2000, *op cit*

[35] WHO, 2007, *op cit*

- Availability of adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them.
- Effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system-design, and accountability.

Figure 1: Objective, function and goal of HSS[36]



Source: World Health Report 2000.

And overall health system outcomes or goals as: improving health and health equity, in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources. There are also important intermediate goals: the route from inputs

[36] WHO, 2000, *op cit* pp 25

to health outcomes is through achieving greater access to and coverage for effective health interventions, without compromising efforts to ensure provider quality and safety.

Realizing these goals is dependent on the structure and design of health services. This is largely influenced by the socio political context which acts as an important determinant. If one were to identify some key determinant it would include

- *The Political System*: The political philosophy of a country i.e. whether it is governed by capitalism, socialism, democratic or autocratic principles has a major influence on the organization and design of Health Service System[37].

- *The Economic Attributes*: The economic attributes like whether the country is developed, developing or under-developed, resource rich or resource poor determines the entire organization of Health Service System.[38]

- *The Level of State Involvement*: The State's involvement in people's affairs also determines the Health service system. Involvement means whether the services are comprehensive, universal, target specific or welfare oriented. Whether the planning process is centralized or decentralized, involves participation of private and public players in programme etc.[39]

- *Dominant Method of Financing*: Health service system is also determined by how other essential services are operated and who pays for it? Whether the main source of financing is tax revenue or is it privately financed by the citizen? And the ratio of public vs. private finance in the entire health delivery system.[40]

[37] Mills, A. and Ranson, K. 2005, *op cit*

[38] *ibid*

[39] *ibid*

[40] *ibid*

1.4. Conceptualizing Health Service System

The health service systems, according to Andrew Green[41] and Anne Mills[42] based on macro level factors and nature of the larger political and economic organization of the country, can be conceptualized in three very distinct ways

- Health care as right
- Health care as investment
- Health care as consumption.

These three philosophical positions of looking into health services and its organizations have influenced design, evolution and adoption of health service system in different countries throughout the world. All the existing models of health services system subscribe or are influenced by one or the other philosophical position.

[41] Green, A. 1999, *op cit*

[42] Mills, A. and Ranson, K. 2005, *op cit*

Table 1: Conceptualizing Health Services System[43,44]

	Health Care as right	Health as investment	Health as consumption
State Role Vs Private Sector	State is Dominant Player. Private sector is minimal to non existent	State and private sector both have specific role. Roles depends upon the Health Service System(HSS) (NHS vs. SHI vs. NHI)	Private sector is dominants. State becomes the regulator and Certification authority. Sometimes plays preventive and promotive role (not profitable for market intervention)
Facility Management	Facilities owned by State including Human Resources (HR)	State and private both own the facilities as it depends upon the HSS	Private mostly owns the Facilities including HR
Purchasing and distribution of services	State purchase and distribute the health care services	State purchase the services directly or through contributory mechanism, distribution of services are done by both state and private players	Purchasing of services are done by user though private insurance or from own saving. Distribution of the service is done mostly by private sector.
Universality	Health care services accessible to all.	Mostly universal although few people get excluded (illegal migrants)	Depends upon paying capacity. Most of the people cannot use appropriate care.
Comprehensiveness	Comprehensive Care. Most of the disease and medical specialties are covered	State decides the health condition to be covered. In many countries dentistry is not covered so also reconstructive treatments	Depends upon paying capacity
Pricing of services	Services are free	State decide the price of services through all sector	Market decides the price

Adapted from : Andrew Green and Anne Mills

[43] Green, A. 1999, *op cit*

[44] Mills, A. and Ranson, K. 2005, *op cit*

1.4.1. Health Care as a Right

Health care as a right puts the access and provisioning of health care services at the core of rights perspective. With the changing global socio economic situation and structure, especially after the post reform period the attainment of health equality looks like a distant dream. This attainment of health equality was emphasized in Alma Ata Declaration and WHO definition but achieving the same remains an enormous challenge because of structural issues. Therefore access to health care and equity in health access is seen as a logical and more practical way of ensuring social justice. This paradigm shift led to a major philosophical change in the entire debate on health. The debate point has now changed from health equality to health equity. The State's responsibility includes providing equitable health access by providing treatment and care, preventive and promotive services to its citizen, making arrangement for purchasing and distribution. The State decides the health care delivery structure, priority of services, manpower and financial resource management etc. Peoples are entitled to services as defined by State as a right. The major health service system model which is influenced by this conceptualization framework is *Shemaskho Model.*[45, 46]

Semaskho Model: Semaskho Model was designed by famous soviet health organizer N. Semasko. This model is based on the principle of justice and equality, that health care access is a right of citizens and it is the State duty to ensure the rights of the citizens are provided and services are available. In Semaskho model, health services are centrally managed, publicly financed and services are provided free of charge to patients. Entire health infrastructures including human resources, health care facilities are owned by state. The role and presence of private sector in health care was negligible. The former Soviet Union, Eastern European countries adopted this model. In recent years Uganda tried to adopt this model of Health Service System.[47, 48]

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[45] Green, A. 1999. *op cit*

[46] Mills, A and Ranson, K. 2005, *op cit*

[47] McPake, B. and Normand, C. 2008, '*Health Economics : An International Perspective*', New York, Rutledge Publication

1.4.2. Health as an Investment

The conceptualization of health as an investment has been influenced by industrialization and economic growth theory paradigm. The idea that economic growth is a means to development, and industrialization is the engine of economic growth is fundamental premise of this perspective. The basic argument in this conceptualization is that, higher productivity leads to better economic development, the availability and consistent supply of the productive workforce is necessary to maintain the growth in productive sectors like industry, agriculture, mining etc. In the post world war era for most of the European countries the indicator for development becomes continuous and steady growth of Gross National Product. Therefore the state needs to ensure better health for its productive citizen so that the flow of able bodied workforce is available throughout. And thus health becomes a priority sector to state to maintain the health of employable citizen. In this framework the state takes the responsibility of the health care for its citizens. The state may not control the health infrastructure but the purchasing and distribution of health services remains with the State. State can also cover curative responsibilities for certain pre determined health conditions. The major health service system Models which are influenced by this perspective are: [49, 50]

Bevanite / Beveridge Model: This model of health service system is based on the Beveridge report and designed by noted Labour party representative and economist A. Bevan. Comprehensive care and universality of health services are the foundations of this model. The financing of the health service system is done through tax revenue. The health establishments are mostly owned and managed by state and so as human resources employed. The focus on specific treatment and standardized procedure help to keep per capita treatment cost very low in this system. The Great Britain's NHS,

[48] Borowitz, M. and Atun, R. 2006, 'The unfinished journey from Semashko to Bismarck: Health Reform in Central Asia from 1991 to 2006', *Central Asian Survey*, 25 (4), pp 419 — 440

[49] Green, A. 1999, *op cit*

[50] Mills, A. and Ranson, K. 2005, *op cit*

Spanish, Scandinavian, Sri Lankan and New Zealand HS are the example of this model of Health Service System. [51]

Bismarck Model: This is one of the oldest model of health service system promoted by Chancellor Bismarck of the then Germany. The concept of welfare state is the main guiding force for this model of health service system. This is an insurance based model where state provides compulsory insurance coverage through contributive deduction at source (salary) of each and every employee. For those who cannot afford to pay the premium, the state runs its own insurance schemes. The beneficiaries have the option to choose from both public and private service provider. Alternatively this health service system is known as Social Health Insurance model. [52,53]

National Health Insurance National Health Insurance model is a mixture of Bevanite and Bismarck Model of Health Service System. In this model the State does the health care service purchasing and the provisioning of the services are made mostly by private sector. This is also an insurance based model where the State run insurance provides health care coverage to its citizens. The prices for each and every health care service are determined by the state and as per the use, the State reimburses the provider. Countries like Canada, Taiwan, South Korea have this type of health service system.[54]

1.4.3. Health as Consumption Good

The conceptualization of health as Consumption Goods is influenced by the idea "free market". This perspective assumes health as an individual condition and health care like any other consumer goods to fulfill individual demand. In this model market plays a pro-vital role in provisioning and pricing of health services. Role of State is restricted to certification and maintaining professional standard treatment and quality of care. The market provides mainly the curative services (profitability) and the State in many cases takes the responsibility of preventive and promotive health. People buy health care

[51] Musgrove, P. 2000, 'Health Insurance: The Influence of the Beveridge Report', *Bulletin of the World Health Organization*, 78 (6)

[52] McPake, B. and Normand, C. 2008, *op cit*

[53] Borowitz, M. and Atun, R. 2006 , *op cit*

[54] Green, A. 1999, *op cit*

service either directly from own resources or opt for private insurance coverage. The market led distribution and purchase of the health services creates inequality in health service system. As pricing of health care services are determined by market most of the time it becomes unaffordable for many people and absence of public provisioning of health care makes the services inaccessible to people. [55, 56]

Private Insurance Model: In this pattern of health service system people purchase health care services from private insurance companies for certain health condition for a fixed amount. The insurance company either directly pays the price (fee) to the provider for service utilized or reimburses the individual against the bills. The premium is usually very high with a higher range of exclusion of disease coverage. [57]

Out of Pocket Expenditure Model: In this pattern the individual purchases the health care services directly from his/ her own saving. The accesses to the services are limited to one's own purchasing power. In this model, individuals most of the time cannot afford to access health care and are forced into a debt trap while procuring, due to limited resources at their end and absence of any form of collective pool and support. [58]

USA and many South American countries follow Private insurance model, whereas the countries in Africa, South and South East Asia follow the out of pocket model. Countries like India and China have a mix of both the models.

The different conceptual framework differentiates one model of Health Service System from the other. However there are certain common cross cutting elements which are essential for operationalizing the health service systems. They are as follows[59]:

- The state or state authorized body which organizes, legalizes, regulates and sets up standards for all the purposes of health service system.

[55] Green, A. 1999, *op cit*

[56] Mills, A. and Ranson, K. 2005, *op cit*

[57] *ibid*

[58] *ibid*

[59] Green, A. 1999, *op cit*

- Population who receives access and use the services and pays for the utilization directly or indirectly.
- A financier, who designs, collects and allocates funding option, funding sources, funds and purchases and distributes the services.
- The provider of the services which may be the state, private party or mix of both at different levels, performing different functions.

The analysis and understating of health service system gives an insight to the political process and trends of political decision made in the countries. As mentioned above it is not possible to see all the characteristics of a model in one country. After 1980s when health reform processes began the health service systems models started being influenced by each other giving rise to a hybrid model of health financing in most of the countries.

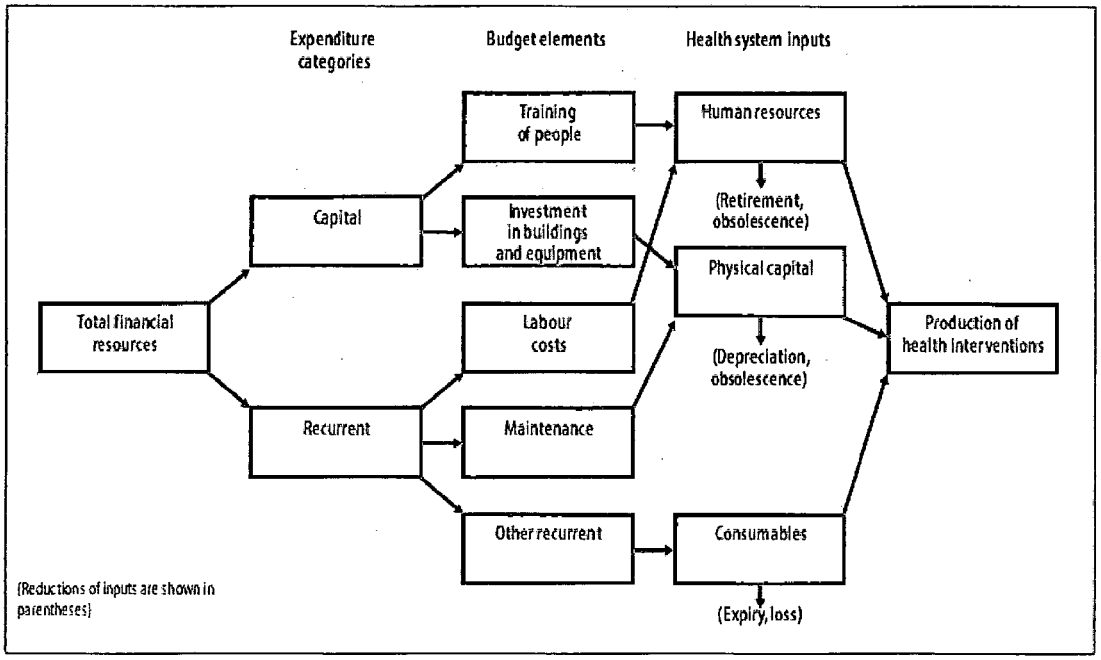
1.5. Health Financing as a Determinant of Health Services System

'The World Health Report 2000'states "The purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care. This means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so."[60]

Within the HSS the pattern of financing is an important determinant for structure of provisioning and utilization of services. There are several models of financing available across countries. Health care financing plays a key role in shaping the subsystem for HSS.

[60] WHO, 2000, *op cit*

Figure 2: Health Care Financing - The Roles[61]



Source: World Health Report 2000

The above illustration summarizes how Health Finance System plays a key role in delivering the health care services and thus improving the general health status. The table shows the major function of health care financing in provisioning, planning, purchasing of the health care services and its components. Health services are not only about medical care, it involves many more factors like which are very important to the health services. A health financing system has to make necessary provisioning for infrastructure for health facilities, manpower, education, and training, diagnostics facilities, medicine etc.

[61] WHO, 2000, *op cit.* pp 75

1.6. Type of Health Financing System

The health economists on the basis of the source of revenue classified health care financing into certain classification. According to Andrew Green [62] and Michael Merson,[63] et. al. health financing system can be classified into following groups -

1.6.1. Tax Revenue and Social Insurance

In this pattern of health financing the source of revenue is the State taxation and compulsory deductive contribution. The taxes include both direct taxes on income and indirect tax like sales tax, surcharges or trade related tax. The State either collects direct taxes from citizen or proportionately deducts certain amount of money from the salary of individuals. It makes provisioning of the services through its own institution or privately contracted ones. The model has the ability to provide universal and comprehensive health, better collective bargaining for the services, addressing equity (both vertical and horizontal) and generate resources. But the main disadvantage with this model is that it is completely dependent upon the available tax base. In the countries where tax base is low this model cannot be implemented. Moreover tax revenue generation is also dependent upon the maturity of financial governance. In countries where financial systems are not so strong the system cannot be implemented.

1.6.2. Private Source and Private Insurance

Another major classification of health financing mechanism is private source of revenue or private insurance model. According to this model the source of revenue is the premium paid by the individuals to the insurance companies or the out of pocket expenditure individual pays to the provider. At the same time access to health care is dependent upon individuals paying capacities. The state or employer may provide certain subsidies but majority of the cost is absorbed by the individual. The model is highly inequitable in nature and revenue generation capacity is very uncertain. In the case of private insurance only those who can afford opt for insurance to access health

[62] Green, A. 1999, *op cit*

[63] Mills, A. and Ranson, K. 2005, *op cit*

facilities with insurance premiums varying i.e. different for different risk groups. In the case of out of pocket expenditure the affordability of individuals to seek health care becomes more limited. In many cases an individual has to borrow money to pay the health care bills and thus falling into a debt trap. Fully voluntary nature of resource mobilization makes future planning highly difficult in this model.

1.6.3. Mixed Model of Financing

This model of health financing is the most widely used and most popular with developing, low and middle income economies. Due to certain structural issues neither of the above mentioned models can work in an economy where taxable citizen base and income level of people is low. The mixed model of financing is a bridge between both the models and both extremes. It gives people who can afford to pay, the freedom to opt for private provider and private insurance and at the same time providing basic services at states cost to the people who cannot afford to pay. In this model the State generally pays for primary and secondary level of care while tertiary and super-specialty care is provided by the private sector. The estimation of total revenue in this system becomes very unpredictable and the over use of resources by one system adversely affects the functioning of other system.

1.6.4. Community Health Financing

This is one of the emerging models of health financing. The failure of state led funding and market led funding in health care leaves a large number of people out of health care services. The increasing cost of health care and failure of state facilities led to inequity in health care access. Therefore the issue of financing health care at a local level gained focus. In Community Health Financing model health financing funds are generated, managed and operated at community level by communities' collective initiative. This model was pioneered by UNICEF in 1980s as Bamako Initiative in Western African region. As the source of revenue generation and service delivery is local, it results in better efficiency, better collective bargaining to keep the cost low, making it more affordable to the poor as compared to the services of a private insurance. The challenge with Community Health Financing lies in its small revenue base, thus limiting the

purchase of health care. This models may seems to be comprehensive in nature but the low per capita purchasing of services makes it very difficult in providing adequate care for its member. Another major limitation with this model is the issue of sustainability, low premium generation and high cost of purchasing renders it less cost effective and short-lived.

1.6.5. Financing Based on Loan, Grant and Deficit Financing

This is a very rare mechanism for health system financing. This mechanism can be seen in countries which face acute shortage of resources, high dependence upon international grants for survival of the economy, or have a very high debt ratio. This is a very temporary system of financing and not sustainable for long term. It is also not possible to provide any comprehensive and universal care in this system.

Although the functions of the health financing system seems like completely separated from each other but in reality it is integrated in the same system and operates at the same time. The main challenge is to integrate the required institutional, organizational and technological mechanisms available and deliver services to all including those who cannot afford to pay and cater to the providers so that they can continue to provide the services without the fear of loss in their investment thus facilitating an environment in which the HSS operates at optimum level, effectively and responsively.

1.7. Function of Health Service System

To ensure that every individual has access to the health care services and provisioning, the health financing system carries out three major function of revenue collection, pooling of resources and purchasing of health care services.

1.7.1. Revenue Collection

Revenue collection is the system through which the health service system collects or receives money from State, individuals, cooperatives and corporate and international sources. The source of revenue can be of various natures i.e. through direct state funding, general taxation (Direct and Indirect taxation), SHI/NHI contribution, Private

Health Insurance Premium, Out of Pocket expenditure, and International assistance. Literature reflects that the sources of collection of revenue for high income group is mainly through taxation and contribution whereas in transforming economies it is a mix of direct state funding (taxation) out of pocket expenditure and in less developed countries the source remains mainly out of pocket expenditure.[64,65]

1.7.2. Pooling of Resources for Risk Mitigation

Resource pooling for risk mitigation means accumulate and manage the available resources to ensure that cost of health risk is distributed on large group and not on an individual. The concept of pooling spreads the financial burden associated with health challenges. It also reduces the uncertainty of individuals about the access and affordability of the needed services and uncertainty of the provider to recover his investment to provide the services. The pooling function in an overall context is the insurance section of health financing system.[66,67]

1.7.3. Purchasing of Health Care Service

It is a mechanism of making payment to the provider in exchange of provisioning and delivery of certain health intervention. The purchasing can be classified in to two categories - passive purchasing and strategic purchasing. Passive purchasing is done through making explicit budgeting for the services to be bought or by reimbursing the money to the provider against the bills or vouchers. The strategic purchasing is a more complicated process. The idea of strategic purchasing is to purchase the services which maximize the health at the best possible cost and at right time and quantity. This involves continuously calculating the best available intervention for each and every health situation, appropriate price and quantity of service required to optimize the performance of health service system.[68,69]

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[64] Gottret, P. and Scieber, G. 2006, *'Health Finance Revisited'*, The World Bank, Washington DC, USA

[65] Green, A. 1999, *op cit*

[66] Gottret, P. and Scieber, G. 2006, *op cit*

[67] Green, A. 1999, *op cit*

[68] Gottret, P. and Scieber, G 2006, *op cit*

1.8. Criteria for Adopting a Health Financing System

The health finance system that a country wants to adhere to depends upon the philosophy of the existing health service system of the country, as the philosophical and conceptualization of position that shapes the health service system also shapes the health finance system. While designing or adopting a health finance system, certain parameters become very important as the performance maximization of the system depends upon it -

1.8.1. Viability and Ease of Use of the System

The health financing system should be viable for the country and suitable to the prevailing socio cultural norm. Each and every country is different from each other in terms of economic status, governance, socio cultural values and the financing system should take account of this variation and be able to perform. First and foremost the system should be able to perform. The system should be easier to use and conform to available technological and managerial capabilities of a country.[70]

1.8.2. Revenue Generating Ability

The model should be able to generate necessary resources to meet the purpose of health service system. It should be able to raise both fixed and recurring capital for smooth operation of health service system without any capital scarcity. The system should be able to finance the existing services and also generate enough capital to induct new services. Self sufficiency is another important aspect of revenue generation.[71]

1.8.3. Effect on Health Care Supply

The health financing system should be able to ensure effective and efficient services at right time in right quantity. The health finance system should be able to provide adequate incentive to the service provider to provide continuous service in an effective

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[69] Green, A. 1999, *op cit*

[70] Green, A. 1999, *op cit*

[71] *ibid*

efficient and responsive manner and also enable fund managers to purchase selective services and emergency services as and when required.[72]

1.8.4. Effects on Demand and Equity

The health finance system should be able to ensure equity of access to health care without over burdening the system. It should be able to address both horizontal and vertical equity so that all the differential income groups, population and all different health risk group are included in the system and at the same time it should be able to deter artificial or unnecessary demand creation for services.[73]

1.8.5. Participation of Stakeholders in Decision Making

The health finance system should be able to ensure participation of all stake holders in decision making. The system should not be biased towards the provider or the users. The decision should be made based on factual information which gives scope to user, provider and managers to collectively decide the allocation of revenue and purchasing of services.[74]

1.8.6. Multi-sectionalisms

The health finance should be able to address the determinants of health and not only make provision for curative services. Addressing determinants of health becomes important for making the HSS more effective and efficient.[75]

The understanding of health financing system becomes important with the changing geo politics. With the collapse of the economies time and again and decline in government commitment and spending, two major issues came into picture. Firstly the appropriate role of state and other institutions in financing health care. Secondly the extent of state intervention and modes of addressing the inequalities created by private and market led system while providing efficient services.

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[72] *ibid*

[73] *ibid*

[74] *ibid*

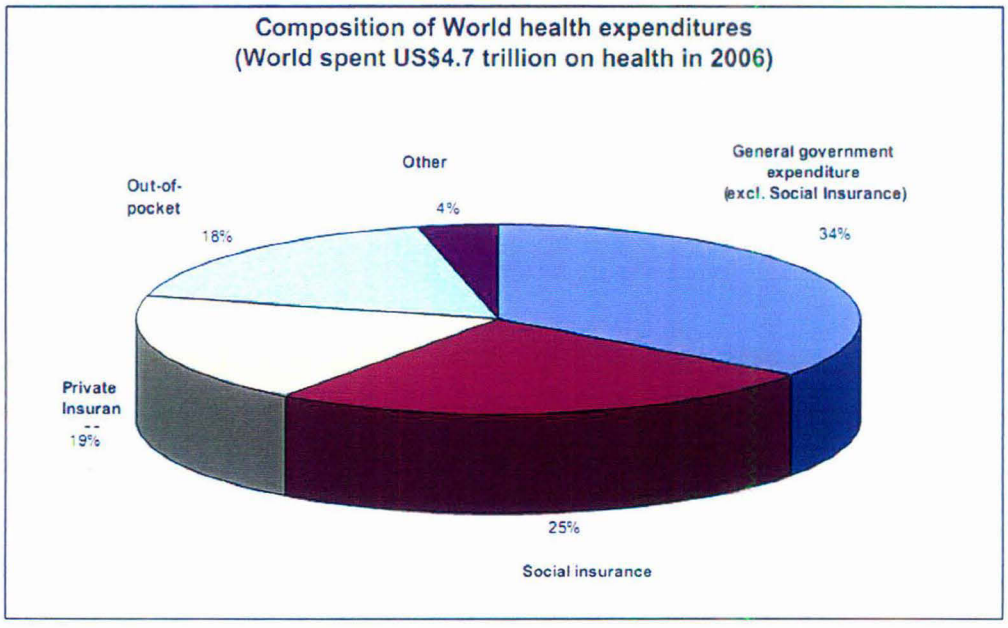
[75] *ibid*

1.9. Pattern of Health Care Financing: An Analysis

The statistics on global health expenditure given by National Health Accounts[76] WHO shows that out of pocket and private insurance accounts for 37% of the total health expenditure where as public expenditure on health are around 34% and the rest 29 % is social health insurance and other health financing system.

Countries from low and middle income block have the highest concentration of out of pocket expenditure. WHO report shows that out of 29 countries where the out of pocket expenditure is more than 60 % of total health expenditure, 19 countries belong to the economic bracket of less than $1000 per capita annual income.

Figure 3: Composition of World Health Expenditure[77]



Source : National Health Accounts 2009 WHO

[76] WHO, 2009, '*World Health Statistics 2009*', Geneva, WHO Press,

[77] National Health Accounts 2009, as available at http://www.who.int/nha/en/ as accessed in 12-02-2010

Table 2: No. of Countries in Income and Expenditure lass and Estimated Out of Pocket Expenditure Share to the Total Health Expenditure[78]

Estimated annual per capita income (US$ at exchange rate)	Estimated share in total expenditure on health (%)						
	Under 20	20–29	30–39	40–49	50–59	60 and over	Total
Under 1000	7	10	9	7	11	19	**63**
1000–9999	16	18	23	15	8	8	**88**
10 000 and over	19	7	4	5	0	2	**37**
All income classes	42	35	36	27	19	29	**188**

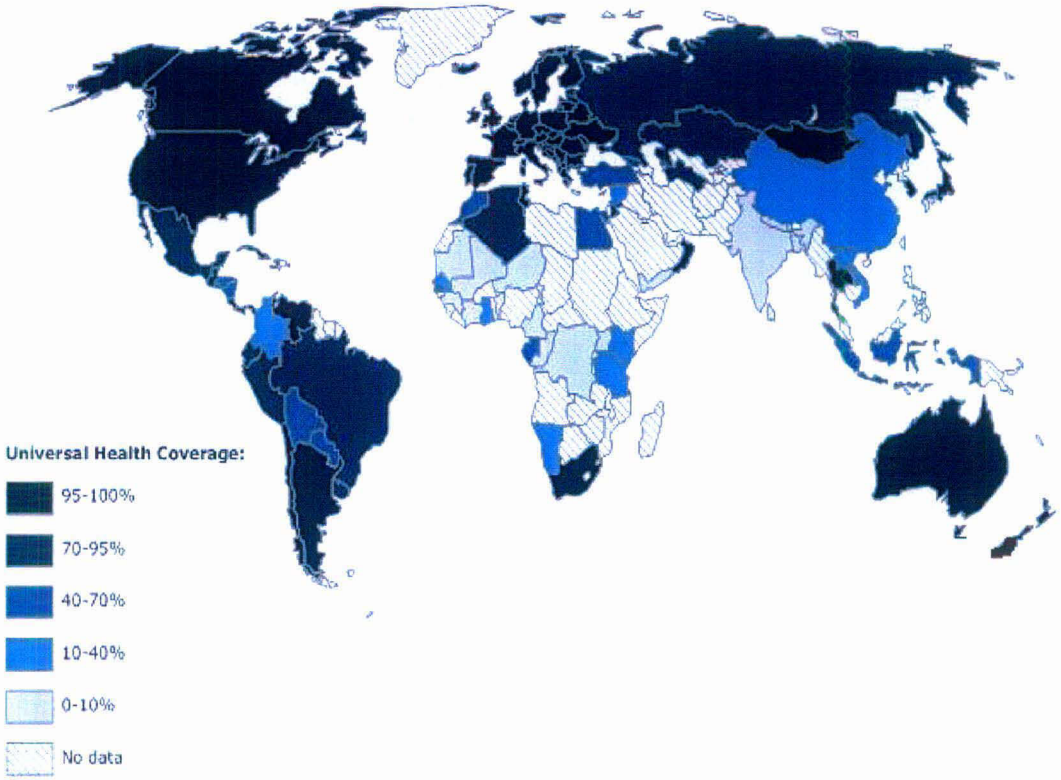
Source: World Health Report 2000

Only 2 countries from $10000 group fall into the same category. Whereas the out of pocket expenditure is under 20% in 42 countries out of which 19 countries belongs to per capita income group of over $10 000. This set of data clearly shows that high out of pocket expenditure in mainly a phenomenon of low and middle income countries.[79]

[78] WHO, 2000, *op cit.* pp 96

[79] *ibid*

Map 1: Universal Health Coverage in Different Countries[80]



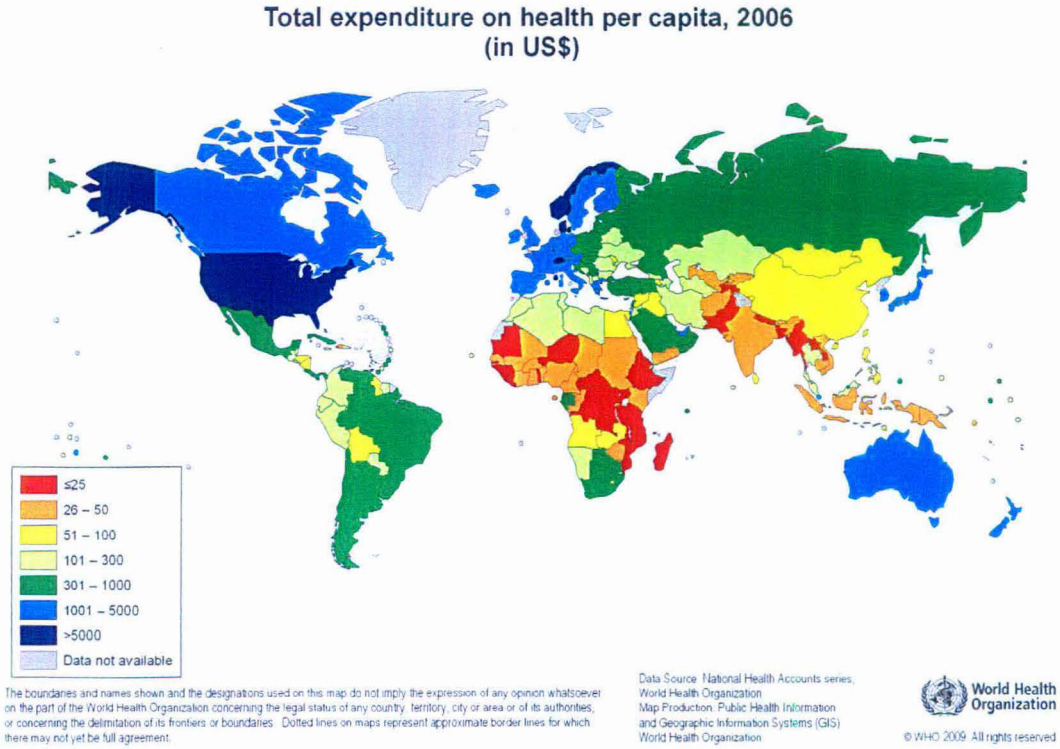
Source: Social Security: The Way of Health in the 2010s, International Labour Organization

The International Labour Organization's data[81] on universal health coverage reflect that the countries where predominant system of health financing is out of pocket expenditure, the health coverage is low. Countries of African and South Asian Region have universal health coverage of less than 40% (Illustration above). The reason for this low universal health coverage may be linked to the lower public spending for health care and higher cost of treatment. The interplay of these two factor results in inequity in health access. And in most of the countries the per capita spending on health care is also low. The per capita expenditure on health countries in African Region and South Asian Region is less than $ 50 (Illustration below)

[80] ILO 2008, '*Social Health Protection, An ILO Strategy Towards Universal Access to Health Care*', Policy Briefing paper, Social Security Department Geneva

[81] *ibid*

Map 2: Distribution of Total Health Expenditure Per Capita



Source: National Health Accounts, World Health Organization[82]

The WHO 2009 statistics[83] given below also confirms the same. Interestingly, the 2009 WHO statistics, also points out to the fact that in South Asian Region private expenditure on health is as high as 66% of total expenditure followed by African Region where it is 53%. In low income countries the same is as high as 64% followed lower middle income countries where the private expenditure on health stands at 59%. The share of out of pocket expenditure in private expenditure is almost 89% in South Asian Region. Interestingly the external assistance as a health financing system is only seen in African countries. The external resources as system of health financing stood at 10.7%.

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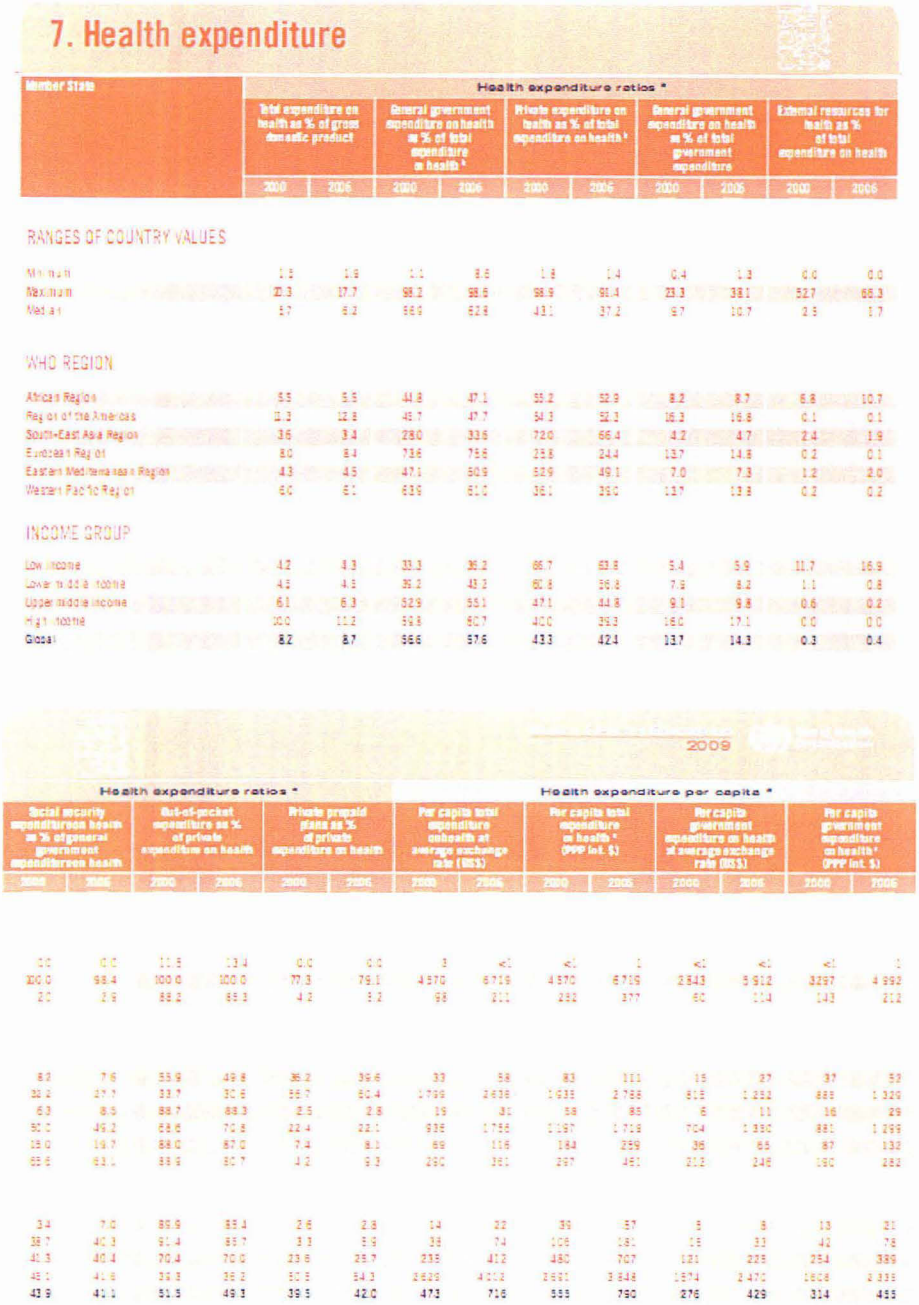
[82]National Health Accounts 2009, as available at http://www.who.int/nha/use/THE_pc_US$_2006.png as accessed in 12-02-2010

[83] WHO, 2009, '*World Health Statistics 2009*', Geneva, WHO Press

Table 3: Composition of Health Expenditure: [84]



7. Health expenditure

Member State	Health expenditure ratios *									
	Total expenditure on health as % of gross domestic product		General government expenditure on health as % of total expenditure on health *		Private expenditure on health as % of total expenditure on health *		General government expenditure on health as % of total government expenditure		External resources for health as % of total expenditure on health	
	2000	2006	2000	2006	2000	2006	2000	2005	2000	2006
RANGES OF COUNTRY VALUES										
Minimum	1.8	1.9	11	8.6	1.8	1.4	0.4	1.3	0.0	0.0
Maximum	20.3	17.7	98.2	98.6	98.9	98.4	23.3	38.1	52.7	66.3
Median	5.7	6.2	56.0	62.8	43.1	37.2	9.7	10.7	2.5	1.7
WHO REGION										
African Region	5.5	5.5	44.8	47.1	55.2	52.9	8.2	8.7	6.8	10.7
Region of the Americas	12.3	12.8	45.7	47.7	54.3	52.3	16.3	16.8	0.1	0.1
South-East Asia Region	3.6	3.4	28.0	33.6	72.0	66.4	4.2	4.7	2.4	1.9
European Region	8.0	8.4	73.6	75.6	25.8	24.4	13.7	14.8	0.2	0.1
Eastern Mediterranean Region	4.3	4.5	47.1	50.9	52.9	49.1	7.0	7.3	1.2	2.0
Western Pacific Region	6.0	6.1	63.9	61.0	36.1	39.0	13.7	13.8	0.2	0.2
INCOME GROUP										
Low income	4.2	4.3	33.3	36.2	66.7	63.8	5.4	5.9	11.7	16.9
Lower middle income	4.5	4.5	36.2	43.2	63.8	56.8	7.6	8.2	1.1	0.8
Upper middle income	6.1	6.3	52.9	55.1	47.1	44.8	9.1	9.8	0.6	0.2
High income	10.0	11.2	59.3	60.7	40.0	39.3	16.0	17.1	0.0	0.0
Global	8.2	8.7	56.6	57.6	43.3	42.4	13.7	14.3	0.3	0.4

2009

Health expenditure ratios *						Health expenditure per capita *							
Social security expenditure on health as % of general government expenditure on health		Out-of-pocket expenditure as % of private expenditure on health		Private prepaid plans as % of private expenditure on health		Per capita total expenditure on health at average exchange rate (US$)		Per capita total expenditure on health * (PPP int. $)		Per capita government expenditure on health at average exchange rate (US$)		Per capita government expenditure on health * (PPP int. $)	
2000	2006	2000	2006	2000	2006	2000	2006	2000	2006	2000	2006	2000	2006
0.0	0.0	11.5	13.4	0.0	0.0	3	<1	<1	1	<1	<1	<1	1
100.0	98.4	100.0	100.0	77.3	79.1	4 570	6 719	4 570	6 719	2 643	5 512	3 297	4 992
2.0	2.6	88.2	86.3	4.2	3.2	98	211	282	377	60	114	143	212
8.2	7.6	55.9	49.8	36.2	39.6	33	58	83	111	15	27	37	53
38.2	37.7	33.7	30.6	55.7	60.4	1 799	2 436	1 935	2 788	815	1 282	889	1 320
6.3	8.5	88.7	88.3	2.5	2.8	19	31	58	85	6	11	16	29
50.0	46.2	68.6	70.8	23.4	22.1	936	1 756	1 197	1 719	704	1 330	881	1 299
13.0	19.7	88.0	87.0	7.4	8.1	69	116	184	259	36	65	87	132
65.6	63.1	88.9	80.7	4.2	9.3	280	361	297	481	212	248	190	282
3.4	7.0	86.6	85.4	2.6	2.8	14	22	39	57	5	8	13	21
38.7	40.3	91.4	85.7	3.3	5.9	38	74	106	161	15	33	42	78
41.3	40.4	70.4	70.0	23.6	25.7	235	412	480	707	121	229	254	389
46.1	41.6	35.8	36.2	50.5	54.3	2 620	4 013	3 691	5 848	1 674	2 470	1 808	2 939
43.9	41.1	51.5	49.3	39.5	42.0	473	716	555	790	276	429	314	455

Source : WHO Health Statistics 2009 pp115-116

[84] WHO, 2009, *op cit*

The above WHO data shows that during the period 2001 to 2006, the government expenditure in relation to the total health expenditure is either static or decreasing. The same trend can be noticed in Total Govt. Expenditure in health in relation to total govt. expenditure. With the sudden change in the health service system across the world like structural adjustment and health sector reforms, privatization of NHS in Great Britain in the name of greater efficiency, shifts in the NHI and SHI models by reducing coverage puts a big question on the health service security. The failure of the state and market to provide comprehensive health care to all its citizens and initiative to achieve equilibrium of demand, supply and cost remains the issue for many health economists. The economists favoring market supremacy found themselves in a catch 22 situation with increasing cost and increasing inequality. On the other hand most of the states justified their inability to infuse necessary funding in the health service system due to lack of resources with global economic downturns aggravating the situation. These complex sets of situations compelled the international agencies and health economists to look for alternative approach to bridge the gap of inequality. Insurance and especially CBHI has been looked as the one of the viable solution.

CHAPTER - 2

HEALTH INSURANCE AND ITS HISTORICAL DEVELOPMENT

HEALTH INSURANCE AND ITS HISTORICAL DEVELOPMENT

Health incidents have a multi faceted effect on human life affecting an individual physically, psychologically, emotionally, socially and economically. In most of the cases the impact is not localized to the person affected but it spills over to the family and society. The burden and implication resulted from a health incident is generally felt for a long duration and sometimes it gets carried over to the next generation[85]. To illustrate the effect of health incidents in individual, family and society, the following table has been compiled and deciphered from different sources -

Table 4: Impact of Health Incidents on Individual, Family and Society

Impact	Physical	Psychological	Developmental	Economical	Social
Individual	Illness, Disability, Suffering	Depression, Stress	Cannot participate in developmental Activities	Loss of wage, and savings, Loss of productivity	Cannot participate in Activities, Limited social interaction
Family	Suffering, pain	Stress	Limited participation	Loss of wage and savings, Loss of productivity, Indebtedness	Restricted participation
Society				Loss of productivity	Social Anxiety, Fear

Health is priceless and disease and disabilities are unpredictable. Individuals and society have very low control over the occurrences of health incidents. The only way to face such events is to ensure access to health care facilities and health care services, in other

[85] Getzen, T. 2004, '*Health economics fundamentals and Flow of fund*', New York, Wiley International publication

words ensuring health service security[86]. But with the continual rise in the cost of medical care, medical expenses have become an increasingly important contributor to financial risk. The cost of medical care becomes the deciding factor to seek treatment, choosing type of treatment and accessibility factor to the health facility. Moreover it has started to determine the health culture. As disease and disabilities are not very easy to control or manage, individuals or society can only develop mechanism to cover the financial burden associated with the disease. These buffers can be very rudimentary, unstructured and basic, like saving money, asking help from friend and family or taking help from charities and government institutes to structured like state-led comprehensive service delivery, community based initiative, private insurance.

2.1 Historical Development of the Health Insurance

Health insurance has a long history which runs along the evolution of health care delivery system. Changes in medical practices like more focus on curative care, development of pharmaceuticals and diagnostics, development of hospitals and corporate hospitals system, decline in public spending in health care, shapes the health insurance and its evolution. Most prominent social health insurance models seen today are mainly based on the development of health service system in Western Europe where the idea of Health as a collective investment dominated and in the US health service system health is seen as individual issue and therefore the health care as looked as consumption good. The history of development of health insurance is history of rising costs of medical care.

With the development of society and continuous quest for knowledge for betterment of life, civilization across the world developed their own medicine and health care system. These systems of medicine were essentially based on understanding of local topography, environment, disease causation beliefs and available knowledge about the human body. The physicians used to treat people based on their understanding of the

[86] Baru, R, 'Financing Health Service: Alternative to Private Insurance', in Prasad, S, and Sathyamala, C, 2006, *Securing Health for all,* Institute of Human Development New Delhi, Ch 19

disease or disorder and used to get paid for their knowledge, medicines and rituals conducted by them for the wellbeing of the patient. But overtime scarcity of formally trained medical practitioners in all the system led to a complete transformation of health care delivery system. Around fifteenth century, hospitals and clinics were established throughout Europe and the Middle East, where a limited number of trained physician attended to a large number of patients at a same time. The development of asepsis, better knowledge of human anatomy, disease causation and surgical procedures shifted the treatment regime from home based care to complete institution based care. The development of hospital based treatment also formalized the payment system as hospitals always had higher fixed and recurring cost and provided more facilities to the patient than the individual's physicians. Another interesting development in this process was the development of the diagnostic technology. The advancement in knowledge about disease causation, bio chemistry and anatomy proved that only a physician's assessment was not always enough and appropriate and therefore physician's assessment had to be supplemented and complemented by the specialized scientific investigations. The costs related to this investigation were to be borne by the patient to get the best possible treatment and better care thus raising the cost of treatment for disease and disabilities.[87]

In the same period another important transformation was taking place. The industrial revolution shifted the income source of population from agriculture to wages or wage based sources. The security offered by the land and firm was replaced by crisis in the wages earning profession. This is the period where concept of health insurance evolved in Europe as a measure of social security and component of welfare state and few years later in USA as a corporate venture.

2.1.1 Development of Social Insurance

Social health insurance was developed on the principle of Social Solidarity and Brotherhood. Around 1800, Europe was undergoing major ideological transformation. The socialist movement, trade unionism and social equality were started to influence the

[87] 'In Sickness and in Health, The History of Health Insurance', as available at http://www.randomhistory.com/2009/03/31_health-insurance.html as accessed on 31-03- 2010

European governments and statesmen. In the late eighteenth century and early nineteenth century Europe the most popular method of risk sharing was the guild system. A group of people bonded by some common factors came together and formed guilds which provided financial security in case of emergency. And over the years these guild become financially very strong and started getting consolidated creating big financial enterprises. The government also realized the power held by these guilds and initiated measures to control them. In 1789 France abolished the guild system to break their power which was followed by the Netherlands in 1798 and by 1890 most of the European countries abolished the long practice guild system. The abolition of guild system created a vacuum in the society and many undercover organizations, private companies tried to control the power of the abolished guilds which created lots of chaos in the society. In the same time Swiss government issued a royal character on commissioning of state physician to provide free medical care to those who could not afford to pay for treatment. Norway and Finland also followed the suit by issuing their own charter in their respective countries to provide free medical care to the needy people. Trade union movement across the Europe started gaining popularity and strength in the same period. In European companies the trade unions became a major force to protect and safeguard the workers' rights and wellbeing.

These three events had a far reaching implication on the history of health insurance. Chaos created by abolishing guild system and growing power of trade unionism became great concern for European states. The inability to pay for treatment by the poor, sudden growth of private guild like system and private philanthropy (selective) in health sector led to growing discontent in the societies. Taking full advantage of the situation, the trade unions started influencing the then politics creating fear amongst ruling class. The fear of losing power to the socialist and trade unions resulted in enactment of legislation in 1870 by Austria, Belgium and the Netherlands to nationalize and converting the philanthropic activities on health to state responsibility. Germany in 1883 under Chancellor Bismarck took over trade unions mutual support activities and instituted Comprehensive Social Health Insurance as a formal system. Chancellor Bismarck's legislation on social security became a model in European countries to initiate social security measures to counter growing socialist and trade union movement. By 1887

Austria, 1892 Denmark, 1894 Belgium, 1899 Switzerland and 1911 Britain adopted a similar model of social security giving health care coverage and other benefit to its population. The adoption of social security measures generally concentrated in Western Europe due to the common industry based economy of these countries. The Southern Europe which was predominantly agriculture based found it difficult to adopt such measures till post second world war period. The economic collapse and physical devastation of the European countries during the Second World War changed the way the countries were viewing their social security measures. Need for nation rebuilding forced these countries to adopt a more concretized form of social security through a tax based system of payment. Between 1948 to 1973, Britain, Denmark and Finland and from 1978 to 1986 Italy, Portugal, Greece, Spain and other southern European countries shifted and adopted a fully tax based system. The following diagram shows the affinity of the state towards the specific type of coverage and transition.[88,89,90,91]

[88] Moran, D. 2003, 'Whence And Whither Health Insurance? A Revisionist History', *Health Affairs*, 24(6)

[89] Saltman, R. et. al. (eds), 2004, '*Social Health Insurances System in Western Europe*', European Observatory on Health Service Systems and Policies Series, Open University Press

[90] Murray, J. 2007, '*Origin of American Health Insurance A history of Industrial sickness fund*', Connecticut, Yale University Press,

[91] In Sickness and in Health, The History of Health Insurance. *op cit*

Table 5: Health Care Finacing Models of Europen Countries and its Transiction[92]

	Predominantly SHI-based	*Predominantly tax-based*	*Year of major legislative change from a role for SHI to a predominantly tax-based system*
Austria	X		
Belgium	X		
Denmark		X	1973
Finland		X	1972*
France	X		
Germany (Federal Republic until 1990)	X		
Greece		X	1983
Ireland		X	1970*
Israel	X		
Italy		X	1978
Luxembourg	X		
Netherlands	X		
Norway		X	1967
Portugal		X	1979
Spain		X	1986
Sweden		X	1970*
Switzerland	X		
United Kingdom		X	1946

*SHI never played a significant role and/or the date indicated marks a break-point where the central state took increased financial responsibility to provide more extended coverage and the role of the tax-based system was substantially increased.

Sources: European Observatory on Health Care Systems' Health Care Systems in Transition reports; Pinto and Oliveira (2001); Guillén (2002); Department of Health and Children of Ireland (2003).

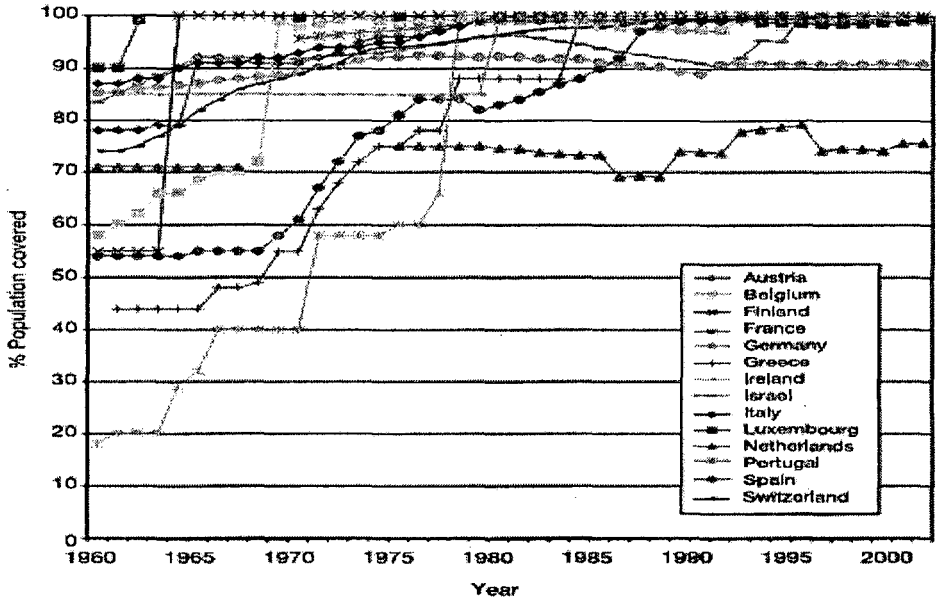
Source: Social Health Insurances Stems in Western Europe, 2004

As of today most of the European Countries follows a tax based on social health insurance system with growing participation of private player in provisioning of the health services. In many countries even private health insurance become a major insurer for the social security programmes or in positioning itself as a supplementary or additional insurer for added coverage. The success of these measures' reflects on the

[92] Saltman, R. et. al. (eds), *op cit* pp 26

coverage indicators. Following illustration shows the coverage of Social Health Insurance covered in selected European countries.[93]

Figure 4: Coverage of Social Health Insurance in Selected Countries[94]



Note: countries with more than 90 per cent coverage since 1960 are excluded (Denmark, Norway, Sweden and the UK). For the Netherlands the population coverage ratios are weighted averages of share of the population covered by the health insurance funds (public) and the whole population covered by AWBZ. The weights are the shares in total costs of the costs covered by health insurance funds and AWBZ. For the social protection ratio, the shares of public finance (government, social security payments and AWBZ) in total expenditure are presented. For Israel the data for 1961–4, 1966–9, 1976–80 and 1982–90 were extrapolated from the available data.

Sources: OECD (2003) and, for Israel, Ben Nun (1999).

Source: Social Health Insurances Stems in Western Europe, 2004

The above data shows that the social insurance schemes cover almost entire population of the country. The coverage has been showing a steady growth from the post world war period and by 1990s most of the countries reached a full universal coverage. In these countries the public allocation for health stands at around 6% of GDP on an average and out of this the public spending on health remain 70%. The following illustration clearly shows the government's commitment for social security and social health insurance.[95]

[93] Saltman, R. et. al. (eds), 2004, *op cit*

[94] Saltman, R. et. al. (eds), 2004, *op cit* pp 25

[95] Saltman, R. et. al. (eds), 2004, *op cit*

Table 6: Public Spending on Social Health insurance by Selected European Countries[96]

	Public expenditure (% of GDP)	*Public expenditure (% of total expenditure on health)*	*SHI expenditure (% of public expenditure on health)*
Austria	5.4	69.4**	61.0**
Belgium	6.2	72.1	48.6
France	7.1	75.8	96.8
Germany	7.9	75.0	91.7
Israel	5.7	69.0	66.9*
Luxembourg	4.9	87.8	88.5*
Netherlands	5.5	63.4	94.1
Switzerland	5.9	55.6	72.7
SHI average	6.1	71.0	89.1
EU 15 average	6.0	74.0	n.a.

* 1999
** Underestimated due to the underestimation of reported public expenditure on health calculated according to SNA 1995 (IHS HealthEcon estimate: 81.6 per cent).

Sources: IHS HealthEcon Calulations (2003); Kerr (2000); OECD (2003); Israel: Israel Yearbook and Almanac (1999), WHO (2003).

Source: Social Health Insurances Stems in Western Europe, 2004

Public spending constitutes a majority of total health expenditure of which almost 90% has been allocated to SHI. The welfare orientation and the concept social solidarity is the driving force for consistent public spending on SHIs in Europe. Although the role of private players role is increasing but it still operates within the framework of SHI system. The state commitment to welfare and solidarity is not compromised in case of social security in Europe, even when countries are transforming to market led economy.

[96] Saltman, R. et. al. (eds), 2004, *op cit*

2.1.2. Development of Private Insurance

The health insurance in USA was a phenomenon of 20th century. Till early 1900 the health care, services and the payments were a private matter. The sickness insurance funds were being formed in an informal way and these sickness funds provided supplementary income only for wages lost due to illness. The logic for covering the wage lost was that at that time wage lost due to illness was usually more than the cost of health care. Therefore the sickness insurance was mainly targeted to absorb the financial burden of the person during the period of illness.

During 1900 the pioneering physicians in America started standardizing medical training and education and institutionalized it as a legal profession. By the early twentieth century, the American Medical Association (AMA) began creating licensing standards and better standards for medical training and medical specialization in higher education. The standardization of medical education paved the way for setting up big hospitals.[97] According to a study by Joseph Ross (2002)[98] "Hospital costs rose from 7.6% of total family medical bills in 1918, to 13% in 1929. Hospital bills and physicians' bills for inpatient services had grown further to 40% of total family medical cost. These rising costs alarmed leaders in medicine, labor, and government. The discussion of health insurance was reborn."

In 1915 AMA in their annual congress raised concern about the rising health costs and people's inability to pay the health care bill. The final report of the congress said even the highest income group is receiving insufficient care, and [that] the basic solution to this problem was to increase the proportion expenditure of national resources to health care. Due to the Great Depression in 1929 hospital receipts and physicians income reduced to a great extent forcing health care industry to look for new mechanisms to stabilize their income. In December 1929, the Baylor University Hospital in Dallas, Texas, announced a plan to sell hospitalization policies to the city's school teachers for fifty cents a month. The American Hospital Association (AHA) started looking it as a

[97] Gorman, L. 2006. 'The History Of Health Care Cost And Health Insurance', *Wisconsin Premier* Wisconsin Policy Research Institute, 19 (10)

[98] *ibid* pp 4

probable solution and encouraged member hospitals to develop similar plans to maintain steady income, particularly to prevent financial breakdown during economic depression. The competition amongst hospitals to offer better prepaid plan started affecting the bottom-line of revenue generation for the hospitals. In 1939 under aegis of AHA Blue cross plan was formulated to minimize inter hospital competition and to provide comprehensive schemes. The blue cross was purely a hospital based schemes and individual physician were not part of it. The fear of hospitals taking away the business of physicians due to the absence of such plans forced American medical association to form similar prepaid plans for its members and in early 1940s the Blue Shield plan by the physician started offering prepaid services.[99]

By 1952 over half of all American population owned some health insurance, although these schemes covered only 15 percent of private expenditures for health care, prepayment plans were being hailed by a presidential commission as "the medical success story of the past fifteen years."

The Difference between the AMA and the AHA created an atmosphere leading to syndication of physicians and hospital. The debate around individual's freedom vs. the state's initiative in health care services as in Western Europe resulted many ups and down in formation of national health insurance plan. Moreover, the question of who shall control such insurance schemes, the hospitals or the financial companies, created another rift amongst the health policy makers and planners. The concept of moral hazard and adverse selection dominated most of the discussion in health insurance planning. The insurance companies even drew guidelines on the behavioral conduct of the individuals they insured.[100,101]

The formation of Blue cross and Blue Shield paved the way to other health insurance schemes. The big corporation across the USA realized that if they provided medical coverage to their workers, it would act as a better incentive. So the companies started

[99] Timeline of AMA history as cited in http://www.ama-assn.org/ama/pub/about-ama/our-history/timelines-ama-history.shtml as accessed in 12-03-2010

[100] Murray, J. 2007, *op cit*

[101] Gorman, L. 2006 *op cit*

giving medical insurance to their employees in payroll either on their cost or through tying up with the other insurance companies. This marked the beginning of employee health insurance in USA.

In 1960 John F. Kennedy, revived the discussion about government's responsibility to provide adequate health care for its citizens. In 1965 L. B Johnson even after strong opposition from organized health care industry persuaded Congress to regard health insurance as a Social Security benefit (Medicare) and to provide healthcare for the indigent through the state grants (Medicaid). [102,103]

The challenge with private health insurance in USA and all over the world is the issue of affordability. With private players providing the health service security for profit, which was supposed to be a state duty, excluded many people, who did not have regular income, stable job, out of the insurance coverage alienating or depriving them from health care. This led to a condition of increased unorganized medical practices, thriving mainly on the people who cannot afford insurance.

2.1.3 Development of Community and Informal Health Insurance

The evolution of informal insurance and CBHI was a very unique phenomenon. The concept of the community health insurance was first developed in the time of civil right movement of 1960s in the U.S. People started realizing that with the modern technology dependent medical care, peoples participation in decision making has been reduced considerably and people have turned into puppets in the hands of technology, insurance companies and government bureaucracy. Most of the insurance plan did not have provision for long term care, palliative care, mental health and treatment from alternative medicine which people thought to be necessary. To add to this discontent, women's movement also questioned the male dominance in medicine and termed modern medicine as suppressive towards women on many counts. In both the cases the main question was of freedom of choice and freedom of decision making.

[102] Murray, J. 2007, *op cit*

[103] Gorman, L. 2006, *op cit*

Because of such limitation in insurance plan, people started forming mutual support groups for specific diseases like cancer, degenerative diseases etc which need long term and palliative care. In 1980 the then West Germany announced cut in government funding for health care leading to a sudden upspring of such mutual help groups. These groups apart from providing care and support also provided financial help to its members seeking alternative treatments which were not covered by existing social insurance and private insurance. The main objective behind this kind of arrangement in developed countries was to reclaim the decision making power about one's own health and also create examples for the government, medical and insurance industry to adopt appropriate alternative treatments for individuals.[104]

The concept of empowerment promoted by mutual support groups took a complete different face when this concept was adopted in developing and under developed countries. Most of these countries were in Asia and Africa, recently liberated from long years of colonial rule. The colonial rulers in most of these countries left with extremely rudimentary infrastructure and resource base. The most critical issue confronting these newly independent countries was to rebuild the country and establish a viable economy with available technology and resources. To make the situation worse, internal and ethnic conflict often followed independence. Military expenditure was always high priority for these new governments followed by issues like industry, mining, agriculture for ensuring economic growth. Other social sectors like health, educations etc. were of least priority. In most of these countries organized public health service system was not available and whatever health services was available it was meant for the colonial rulers or their military. The high health care cost, non availability of public health services and dominance of private providers forced people to form local community support groups and make alternative arrangement for health care payment. The health insurance groups formed under Bamako Initiative are good examples of these arrangements and Algeria

[104] Razum, O. and Nayar, K. R., 'Third option or no option, Self Help in Health Care' , in Uirich, L And Radermacher R,(eds), 2006, *Financing Health Care A Dialogue Between S E Europe And Germany*, International Public Health, Vol 18, Federal Ministry for economic Cooperation and development Germany

is one of the pioneering countries where community health financing was tried as method of health financing.[105]

Over the years CBHI become a major system of health care financing in developing and less developed countries. It has transformed into a popular and viable alternative to provide access to health care for everybody at a reasonable price. A broad working definition of CBHI is "Any scheme managed and operated by an organization, other than a government or private for-profit company, that provides risk pooling to cover all or part of the costs of health care services".[106] This definition has three major components i.e. community initiative for risk pooling, voluntary membership to the schemes and prepayment for health care associated cost. The CBHI generally developed around some common entities like[107]

a. Geographical entity like village, block, local self governance area,
b. Professional entity like trade union, informal workers union,
c. Service provider like hospital, bank or credit society or a community based / non-governmental organizations.

The introduction of user fees at different level has reduced the peoples' capacity to access health care facilities. Health sectors reforms around the world have acted against the strengthening of the existing public health service system by reducing public expenditure on health. Also as a part of reform many function of the public Health service system have been contracted in or contracted out to the private player. In many countries, because of the internal and external conflict, or prolonged dependence on the external funding or donation has resulted in collapse of health infrastructure creating inaccessibility to the services. The rising out of pocket expenditure on health becomes one of the major barriers for accessing health care and creating indebtness amongst the

[105] Ogunbekun, I. et. al. 1996, 'Costs and Financing of Improvements in the Quality of Maternal Health Services through the Bamako Initiative in Nigeria', Health Policy and Planning, 11(4) pp. 369-384

[106] Bennett, S. 2004, 'The Role of Community-Based Health Insurance within the Health Care Financing System: A Framework for Analysis, *Health Policy And Planning* 19(3) pp. 147–158

[107] Ahuja, R. 2004, 'Health Insurance for the Poor', *Economic and Political Weekly*, July 10, pp 3171 – 3178

poor. Because of such reasons and global concern about reducing the inequity created by the failure of both market and public health service system, the CBHIs started getting renewed interest from various stakeholders like academia, implementers, policymakers and international organizations. The commission on macroeconomics and health also stressed on the importance of channelizing the out of pocket expenditure on health through the community based health financing mechanism.[108]

CBHI is a global phenomenon. The presence of CBHI can be seen in all the continents, especially in the developing countries where the people's capacity to spend and the coverage of social security are low. The CBHI efforts are mainly localized in nature. The comparative studies of the CBHI in Africa and Asia shows a striking difference. The membership base and the geographical spread of CBHIs of Asia are large and more spread out than the CBHIs of Africa. The linkage with the government and tie up with the various service providers are more structured and well managed in case of the CBHIs in Asia as compared to the CBHIs in Africa. Another interesting characteristic of most of the CBHI in Asia is that they are linked to bigger MFIs, which is not the case for Africa, giving a larger financial security for the Asian CBHI.[109]

At the time of state failure to provide quality essential care to the poor and marginalized and the failure of market (convenience of market) to include them in their insurance plan, CBHI are able to mobilize resources, provide financial security and accessibility to health facilities and limit out of pocket expenditure. Community-based health insurance has been able extend coverage to a large number of people who would otherwise not have financial protection.[110] It also fills the gaps created by other health financing system both public and private in the process of transforming into a larger scale system. As a part of this transformation the health service system left out many groups or section out of protection because of structural issues. The CBHI can service

[108] Sachs, J. 2001, '*Macroeconomics and Health: Investing in Health for Economic Development*', Report of the Commission on Macroeconomics and Health, WHO, Geneva

[109] Tabor, S. 2005, '*Community-Based Health Insurance and Social Protection Policy*', Human Development Network, Washington DC, The World Bank,

[110] Jakab, M. et. al. 2001, 'Social Inclusion and Financial Protection through Community Financing', *Health, Nutrition, and Population Discussion Paper*, The World Bank, Washington DC

these groups as an ad-hoc/intermediate system till the major system is ready to include the left out sections. However the protections provided by the CBHI are limited by its resource generation capacity. The services offered are directly proportional to the revenue generation capacity. The limitations in revenue generation raise the question of sustainability of these schemes. CBHI in many times fails to provide services to the poorest of the poor even though it is meant to cover them. The household which can afford to pay tends to dominate the CBHI membership and leaves out the marginalized who are unable to pay premium.[111]

The next chapter deals with CBHI as a method of health care financing and the modalities of the insurance. It also looks into various models of CBHI generally followed and practiced throughout the world.

[111] Gottret, P. and Scieber, G. 2006, *op cit*

CHAPTER - 3

COMMUNITY BASED HEALTH INSURANCE: MODALITIES AND MODELS

COMMUNITY BASED HEALTH INSURANCE: MODALITIES AND MODELS

CBHI has been seen as a form or type of health financing that can ensure health equity and access to basic health care to the population. In majority of low and middle income countries, the inequity of health care access is rising because of the shortcomings on the part of public and market failure in health service provisioning. The CBHI is gaining importance as an alternative to provide the health care services in economies marked with failure of health service system because of its affordability, localized nature and close support system associated with it. The user fees and the premiums in private health insurance are generally higher and unaffordable to the poor compared the cost of enrolling in a CBHI. Before discussing the CBHI as a method of health financing, its modalities and models it is necessary to understand the basic principle of health insurance mechanism.

3.1. Principles of Health Insurance

The insurance and health insurance in particular, operates on the principle of risk pooling of loss and sharing financial burden and creating balance of financial security between better days and worse days.[112] The foundation of insurance is drawn or based on Cost Benefits Analysis and Cost Effectiveness Analysis for making choices. Every person is a profit maximizing individual, therefore each and every decision of individuals is influenced by the amount of received upon his investment and seeks the best possible services at lowest possible cost. These decisions are generally informal and based on internal calculation and not often a conscious thought. The decisions of choosing services (facilities) are taken on the basis that the opportunity cost between the services and expected value benefit to be gained from the alternative. But health

[112] Getzen, T. 2004, *op cit*

concern may not always follow a pure economic pattern as it revolves around human lives[113].

So when the costs of the treatment are ever increasing the logical choice for the profit maximizing human being is to share the risk and maximize the coverage against the disease. As health incidents are unpredictable, therefore nobody can predict who will fall sick and who will not, but everybody will not fall sick at the same time. Therefore if the risk is shared amongst the people, the financial burden of treatment can be reduced, as the cost is subsidized by the entire members of the community. The insurance therefore is pricing of the risk and selling the risk to individuals on the basis of expected value benefit and opportunity cost. Insurance gives access to the resources and makes the resources available by creating health service security when needed by its members. In insurance terms the choice to opt for insurance depends upon the following reason and calculation[114],–

3.1.1. Risk Aversion

Life is full of risk and these risks are very unpredictable. But with the available technology and knowledge, the risk can be managed, or limited. The management or the limitation of risk generally cost a fraction of what it might have cost to take the risk. Therefore people opt for insurance to maximize the benefit and reduce risk by averting risk burden.[115]

3.1.2. Adverse Selection

Normally every individual has equal chance of getting sick and being disabled without any preselected criteria. But by virtue of profession, social gradient, personal behavior and genetics, influences the propensity to be at risk. The person at risk group tends to buy more insurance to compensate for the additional risk. The insurance company also tries to average the higher risk by selling more insurance to the not so high risks groups.

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[113] *ibid*

[114] Morrisey, M. 2007, *'Health Insurance'*, AUPHA Press, Washington DC,

[115] *ibid*

In practice the insurance company generally charges differential premiums to avert adverse selection.[116]

The choice for opting health insurance depends upon the calculation of the medical benefits which are to be gained.-

3.1.3. Health

Ensuring health service security helps in preventing major health crisis. The health seeking behaviour of individuals improved when the individual is sure of having access to good health care at affordable cost at all the times, averting major health crisis.[117]

3.1.4. Productivity

The better health status leads to better productivity and thus increasing house hold and individual income.[118]

3.1.5. Reduction of Future Medical Cost

The security for financial assistance, access and affordability for any future health crisis also works as an incentive to opt for health insurance.[119]

On the other hand the pricing of health insurance also depends upon certain calculation of medical cost. Higher the cost calculated more will be the price to be paid for the insurance. The major medical costs are taken into consideration while calculating the premiums are –

3.1.6. Cost of Medical Care

Like all other consumable services, medical care also comes with a price. The price includes the cost of expertise, establishment, technology, pharmaceuticals and

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[116] *ibid*

[117] *ibid*

[118] *ibid*

[119] *ibid*

administration. So the ultimate cost of the treatment is always higher than the actual cost of the treatment and influenced by facilities or providers.[120]

3.1.7. Follow up and Treatment

Medical problems are generally not a onetime affair and need follow-ups involving secondary treatment cost which are not part of the direct treatment. Therefore if the secondary treatment cost is high for certain disease the premium will increases proportionally.[121]

3.1.8. Time and Suffering of the Patient and the Family

Medical condition is always associated with the suffering, pain and loss of productive time. These kinds of associated cost are generally far more than the actual cost incurred in the treatment. These costs are very difficult to calculate and compensate but it affects individuals.[122]

3.1.9. Providers Time

The provider's time and convenience also affect demand and supply of the health care services. The demand and supply of the services are determined to a great extent by the provider, his reputation, competencies and expertise. More the demand for the provider, the cost of supply of the services will also be high, influencing the price of insurance.[123]

3.1.10. Moral Hazard

When an individual has some kind of risk coverage then the individual tends to take advantage of the coverage by either indulging in risky behavior or over utilizing the facility compared to a person who does not have the same risk coverage. This is called moral hazard and it plays an important role in calculating the cost of the insurance.[124]

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[120] *ibid*

[121] *ibid*

[122] *ibid*

[123] *ibid*

[124] *ibid*

CBHI like any other health insurance provides financial protection from high cost of health care and its impact on household economy. Most of the health economists see CBHI as a transitional mechanism to provide universal health access and health equity in low and middle income countries.[125] CBHI is also seen as a poverty reduction and household debt reduction strategy. In most of low and middle income countries the public health service systems are either not functioning, or not effective. The user fee generally acts as a deterrent to the access of health care by poor people. And in many instances the free services are not usually free but accompanied with associated cost like medicine, investigation, transportation etc. which creates a huge financial burden. With the reduction of public spending on health, a number of services offered under public health services were curtailed. These changes in health service system directly influence the health seeking behaviour like delay in treatment- seeking results in exposing the population to a greater health risk. The low and middle income countries have a higher concentration of disease like Malaria, TB, diseases related malnutrition and HIV/AIDS (Especially in Africa). These diseases act against the household financial security in two ways. Firstly the treatment period is generally very long and secondly it is associated with loss of productivity.[126] In this situation the cost of health care becomes catastrophic because of high treatment cost associated with loss in family income generally creating debt for the household. The CBHI is a mechanism which is aimed to provide health service security to the household with low income and asset as both the state and private insurance schemes are not equipped to provide health care for poor people without regular income.[127] The CBHI is seen as a local level initiative with voluntary membership where the membership fee is decided upon mutually by the member to provide basic financial security during health crisis.

[125] Mladovsky, P. and Mossialos , E. 2008, 'A Conceptual Framework for Community-Based Health Insurance in Low-Income Countries: Social Capital and Economic Development', *World Development*. 36(4) pp. 590–607,

[126] Tabor, S. 2005. *op cit*

[127] Ahuja, R. and Jütting, J. 2003, '*Design Of Incentives In Community Based Health Insurance Schemes*', Working Paper No 95, Indian Council For Research On International Economic Relations, New Delhi,

Efficient management and operation of a CBHI depends upon certain major factors like[128] –

3.1.11. Enrolment, Membership and Revenue Collection

The success of CBHI depends upon a healthy enrolment. The membership criteria should not be biased towards specific social or economic group. The enrolment to the scheme should be sufficient enough to assure a viable generation of revenue to provide services to members. Reducing out of pocket expenditure will not be possible if the revenue generation remains low. The higher the amount of health insurance contributions, the more people can avoid the financial burden of treatment costs and access care when required. The revenue of CBHI is not only limited to the members contribution but also include subsidy provided by Government Service providers, parents organization, and other donors. The financial security increases manifold if the CBHI has more linkage to various agencies and authorities.

3.1.12. Practice of Risk Pooling

The risk pooling practice is a major success factor of a CBHI Operation. CBHI generally operates on the basis of calculation of average treatment cost. The risk pooling is based on attracting healthier members to the scheme which can subsidize the cost of health care used by the risk group. In a poor economic setting usually financially better off population is healthier than the marginalized ones. If this group of population does not opt for the scheme, the average treatment cost will remain high resulting from lower contribution for the members. The CBHIs ability to cross subsidize contribution and risk helps it to provide comprehensive care.

3.1.13. Strategic Purchasing of Services

The strategic purchasing is very important as it ensures arrangement of best possible service provider and most economical with best payment system. The major problem for the CBHI is to get consent from its members on deciding the list of healthcare

[128] Carrin, G. et. al. 2005, 'Community Based Health Insurance in Developing Countries: A Study of its Contribution to the Performance of Health Financing Systems', *Tropical Medicine and International Health* , 10 (8) pp 799–811

service providers for its member, the number of insured health services or benefit package, set quality standards of care and to the payment mechanism for service provider. Getting mandate on all the above mentioned factors become very difficult task for the fund managers of CBHI, as the need and perception of each and every member is different. The location of service provider, inclusion of additional services like investigation, transportation, alternative system of medicine etc. affect the subscriber base, universality and comprehensiveness of the CBHI.

Table 7: Factor Influencing Functioning of CBHI

Health financing subfunctions	Factors influencing performance of CHI
Revenue collection	Enrolment
	Affordability of contributions
	Unit of membership
	Distance
	Timing of collection
	Quality of care
	Trust
	Prepayment ratio
	Mix of contributions by households, central and local government, donors
Pooling of resources	Trust
	Mechanisms for enhanced risk pooling
Purchasing of services	Contracting
	Provider payment mechanism
	Referrals
	Waiting period

Source: Carrin, Guy, Community-based health insurance in developing countries: a study of its contribution to the performance of health financing system, 2005

The above illustration clearly summaries the factors that influence the functioning and success of CBHI as discussed in the previous paragraph.

3.2. Typology of CBHI

Based on the above mentioned issues and operational linkages, the existing CBHIs can be classified into few specific models. Sara Bennett[129] has classified CBHI into five Models and N. Devadasan[130] has classified it into 3 models in their respective research. The understanding of these models is necessary to have a comprehensive view of the operation and effectiveness of CBHI.

3.2.1. Classification by Sara Bennett

Sara Bennett in her comprehensive work on CBHI throughout the world analyzed various CBHI models, their operation, coverage, management and how the CBHI address the issue of equity and access of health care. In her paper "The Role of Community-Based Health Insurance within the Health Care Financing System: A Framework for Analysis" she has given the existing models of CBHI which are in operation. Her argument is that most of the model evolved from one basic model which was modified to suite different operational issues. In her framework she disused the basic model and its four derivatives, which are looked as different models because of their vast difference from the basic model.

This is the Basic model given by Sara Bennett. This model is very simple and linear in nature. Here the members pay premium to the CBHI scheme for the insurance which the scheme pays to the service provider for an assured set of services and the members whenever required access the services as defined by the scheme from the provider. This is a classic mechanism of what CBHI is supposed to do. This model has some inherent issues like comprehensiveness of benefit. In such model it is not possible to give comprehensive care as many of the services, which involves higher cost many not be included in comprehensive package.

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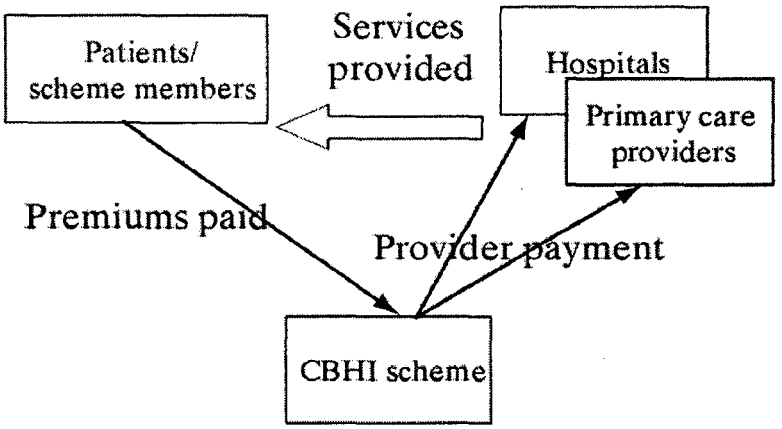
[129] Bennett. S , 2004, *op cit*

[130] Devadasan, N. et. al. 2004, 'Community Health Insurance In India: An Overview', *Economic And Political Weekly* July 10, pp 3170-3183

The models of CBHI as suggested by Sara Bennett are discussed below:

Model 1: Basic Model[131]

Figure 5: Basic Model



Source: Bennett, S, The Role of Community-Based Health Insurance within the Health Care Financing System: A Framework for Analysis 2004

This model is not generally seen in practice as many more factors like co-payment, subsidies, universal coverage etc. influences the functioning of the schemes.

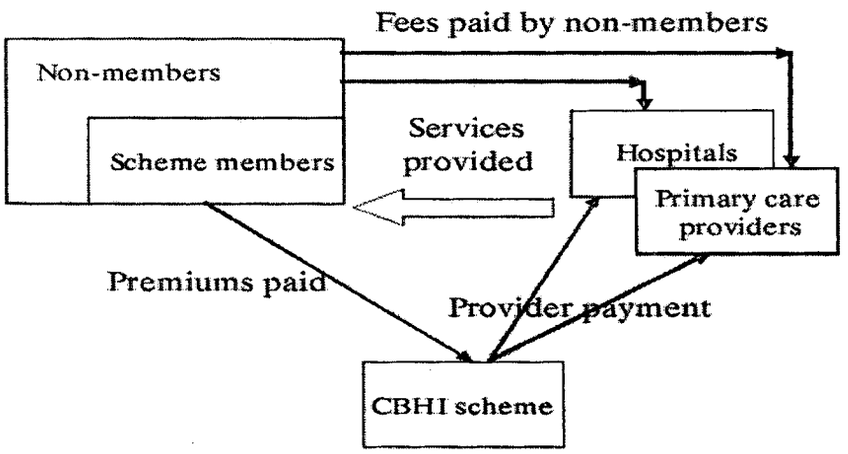
Model 2: Inclusion of Non Members to Service Provisioning[132]

It is not possible for CBHIs to achieve complete universal coverage for their target population due to various reasons like, apprehension, inability to pay premium, and social stratification.

[131] Bennett, S, 2004, *op cit*

[132] Bennett, S, 2004, *op cit*

Figure 6: Inclusion of Non Members in Service Provisioning Model



Source: Bennett, S, The Role of Community-Based Health Insurance within the Health Care Financing System: A Framework for Analysis 2004

Therefore this resulted in many households remaining out of CBHI coverage. But whenever a medical emergency takes place, the non members also seeks services from the provider. To accommodate such non members demand for services CBHIs generally modify their models giving them a limited coverage. In most of the cases the provider charges a separate fee from non members for the services utilised. This model is very common where the CBHI scheme has tie up with unsubsidized provider and prior experience of utilization of services by non member. The SEWA CBHI scheme in India is close to this model.

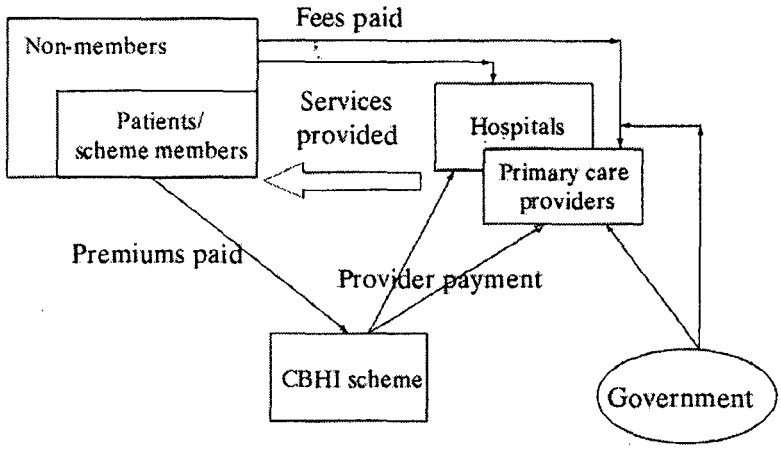
But this model has to deal with some serious operational issues. The issues of the proportion of nonmembers to the total target population and their profile is one such issue. If the proportion of non members is greater than members, then the CBHI scheme will not be able to survive. If the poor and marginalized which requires the security most are not the members then the CBHI may have some issues in pricing of product or social inclusion. The model further raises some more question like how the services are distributed between members and non members, as it is limited, what is the ratio of providers revenue earned from the user fee and CBHI payment, whether there is any difference between the, quantity and quality of paid service and CBHI services as the

members should not be discriminated because of utilization of services by non members. This model does not work if providers' services are subsidized by some outside agency like Government, or donor and aid agencies.

Model 3: Inclusion of Non Members and Subsidized Services[133]

This is the most common model for the CBHIs in Sub Saharan African Countries. In these countries the CBHIs generally uses insurance coverage to pay for the utilization of public funded services. In most of the eastern and southern African countries the health services system charge a high user fee as the public health service systems are in transition

Figure 7: Inclusion of Non Members and Subsidized Service Model



Source: Bennett, S, The Role of Community-Based Health Insurance within the Health Care Financing System: A Framework for Analysis 2004

from public funded to cost sharing based models after the reforms. However the services (Public) are generally subsidized compared to the private services as government bears a portion of the cost. In this model the members of the schemes get double subsidy as CBHI apart from the government also covers part of the cost. However the non members who have utilized the services still have to pay for the services which are in principle subsidized. Like the previous model this model also

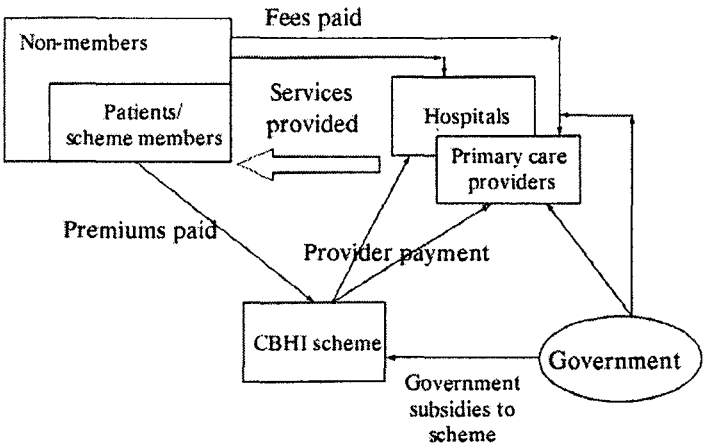
[133] Bennett, S. 2004, *op cit*

raises some valid questions like the level of difference in revenue earnings from CBHI, subsidy and out of pocket expenditure for the provider, level of reduction of out of pocket expenditure for non members, level of improvement in access to the facilities because of the CBHI and subsidy (at deferent level), and synchronization of benefit package by CBHI with government subsidy.

Model 4: Direct Subsidy to the CBHI Schemes by Government or Other Agency [134]

The fourth modified design as described by Sara Bennett looks into a situation where CBHI schemes are being financially assisted or subsidized. This type of model is not very common in practice.

Figure 8: CBHI with Direct Subsidy Model



Source: Bennett, S, The Role of Community-Based Health Insurance within the Health Care Financing System: A Framework for Analysis 2004

In recent years, in countries like Thailand, Cambodia, Tanzania this kind CBHI is getting popularity. The government pays an equal amount to the premium paid by the members or to the total collected revenue. The reasons for paying the equal grant are varied like to bring equity in health security or to bring down the premium to an affordable level. The costs of treatment in low and middle income countries are

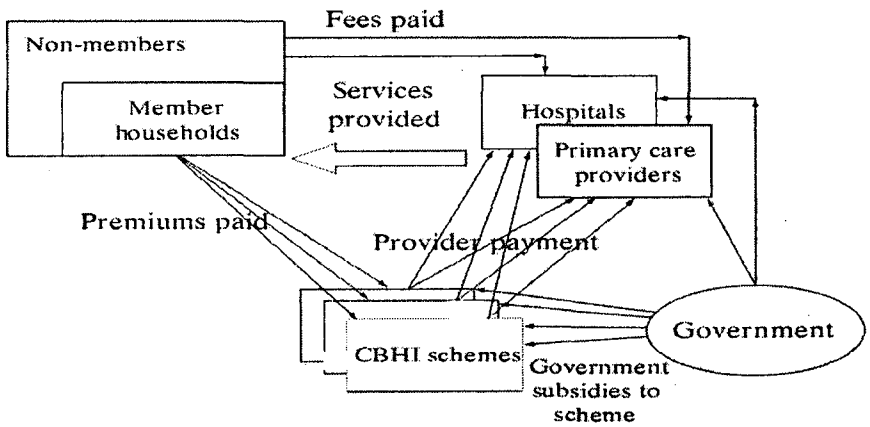
[134] Bennett, S. 2004, *op cit*

relatively high for the poor and marginalized section. The CBHI may not be able to give a comprehensive coverage to its member for the amount they pay as a premium. Therefore it becomes necessary to arrange for additional finance to make the CBHI viable to cover essential medical care. The Government generally provides the additional support out of their responsibility to provide basic services to its citizen. In many cases some external donor or aid agencies also provide assistance to CBHIs to provide better service benefit package. What becomes interesting in this model is to see how CBHIs use the direct subsidies provided to them? Whether the additional funds are being used for enhancing the service package or to increase the coverage? The answers to these questions remain with the management of the CBHI as the additional money is meant for enhancing the package.

Model 5: Multiple Risk Pooling [135]

Multiple risk pooling models exists in the countries where different kind of health service security models like Social Health Insurance, well functioning public health service system or even highly subscribed private insurance system are operating.

Figure 9: Multiple Risks Pooling Model



Source: Bennett, S, The Role of Community-Based Health Insurance within the Health Care Financing System: A Framework for Analysis 2004

[135] Bennett, S. 2004, *op cit*

The existence of multiple risks pooling system makes the situation very complicated. The reason for the existence of the multiple risk pooling can be varied, like non clarity in the part of government, the type of model for risk pooling to be adopted, or different service coverage for different risk pooling system or segregated and competitive market where people are free to choose from different risk pooling system. The main problem with the multiple risks pooling system is the provider tries to earn more revenue by pitching the schemes against one another. The schemes also try to push high cost- high risk services to other schemes. This model is very common in highly privatized economy. The members generally have to pay different premium to different schemes to get comprehensive coverage. In this kind of design the cost of getting service benefit is generally high with chances of creating health inequity in accessing health care services.

3.2.2 Classification by N. Devadasan

In the article "Community Health Insurance In India: An Overview" by N. Devadasan[136] and et.al the CBHI designs are classified in three distinct group on the basis of insurer. The typologies of CBHIs as classified by Devadasan are discussed below –

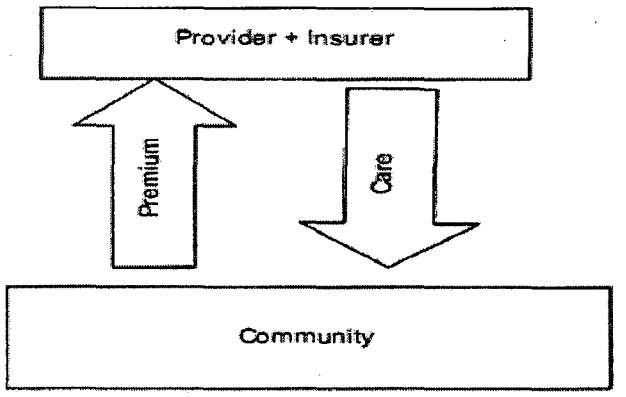
Model 1: Provider Based Model (Hospital Based)[137]:

In this design of CBHI the service provider generally a hospital act as an insurer. The service provider offers a cashless system of health care for predefined sets of services decided collectively on a pre payment basis for its members. The community or the members pays premium directly to the hospital on monthly or yearly basis. The hospital manages the funds and provides the services to the members as and when required.

[136] Devadasan, N. 2004 *op cit*

[137] *ibid*

Figure 10: Provider Base Model



Source : Devadasan ,N. Community Health Insurance In India: An Overview, 2004

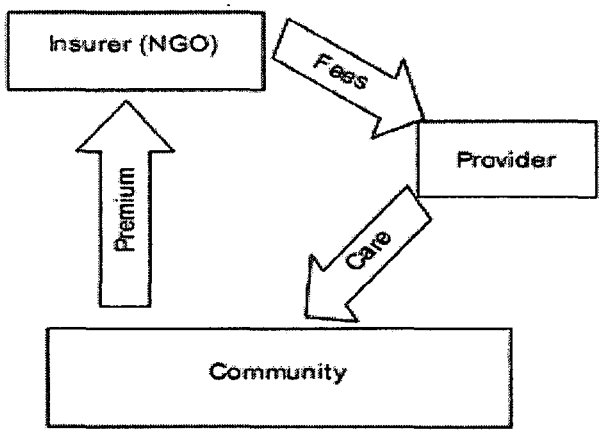
In this model the hospital tries to keep the cost in check by various means like they will only use generic drugs or take subsidies from other sources. The cost of managing this design of CBHI is low as there is practically no administrative cost incurred to manage the fund. The major drawback of this model is that the benefits covered are only those which are available with the insuring hospital. The benefit cannot be claimed in any other places.

Model 2: Where Insurer is an NGO[138]

In this design of CBHI generally a NGO or CBO acts as the insurer. The NGO/CBO organizes the community and initiates the insurance. The services availed can be cashless or on reimbursement basis. The NGO/CBO negotiate with a set of independent service provider for certain sets of services and based on the average cost of the treatment and administrative cost the premiums are collected from the community or members. The payment to the providers may be on number of user basis or fixed basis. In case of a cashless system the members can use the services directly from the providers and NGO/CBO pays the fee directly to the providers.

[138] *ibid*

Figure 11: NGO/ CBO Based Model



Source: Devadasan ,N. Community Health Insurance In India: An Overview, 2004

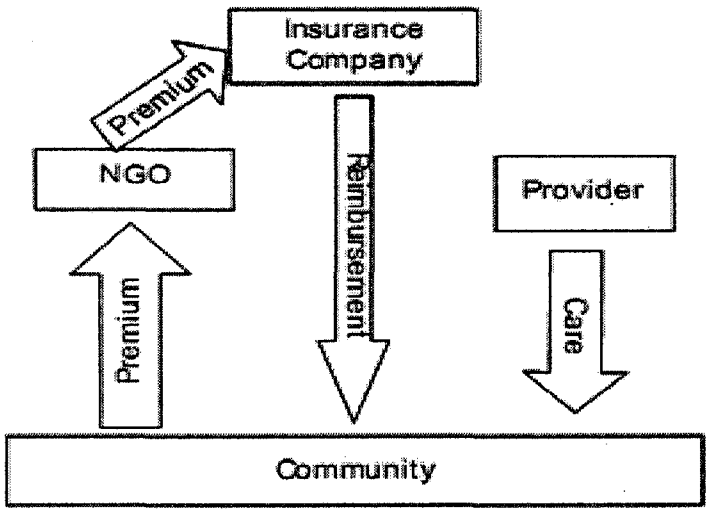
In reimbursement system the member initially pays and the NGO/CBO reimburses the cost on production and verification of bills. The cost of the premium in these schemes depends upon the negotiating power of the NGO/CBO with the independent service providers. Generally the providers are for profit institution which can increase the price of the benefit package. Many a times the providers do not want to include diseases of chronic nature and which have long duration of treatment turning it difficult for the NGO/CBO to provide a comprehensive coverage. Another issue with these schemes is the expertise of fund management with the NGO part. If fund management is not strong, the sustainability of the CBHI becomes questionable.

Model 3: Third Party Management[139]

The third designs classified by the authors are a third party based model where the NGO/CBO takes insurance cover from a professional insurance company for a particular set of services.

[139] *ibid*

Figure 12: Third Party Management Model



Source: Devadasan ,N. Community Health Insurance In India: An Overview, 2004

In recent years this design has become very popular as the responsibility of the NGO becomes limited to negotiate with the professional insurer rather than negotiate with the independent service providers and managing the funds. In this design the NGO/CBO buys insurance coverage for its members from an insurance company for some specific services. The NGO collects the premium from the members and pays the insurance company as a premium for the services purchased. The negotiation with the service providers is the responsibility of the insurance company. The members can get a cashless or a reimbursement basis service from the service providers notified by the insurance company for a fixed amount for fixed sets of services. The major drawback of this model is that the NGO or CBO does not have control over the pricing of services. The services cost may be decided at a level which is beneficial to the insurer rather than the consumers and costs may also vary from facility to facility.

The CBHI schemes are very popular throughout the world especially in low and middle income countries. Therefore it has become essential to review the schemes and evidences created by them to understand the extent of success in addressing the issues of equity, universality and comprehensiveness in health care.

The following chapter deals with reviewing evidences produced by these schemes through review of existing literature in the light of health equity, universal coverage and comprehensive care.

CHAPTER - 4

COMMUNITY BASED HEALTH INSURANCE: REVIEW OF SCHEMES

COMMUNITY BASED HEALTH INSURANCE: REVIEW OF SCHEMES

The former secretary general of UN Kofi Annan once stated that the biggest enemy of health in developing countries is poverty.[140] Health and poverty plays a vicious circle in low and middle income countries. The heavy burden of infectious diseases along with the high level of cost push the individuals and household in a poverty trap which again perpetuate the onset of diseases in the individuals.[141]

Improved health service security [142] by ensuring better access to affordable comprehensive health care for the poor and marginalized may be the only way to address the growing inequity in health.[143] Over the period of last two decades CBHI has been promoted and popularized in low and middle income countries across the world as a practical measure to improve health service security. CBHI addresses the issue of health service security in two major ways. Firstly, it ensures financial security during medical emergencies preventing medical poverty trap. Secondly, it improves access to treatment and preventive services leading to improved health status[144]. Because of the medical poverty trap in Low and middle income countries loss of income and household financial security because of the illness and death of family members is regarded as the highest risk factor. The studies conducted by various researchers like Emerson, Matul and McCord proves this.[145] Addressing insecurity becomes a major issue for health economists and policy makers as it has a two way effect – firstly, it increases the household debt of families as most of them do not have savings to meet the cost of treatment or do not have any other formal or informal

[140] World Health Assembly 2001 Key Note Address, as available on http://www.un.org/News/Press/docs/2001/sgsm7808.doc.htm as accessed on 03-04-2010

[141] Whitehead, M. et. al. 2001. 'Equity And Health Sector Reforms: Can Low-Income Countries Escape The Medical Poverty Trap?' *The Lancet 358* pp 833-836

[142] Baru, R. 2006, *op cit*

[143] Brown, W. and Craig, C. 2000, '*Insurance Provision in Low-Income Communities – Part II: Initial Lessons from Micro-Insurance Experiments for the Poor*', Microenterprise Best Practices Project

[144] Rugers, J. 2006, ' Measuring Disparities in Health Care', *British Medical Journal* ,333; pp. 274

[145] Craig, C. (ed). 2006, *Protecting the Poor*, ILO, Geneva,

mechanism to meet the cost and secondly, because of financial constraint there is a delay in treatment seeking which results in medical emergency and far more increase in medical cost.

The health service systems in low and middle income countries are in a dismal state with contestation between the state provisioning and market participation. Most of these countries have gone through health system reforms which promoted a new kind of health service system over the existing the mechanism. The reduction of public spending and increasing private participation in health service delivery is directly related to increasing inequity in access to health services. The health services are no more affordable to the poor.[146] The user fee and other public health care services promised as free services also come at a price. This confusion in provisioning the health care services, (whether by public system or private system / free or with fee) reduces the access and utilization of health care by poor.

This chapter tries to analyze the role of CBHI in improving health equity, universal coverage and comprehensive care in low and middle income countries based on available evidences. This chapter mainly deals with the CBHIs of Africa and Asia. Asia and Africa are taken as they share some common characteristics. Both these continents share a history of colonial rule and most of the countries gained independence after the Second World War. In addition many of these countries, especially in Africa has poorly developed health service systems as a result of which there was partial or lack of access to large populations. The big challenge in these countries was ensuring universal access to comprehensive health care for the poor or low income groups'.[147].

The CBHI projects were one of the strategies developed to improve equity in access to health services across several developing countries. Based on the systematic review of literature the study proposes to examine to what extent these projects have addressed

[146] McIntyre, D. et. al., 2008, 'Beyond Fragmentation And Towards Universal Coverage: Insights From Ghana, South Africa And The United Republic Of Tanzania', *Bulletin of the World Health Organization* 86 (11)

[147] Ahuja, R. and Narang, A. 2005, 'Emerging Trends in Health Insurance for Low-Income Groups', *Economic and Political Weekly* September 17, pp 4151-4158

the core principles of equity, universality and comprehensiveness as defined by the primary health care approach.

4.1. Equity in Health Care

Health equity is one of the very complex concept and challenge in health care provisioning and debates around health service security. The Universal Declaration of Human Rights (UDHR)[148] states "Article 25. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." In this article of UDHR emphasis is given to ensure equity in health care access, and health service security and the determinants of health. Nobody should be denied the right to utilizes and accesses the health services when required. WHO defines[149] the inequity in health as "differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust." This definition remains very narrow and does not include the types of differences and how to avoid them. A wider definition was given by James A Macinko and Barbara Starfield defines health equity[150] as "the absence of systematic [and potentially remediable] differences in one or more aspects of health status across socially, demographically, or geographically defined populations or population subgroups." Equity in health services "implies that there are no differences in health services where health needs are equal (horizontal equity) or that enhanced health services are provided where greater health needs are present (vertical equity)." This definition of the health equity stress that the differences in health status arise because of

[148] Universal Declaration of Human Rights as available at:http://www.ifs.univie.ac.at/intlaw/konterm/vrkon-en/html/doku/humright.htm#1.0, as accessed in 04-04-2010

[149] PAHO, 1999, 'Principles and Basic Concepts of Equity and Health – Discussion paper' PAHO-WHO, Washington DC

[150] Macinko, J. and Starfield, B. 2002 , 'Annotated Bibliography on Equity in Health, 1980-2001', *International Journal for Equity in Health International Journal for Equity in Health* , 1:1, 22 April

social, geographical and population determinants and horizontal and vertical equity are greatly influenced by these determinants. The health inequalities are results of the socio economic differences present within the countries and also between countries which directly determine the people's propensity of risk to illness and the actions to prevent or treat illness when necessary.[151] The commission on Social determinants of health observes that[152] Health Inequities are the result of a complex system operating at global, national and local levels which shapes the way society, at national and local level, organize its affairs and embodies different forms of social position and hierarchy. The place people occupy on social hierarchy affects their level of exposure to health damaging factors, their vulnerability to ill health and consequences of ill health.

The issue of health equity becomes more important with changes in the health services provisioning and health care financing practices. With the stagnation and reduction of the global public health expenditure[153] and increasing out of pocket and private financing of health care[154,155], the less and less people are able to access the health services . The health service systems (both state led and market led) have some inherent intricacies like the chronic under resourcing of health service system, lack of proper leadership, shortage of health personnel or changing in financing practice (for state led health service system) increasing cost for service utilization, technology dominance, focus on certain services (for market led health service system) creates health inequity. Moreover the responsiveness of health service system, community participation, explicit policy for including the marginalized section in the health service system also affect the health equity.[156]

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[151] Marmot, M. 2007. 'Achieving health equity: from root causes to fair outcomes', *The Lancet* 370: 1153–63

[152] *ibid* pp 1156

[153] WHO 2009 *op cit*

[154] WHO 2000 , *op cit*

[155] WHO 2009 *op cit*

[156] Equity in Health System Development, Dossier Series, as available at http://www.ccghr.ca/docs/CIDA_Africa/EquityinHealthSystemDevelopment_dossier.pdf accessed on 12-03-2010

The question of health equity is of utmost importance for CBHI system and for its management and operation. CBHIs are being promoted as an effective mechanism to address the health inequities created by the failure of the dominant system of health service. A dominant health service system whether public or private is supposed to ensure access, utilization of health care services by the population whenever needed. It has been seen that over the years the access to the facilities and utilization of health services is reducing in low income countries. The health service system often creates these inequities. The public health service system in the low and middle income countries tends to address the services which are utilized more by the people who can afford it while imposition user fees deter the poorest from using the services.[157]

4.2. Universal Coverage in Health Care

One of the basic problems faced by most of the dominant health service system is to achieve the universal coverage of health service system to the population it caters. The definition of universal coverage as given by Joseph Kutzin[158] states "physical and financial access to necessary health care of good quality for all persons in a society. It implies protection against the risk that if expensive (relative to an individual's or family's means) health care services are needed, services of adequate quality will be physically accessible, and the costs of these services will not prevent persons from using them or impoverish their families." The definition states that every person should be assured of access and affordability of health care services whenever required and that they should not be stopped from utilizing or access health facilities because of their social and economic condition. Achieving universal coverage is an important objective of CBHI because of two major reasons. Firstly CBHI is being promoted to provide health care services to the population group who are outside of the health service system because of the social or economic determinants, secondly CBHI should also bring the health equity through ensuring access and affordability of the services.

[157] Marmot, M. 2007, *op cit*

[158] Kut Zin, J. 2000, 'Towards Universal Health Care Coverage', *Health, Nutrition, and Population Family Paper.* The World Bank Human Development Network, USA

4.3. Comprehensive Coverage in Health Care

To ensure better financial protection to the poor it is necessary to provide comprehensive coverage. Comprehensiveness means that the scheme covers various services necessary for the health care like inpatient, outpatient, referral, medicine etc. Ensuring comprehensiveness is necessary for the CBHI as all these components contribute equally towards cost of the treatment. It is ideal to have a comprehensive care different illness need different care and service. While some disease can be cured through outpatient consultation some may need hospitalization, the cost of medicine may also very as the medication may be needed for different time duration. Thus it is necessary to look into the comprehensive nature of CBHI schemes.

4.4. CBHI Schemes and Evidences

The first experiment with health insurance by communities or community based organization was done in West Africa between late 1980 and early 1990 under the Bamako Initiative[159]. UNICEF along with WHO initiated the Bamako Project in Western African Countries to ensure universal access to primary health care. To achieve the universal access to primary health care the Bamako initiative formed some guiding principles. Firstly the primary health care service provisioning should attain a self sufficiency through generation of revenue at facility level. This principle paved the way for charging user fees from the facility user to turn the facility programmatically viable and self sufficient. Secondly the cost of the medicine should be kept minimum and access to medicines to be improved. To achieve this only use of generic medicine were recommended and branded medicines were discouraged [160]. Thirdly to ensure transparency and accountability at facility level and in the complete health service delivery structure the participation of community was encouraged. The Community Based Organization of the Bamako initiative nations got the opportunity to actually manage and influence the functioning of the facilities. However, soon the Community

[159] Garner, P. 1989, 'The Bamako Initiative Financing Health In Africa By Selling Drugs', *British Medical Journal*, 299 pp 278 -279.

[160] Craig, C. 2006, op cit

Based Organizations who were part of the facility management system realized that the people are too poor to afford the health care facilities by paying the user fees. Therefore the schemes, mainly prepaid schemes, were developed around the facilities by the CBOs to ensure financial assistance to the people. Although the initiatives were taken by the CBOs the seed fund for the schemes were generally provided by some external organizations like International development agencies, Church organizations etc. [161]

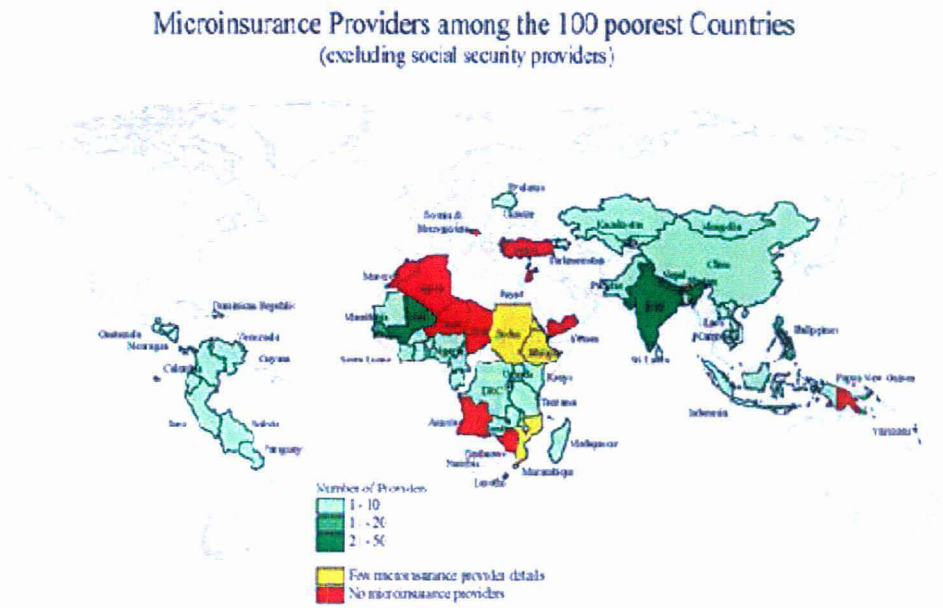
The success CBHI model in Bamako initiative countries generated interest among the health economist and other experts to look it as a model to ensure health equity and universal coverage and comprehensive care.

During the decade of 1990s the CBHI was promoted in most of the low and middle income countries throughout Africa, Asia and Latin America. A study conducted by the Micro-insurance centre traces the provider of community and micro insurance across the world.[162]

[161] Craig, C. 2006, op cit

[162] Roth, J. et.al. 2007, '*The Landscape Of Micro Insurance In World's 100 Poor Countries*', The Micro Insurance Center, USA

Map 3: Distribution of Micro Insurance in 100 Poor Countries[163]



Source: Landscape of Micro Insurance in World's 100 Poorest Countries, USA 2007

With the growing interest in CBHI as a health service system to ensure health equity, it is very important to critically examine the evidences showed by the existing CBHIs.

4.4.1. Health Service System in Africa a Case for CBHI

One of the major problems for the government of the Africa was to ensure the access to health care for its population. Most of the African nations were struggling with the issues of providing social security to its population. To make the matter worse, health sector reforms implemented in the African nation under the guidelines of World Bank and IMF in the late 1970s forced these countries to introduce user fees to make health facilities sustainable and ensure consistent quality of services in the facilities. For e.g. 1989 Kenya introduced the User fees followed by Tanzania, and Uganda in 1993 and

[163] Roth, J. et al. 2007, *op cit*

other southern African countries soon after.[164] With the reemergence of communication disease and HIV/AIDS and its associated infection, increased the already existing gap between the need and access of the health services.[165] The public spending on health in the same period in Africa countries were very low and often inadequate to meet the health service need of the population.[166]

Table 8: Government Health Care Spending of Selected Africa Countries Compared to Total Govt. expenditure

	1998	1999	2000	2001	2002
Benin	6.5	8.3	7.2	8.8	8.1
Burkina Faso	9.8	5.4	5.6	5.9	8.1
Cameroon	3.2	3.4	4.8	5.5	7.8
Ethiopia	5.8	4.3	3.4	4.8	4.4
Ghana	2.7	3.3	3.0	3.7	5.7
The Gambia	—	—	12.8	14.6	16.3
Guinea	4.4	4.4	4.2	7.5	6.5
Guinea-Bissau	—	—	4.3	3.5	—
Madagascar	3.6	2.8	2.7	4.4	2.7
Malawi	9.6	8.0	6.6	8.3	9.3
Mali	5.2	4.4	6.1	7.1	3.3
Mauritania	6.8	6.7	5.4	7.1	9.3
Mozambique	11.1	11.3	12.1	11.2	12.0
Niger	9.0	11.7	11.9	—	—
Rwanda	1.9	2.6	2.9	3.3	3.1
Senegal	4.9	5.2	5.8	8.7	11.7
Sierra Leone	—	4.7	5.4	6.8	8.1
Tanzania	—	8.5	7.3	9.1	10.1
Uganda	6.7	6.5	7.4	8.6	9.6
Zambia	6.9	5.5	4.7	4.7	6.9
Median	6.2	5.1	5.5	5.9	8.1

Source: Hinchliffe 2004.
— not available.

Source: Health Financing Revisited, World Bank, 2006

[164] Musau, S. 1999, *op cit*

[165] Arhin Tenkorang, D . 2004, 'Experience of Community Health Financing in the Asian Region' at Preker.(eds*) Health Financing for Poor People: Resource Mobilization and Risk Sharing*, World Bank, Washington

[166] Gottret, P. and Schieber, G. 2006, *op cit*

Due to the stagnation of the public spending in health the share of private and external spending (including loan, grant and services in kind) constitute a higher share in the total spending in health. The study conducted by the African union shows that the poorer the country the more is the dependency in private or external health care.[167]

Table 9: Pattern of Spending in Selected African Countries

Sub-region	Number of countries	Total population (000s)	Average GDP per capita	Total health expenditures per capita	Government health exp. as % of total govt exp.	Government health exp. as % of total health exp.	Private health exp. as % of total health exp.	External resources for health as % of total health exp.
Western	15	271,992	$598	$26	5%	34%	66%	11%
Central	7	111,868	$684	$22	7%	50%	50%	9%
Eastern	13	278,059	$314	$16	10%	51%	49%	33%
Southern	4	6,967	$2,973	$187	12%	67%	33%	8%
GDP per capita								
Less than $250	9	179,384	$152	$7	11%	55%	45%	41%
$250 to $499	13	202,113	$340	$19	11%	44%	56%	29%
$500 to $999	10	260,163	$693	$30	5%	35%	65%	10%
$1000 or more	7	27,226	$2,602	$91	8%	67%	33%	6%
Total	39	668,886	$519	$23	7%	44%	56%	17%

Notes:

1. Excludes South Africa, countries with populations <1 million, Sudan and Somalia.
2. Total health expenditures are broken down into government and private expenditures. External resources for health include all grants and loans for health goods and services, in cash or in kind. These pass through governments or private entities and are not mutually exclusive categories. As a result, government health expenditures are likely overstated as a percent of total health expenditures.
3. All estimates are weighted by population size.

Source: African Union Health Ministers Conference Report 2009, Ethiopia

The higher private and external expenditure on health is not only affecting the national health services but also affecting the individual lives in these countries as it directly impacts the accessibility and affordability of health care. The introduction of reform strategies like user fees and contracting out of health facilities has reduced the accessibility of the poor to the national health services system. The benefit of the health

[167] '*Universal Access To Quality Health Services: Improve Maternal, Neonatal And Child Health*', 2009, Report of the African Union Conference Of Ministers Of Health Addis Ababa, Ethiopia

service system and the public spending on health were enjoyed basically by the well off population who can afford the services provided by the national health services system. According to the study conducted by Castro Leal et al[168] , poorer house hold report less illness and seek lesser treatment from the health care provider although the frequency of illness incident is higher in this segment. More over the number of poorer household seeking health care facilities from the traditional healers are significantly higher than that of the richer quintile. The following table explains health seeking time and choice of providers in the selected countries.

Table 10: Difference between the Illness and Treatment Pattern among Richest and Poorest Population Groups in Africa[169]

Table 1. Percentage ill and treatment response, by quintile, in selected African countries

Country	% ill during previous 4 weeks	Of those ill, % seeking			
		No care	Modern public care	Modern private care	Traditional care
Côte d'Ivoire (1995)[a]					
Poorest 20%	30	73	26	1	NA[b]
Richest 20%	50	35	55	10	NA
Ghana (1992)[a]					
Poorest 20%	33	59	23	14	4
Richest 20%	58	43	28	24	5
Guinea (1994)					
Poorest 20%	24	60	15	0	26[c]
Richest 20%	32	31	52	6	10[c]
Madagascar (1993)[a]					
Poorest 20%	20	72	20	3	5
Richest 20%	34	52	29	16	3
South Africa (1994)[a]					
Poorest 20%	12	25	46	23	6[d]
Richest 20%	26	14	9	74	3[d]
United Republic of Tanzania (1993–94)					
Poorest 20%	12	42	37	17	3
Richest 20%	22	27	32	39	1

[a] The reference period was 2 weeks, so proportion was multiplied by 2 to make estimates approximately comparable.

[b] NA = not available.

[c] Private care received at home.

[d] Includes all other providers.

Source: Public Spending In health In Africa: Do the Poor Benefit, Bulletin of world Health organization 2000, 78(1)

[168] Leal, C. et. al. 2000, 'Public Spending In health In Africa : Do the Poor Benefit', *Bulletin of world Health organization*, 78(1)

[169] *ibid*

The same study also observed the similar trend in case of utilization of health facilities. The richer quintile tends to utilize more health services as compared to the poor quintile.

Table 11: Difference in Health Care Service Utilization Pattern among Richest and Poorest Population Groups in Africa[170]

Table 3. Benefit incidence of public spending on health in selected countries

Country	Quintile shares of							
	Primary facilities		Hospital outpatient		Hospital inpatient		All health	
	Poorest	Richest	Poorest	Richest	Poorest	Richest	Poorest	Richest
Africa								
Côte d'Ivoire (1995)[a]	14	22	8	39			11	32
Ghana (1992)	10	31	13	35	11	32	12	33
Guinea (1994)[a]	10	36	1	55			4	48
Kenya (1992)[a, b]	22	14	13	26			14	24
Madagascar (1993)[a]	10	29	14	30			12	30
United Republic of Tanzania (1992–93)	18	21	11	37	20	36	17	29
South Africa (1994)[a]	18	10	15	17			16	17
Others								
Indonesia (1990)	18	16	7	41	5	41	12	29
Viet Nam (1993)	20	10	9	39	13	24	12	29

[a] Hospital subsidies combine inpatient and outpatient spending.

[b] Rural only.

[c] NA = not available.

Source: Public Spending In health In Africa: Do the Poor Benefit, Bulletin of world Health organization 2000, 78(1)

The above data clearly shows that the richer people are utilizing health care services more because of the affordability and accessibility as the limited public sending in health cannot provide necessary health care required by entire population.

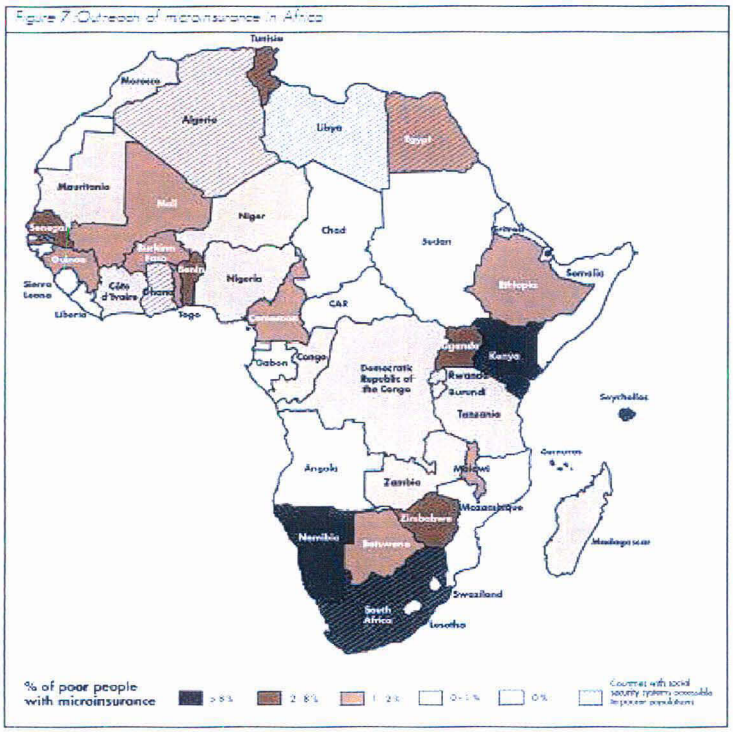
This inequality in access and universal coverage and comprehensive package of care forced the governments and the international and other bi- lateral and multilateral agencies to promote CBHI among African countries. In this countries where the health service system is overburden with user fees and payment for each and every service the

[170] *ibid*

CBHI came up as a alternative to the existing National health service system. A recent study by Matul et. al.[171] show that in most of the countries where the social health insurance is not available or does not covers the insurance need of the poor people the CBHI plays a important role if not a substantial one. As the CBHI is still evolving and have the support of government and the aid agencies the coverage is increasing.

The same study also tried to map percentage of poor people covered under the Micro insurance schemes providing life coverage and health coverage. Among the Micro insurance scheme, majority of the schemes are operated by the community or community based organization.

Map 4: Distribution of Micro Insurance in Africa



Source: The Landscape of Micro insurance in Africa, International Labour Office. Geneva 2010

[171] Matul, M. et. al. 2010, '*The Landscape of Micro insurance in Africa*', International Labour Office. - Geneva:

The concentration of the CBHI can be seen mainly in Western African countries (Francophone Africa) and Southern African Countries (Commonwealth Africa) in compared to the other areas. This is one of the issues which will be discussed in later part of the chapter.

However the important issue that needs to be examined is the extent to which this scheme is successful in addressing the question of health equity, universal coverage and comprehensive care for the population.

4.4.2. Health Service System in Asia a Case for CBHI

The Asian countries specially the south east and South Asian countries shares similar kind of geopolitical characteristics with the African countries. Most of these countries are newly independent countries from British, French and Dutch colonial rule. Most of these countries are resource poor and with a low per capita income. Like the African counterpart most of these countries undergone massive reforms in health sector in the decade of 1990. The results of the reform were that the government spending in health care remained stagnated or decreasing.

More over this period was marked by the increase involvement of private sector in providing the health care facilities. Baru[172] shows that there in an incremental increase in the private health care facilities as well as the private bed strength across the south Asia. The increasing involvement in the health care service delivery in this region and adoption of other reform measures like user fee, paid service, contracting in and contracting out of health allied services. Data shows that the private expenditure and out of pocket expenditure constitute the majority of the total health expenditure.[173] The private expenditure in health constitutes almost 76% of total expenditure in health and out of which almost 97% is out of pocket health expenditure. The high out of pocket expenditure and low public expenditure on health makes the health service system non accessible to entire population raising question on universality of coverage. More over

[172] Baru, R. 2003, 'Privatization of Health Services: A South Asian Perspective', *Economic and Political Weekly*, 38 (42) pp 4433-4437

[173] World Health Statistics, 2009, *op cit*

the inaccessibility and affordability of limited health care services by the population raise the inequity in health in this area.

Table 12: Pattern of Health Expenditure in Different WHO Regions

TABLE A1.1 Composition of health expenditures in high-, middle-, and low-income countries, population-weighted averages, 2002

	Per capita GDP (current US$)	Per capita GNI (current US$)	Per capita health expenditures (US$)[a]	Per capita health expenditures (international dollar rate)[b]	Total health expenditures (% of GDP)	Public health (% of total health expenditures)	Social security expenditures (% of total public health expenditures)	Private (% of total health expenditures)	Out-of-pocket (% of private health expenditures)	External (% of total health expenditures)
Regions										
East Asia and the Pacific	1,013.68	999.76	63.66	250.30	5.21	35.29	39.35	64.71	91.66	0.72
Eastern Europe and Central Asia	2,416.54	2,371.17	151.07	459.29	5.93	61.33	41.35	38.67	85.10	1.58
Latin America and the Caribbean	3,284.31	3,182.82	217.85	515.57	7.04	50.27	32.50	49.73	74.28	1.39
Middle East and North Africa	2,153.12	2,105.48	98.92	252.17	4.83	44.92	23.60	55.08	84.77	1.02
South Asia	475.17	471.92	26.04	140.39	5.45	23.66	8.04	76.34	97.08	2.48
Sub-Saharan Africa	487.14	440.72	31.58	119.71	5.32	39.58	1.92	60.42	79.17	17.58
Income levels										
Low-income countries	423.63	408.55	29.52	115.18	5.30	29.14	6.18	70.86	92.64	7.89
Lower-middle-income countries	1,333.33	1,309.93	81.60	304.50	5.60	41.59	35.55	58.41	86.02	0.86
Upper-middle-income countries	5,268.89	5,156.73	309.96	602.33	6.18	56.27	53.43	43.73	82.93	0.43
High-income countries	27,464.45	27,653.55	3,039.30	3,168.54	10.37	65.15	43.95	34.85	55.78	0.03

Sources: World Bank 2005; IMF 2005; WHO 2005.

a. Exchange rate–based U.S. dollars.

b. Purchasing power parity–adjusted U.S. dollars.

Source: Health Financing Revisited, 2006

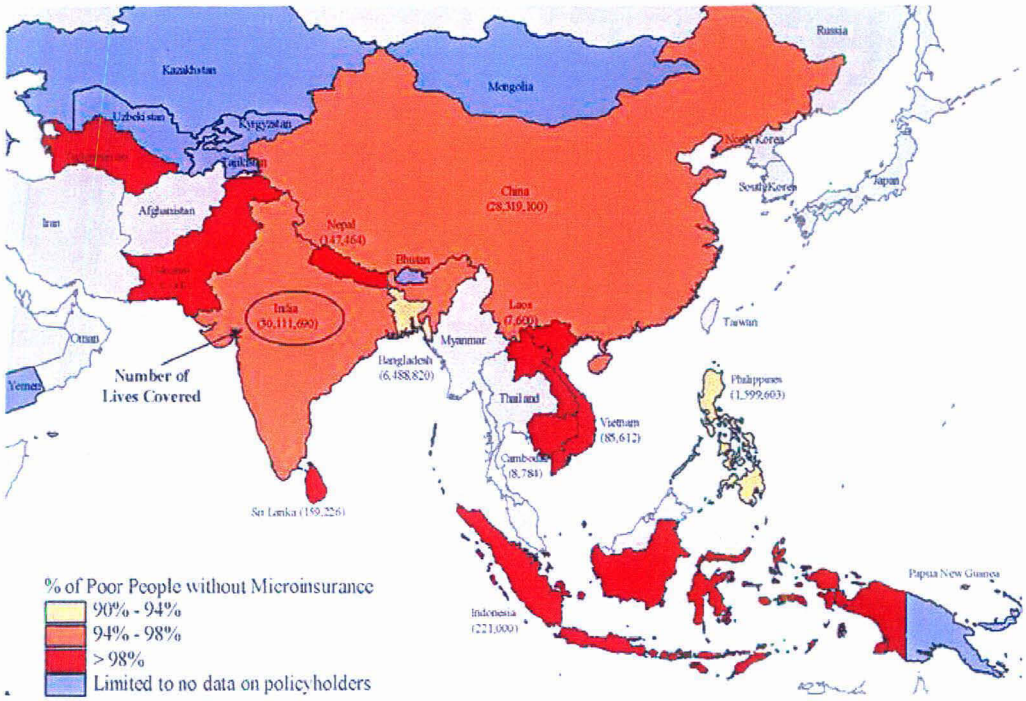
According to Owen O'Donnell[174]. et.al , in most of the South Asian countries the health care system in not geared to meet the needs of poor people. Most of the services have bias towards the rich population group. The inpatient care is more utilized by the rich and who effort to pay certain amount. The economically better off section across all these countries enjoys larger share of the health subsidy provided by the government. More interestingly the higher percentage of the government subsidy goes to the hospital care while the primary care receives only a marginal amount of subsidy even it caters to more number of poor people.

[174] O'Donnell, O. et.al. 2007, 'The Incidence of Public Spending on Healthcare: Comparative Evidence from Asia', *The World Bank Economic Review*, 21, (1), pp 93–123,

As stated above both Africa and Asia shares similar colonial characteristics and the socio economic indicators of both the continent are also more or less similar. The "Success" of CBHI schemes in African countries influenced the policy planner in south Asian countries to adopt similar initiative in their respective countries. The colonial connection of many erstwhile Asian and African colonies and the French influence in Francophone Africa to ensure health equity by promoting CBHI also played an important role in initiating CBHI scheme in Asia. Over the years CBHI became one of the major health service systems in the South Asian Region. The Landscape study[175] conducted by the Micro insurance centre shows that Micro Insurance including CBHI provides Life and health care coverage to 2 % – 10% of the population of the various Asian countries.

Map 5: Distribution of Micro Insurance in Asia

Map 4: Microinsurance covered lives in Asia



Source : Landscape of Micro insurance in world's 100 poorest countries, USA 2007

[175] Roth, J. et. al. 2007 *op cit*

The Landscape study shows that the concentrations of the micro Insurance schemes are mainly in the south Asian regions which were part of the various (British, French and Dutch) Colonial empire.

4.5. CBHI schemes and Evidences in Universality, Equity and Comprehensiveness

Universal coverage of health services is one of the major thrust areas for the CBHIs. Most of the CBHIs aims to achieve universal coverage in there schemes area. Majority of the CBHI schemes are either facility based or community (Geographical area) based addressing the health needs and providing financial protection for a specific population group. The population groups are not homogeneous and always have different level of socio economic status. The stratification of these societies can be at various levels. The stratification is generally at three levels [176] firstly social stratification based on population sub groups (tribe/caste), gender, religion, education etc, secondly economic stratification based on individual and household income and thirdly the geographical stratification based on the place of living. Therefore it becomes imperative to study the CBHI schemes across the continent to see how CBHIs in Africa and Asia are addressing the issue of universal coverage. The review conducted by Robert Basaza et. al [177] on the CBHI of east Africa (Kenya, Uganda, Tanzania) shows that the coverage of the CBHI schemes are very negligible. In Kenya the coverage was around 1% of the total casement population of the 30 CBHI schemes under review. In Uganda the coverage was around 2% from 12 scheme area and in Tanzania the coverage was around 6% from 77 CBHI under studies. At an individual level no CBHI achieved more than 15% coverage in its casement population. Sara Bennett[178] differentiates the coverage on the basis of compulsory and non compulsory nature of the schemes. The compulsory schemes have been able to achieve close to universal coverage in its casement area (mainly in China). Also to be noticed is that the coverage of the schemes from the Asia

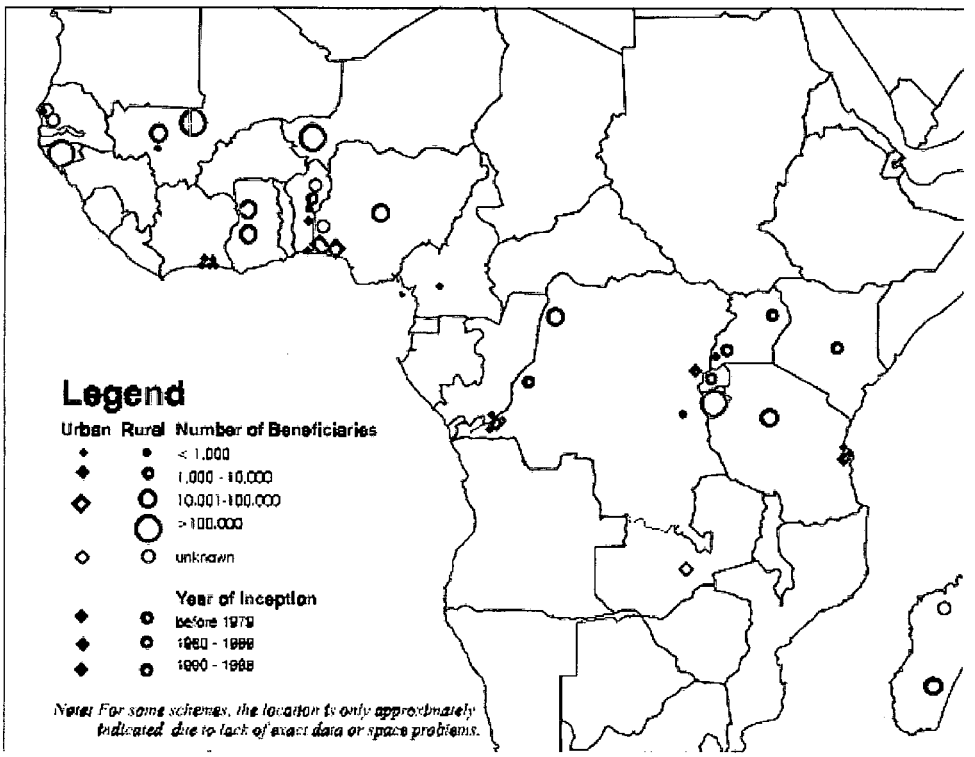
[176] Tanja, A. et. al. 2010 , 'Socio-economic inequalities in childhood mortality in low- and middle-income countries: a review of the international evidence', *British Medical Bulletin*; 93 pp. 7–26

[177] Basaza, R. et. al. 2009, 'What are the Emerging Features of Community Health Insurance Schemes in East Africa', *Risk Management and Healthcare Policy* 2 pp. 47–53

[178] Bennett, S. et. al.1998, 'Health Insurance for People Outside Formal Sector Employment' APA Paper No. 16, WHO, Geneva

is relatively high when compared to the African Schemes. Moreover the poorest of the poor are not included in the schemes and if the schemes have both rural and urban population then generally the rural populations have less coverage.

Map 6: Coverage of CBHI in Terms of Members in African Region



Source : The Emerging movement of Community Based Health Insurance in Sub Saharan Africa 2000

Waelkens and Creil as referred in Tabors estimated the coverage at around 8%[179] of the targeted population in sub-Saharan region. In another study by Masau[180] estimated the coverage is in between 0.3 % to 6.5% in their operating population. Study by Arhin tenkorang put the coverage of 6 major CBHI scheme at 2% to 66% of the total targeted population. In the review by Carrin[181] states that in Lalitpur scheme in Nepal the coverage is about 48%. The same review shows that the coverage of CBHI in Rwanda

[179] Tabor, S. 2005, *op cit*

[180] Musau, S. 1999, '*Community-Based Health Insurance: Experiences and Lessons Learned from East Africa*', Partnerships for Health Reform Project, Abt Associate USA

[181] Carrin, G. et. al. 2005, *op cit*

and Senegal is at 8 % and 37.4 % – 90.4 % respectively. In India the coverage of the schemes are about 10 % to 50 %[182] of the total target populations. The ILO Step[183] document reviewed 51 schemes and come up with some absolute figure of individual covered but it does not give any proportional analysis of the coverage. The same study shows that almost 80 % of the CBHI schemes studied have a membership base of less than 100,000 and more than 33 % of all the schemes have coverage of less than 5000. The study by Devadasan shows a similar figure with the Yashaswini Scheme having more than 2.5 million members. Chankova[184] ET. Al puts the enrolment figure of schemes studied in West Africa in between 2200 to 46500. Baeza[185] et al. in 2002 for ILO reviewed 258 CBHIs schemes from Africa Asian and Latin America. The review shows that, 22% of the CBHI has less than 100 members, 33% has 100-500 members, 28% has 500 to 10,000 members, 14% has 10,000 to 100,000 members and only 2% has more than 100,000 members.

One of the major objectives of the CBHI is to achieve the health equity and comprehensive care in the poor and marginalized by assimilating them in the health service system. Evidences shows that in most of the cases the health inequity is a result of long failure of the public health service system and in recent years the failure of market led or private health service system.[186,187] As stated above, making health services accessible and affordable to the population is the major strategy to ensure health equity. Although most of the CBHI tries to design the schemes making it affordable and accessible by the poor, the data on coverage shows that the actual number of people enrolling themselves in the schemes are still very small. The ILO study shows that out of 258 CBHI reviewed 146 schemes include out-patient service

[182] Devadasan, N . et. al. 2005 *op cit*

[183] ILO, 2005, *'India: An Inventory Of Micro Insurance Schemes'*, Strategies And Tools Against Social Exclusion And Poverty (Step) Programme, Geneva

[184] Chankova, S 2008, 'Impact Of Mutual Health Organizations: Evidence From West Africa', *Health Policy and Planning* 23: pp 264–276

[185] Baeza, C. et. al. 2002, *'Extending Social Protection in Health Through Community Based Health Organization'*, Universitas programme, International Labour Office, Geneva

[186] Palmaer, N. et. al. 2004, 'Health Financing To Promote Access In Low Income Settings—How Much Do We Know', *The Lancet,* 364, pp 1365–70

[187] Ghosh, B. 2008, *op cit*

while 2 schemes included preventive care along with the OPD services. In case of in patient service 146 schemes offer inpatient hospitalization cost, and 3 CBHI schemes only offer inpatient facilities for basic maternity care. The cost of the medicine is covered by 131 CBHI schemes. Out of all the reviewed schemes, 121 CBHI schemes offer comprehensive coverage including outpatient, inpatient and cost of medicine while rest of the schemes is offered only selected services. [188] The CAS schemes in Burundi Covers all inpatient care in the government clinic and hospital. The Nkoranza schemes Ghana, Community Health Fund Tanzania covers The OPD services in any clinic while inpatient services in selected registered facilities are covered. Abota schemes Guinea Bissau and Nkorazna scheme in Tanzania offers referral services. The coverage on cost of drugs depends upon the free or subsidized availability of the supplies. Many a times the patients have to buy drugs for the treatment. [189] The ACCORD schemes in India provide services in two level it. To a certain members it provides comprehensive coverage including preventive and promotive services, while for the others have to pay for the medicine and a certain amount for hospitalization.[190] SEWA schemes offer predominantly primary care with limited hospitalization benefit; whereas the health card system in Thailand offers both primary and secondary care.[191]

About HIV/AIDs coverage the review shows all the major CBHI in Africa i.e. Kisiizi Hospital scheme – Uganda, Chogoria Hospital Scheme – Kenya, Community Health fund – Tanzania, Nkoranza CBHI – Ghana, Rwandan Prepayment schemes does not offer any coverage to the people suffering from HIV/AIDS. The Atiman Scheme, Mburahato Scheme from Tanzania also exclude TB and other Chronic disease apart from HIV/AIDS.

[188] Baeza, C. et. al. 2002, *op cit*

[189] Tenkorang Arhin, D. 'Experience of Community Health Financing in African Region' in Preker A (eds.) *Health Financing for poor*, 2004,The World Bank, Washington DC Ch. 4

[190] Devadasan. N Et. al. 2004, 'ACCORD Community Health Insurance Increasing Access to Hospital Care', *Economic and Political Weekly* July 10, pp 3189 - 3194

[191] Bennett ,S.2004, *op cit*

Table 13: Breakup of Out of Pocket Expenditure on Health

	Out-of-pocket Health Payments				
	Medicines	Inpatient	Outpatient	Traditional	Others
	%	%	%	%	%
Bangladesh	67.1	6.3	8.1	5.0	13.6
Burkina Faso	62.2	9.7	8.0	7.8	12.3
Chad	11.1	43.8	12.0	12.2	20.9
Comoros	47.6	16.9	15.6	3.0	16.9
Cote D'Ivoire	32.2	29.4	15.6	5.5	17.2
Ethiopia	43.3	16.8	24.6	2.3	13.0
Ghana	40.1	23.3	21.8	5.6	9.1
India	44.4	25.4	16.9	3.3	9.9
Kenya	31.0	32.8	17.1	1.5	17.5
Lao PDR	47.8	25.2	10.1	10.7	6.2
Malawi	48.1	15.9	27.1	4.4	4.4
Mali	30.8	23.3	20.2	9.9	15.8
Mauritania	31.0	22.4	12.1	3.6	30.9
Myanmar	47.8	11.9	26.6	5.2	8.4
Nepal	68.8	13.9	4.3	1.5	11.5
Pakistan	45.5	21.2	14.5	7.0	11.8
Senegal	31.5	24.8	13.8	12.9	17.0
Vietnam	37.0	27.2	21.9	5.0	8.9
Zambia	34.8	26.9	15.2	9.3	13.8
Zimbabwe	25.2	12.0	30.6	14.5	17.7

Source: Medicines Coverage and Community Based Health Insurance in low-Income Countries 2008

The need for medicine coverage is very important as it constitutes the largest share in out of pocket expenditure. Catherine Valentin shows that most of the CBHI does not give medicine cover to its members. The low membership, limited revenue collection and higher cost of branded drugs, non availability of generic drugs supply to the health facilities makes the provisioning of the medicine unrealistic and non viable for sustainability of the CBHI.[192] The basic nature of comprehensiveness is compromised as the cost of the medicine has to be borne by the members. The non medicine coverage is a reason for the low penetration of CBHI amongst the poorest as they have to bear the double burden by paying for premium of CBHI and the cost of medicine.[193]

[192] Vialle-Valentin, C. 2008, 'Medicines Coverage and Community Based Health Insurance in Low-Income Countries', *Health Research Policy and Systems*, 6:11

[193] *ibid*

The above analysis shows that most of the CBHI is not able to achieve universality in providing services. Even though the schemes operate in a local area the coverage is still very low. The data on Asian schemes are limited as numbers of studies focused on the coverage of Asian schemes are limited. The reason for the low coverage can be attributed to high premium for the coverage and individual member premium rather than household premium and not immediate benefit from the schemes.[194,195] Tabor and Bennett observed in their respective studies that the coverage in Asia are better that the coverage of the schemes in Africa. The ILO study and study by Bennett shows that the Asian CBHIs are larger and generally linked to a micro finance organization which can give better financial security to the management of schemes (SEWA in India, Grameen in Bangaladesh). By and large the CBHI in China have the largest memberships as in most of the schemas the membership is compulsory and most of these CBHIs in China are initiated by the government. The string cooperative movement in South East Asian countries also helps in creating a larger CBHI schemes for its members as the members of the cooperatives becomes automatically the members of the CBHI. However the issues with the African CBHI barring a few, most of the schemes are linked to hospitals or health facilities which have limited resources to cover the entire target population[196]. Moreover the CBHIs in Africa are too dependent on the external assistance. In Africa more than 160 CBHI schemes are donor initiatives and depended on the donor for the initial seed money. Between the years 2003 to 2006 some 9 major donors invested over $ 10 million in CBHI schemes directly in a conservative calculation. The investment through the sub grants and other associated health reforms grants were not taken in to calculation as per USAID report.[197]

Inclusion of the poorest of the poor is another concern in estimating the memberships. Although the CBHIs aims to include all in their schemes but the poorest section is left out of the schemes because of the obvious economic reason. The Nkorzana scheme's

[194] Devadasan, N. et. al. 2005, *op cit*

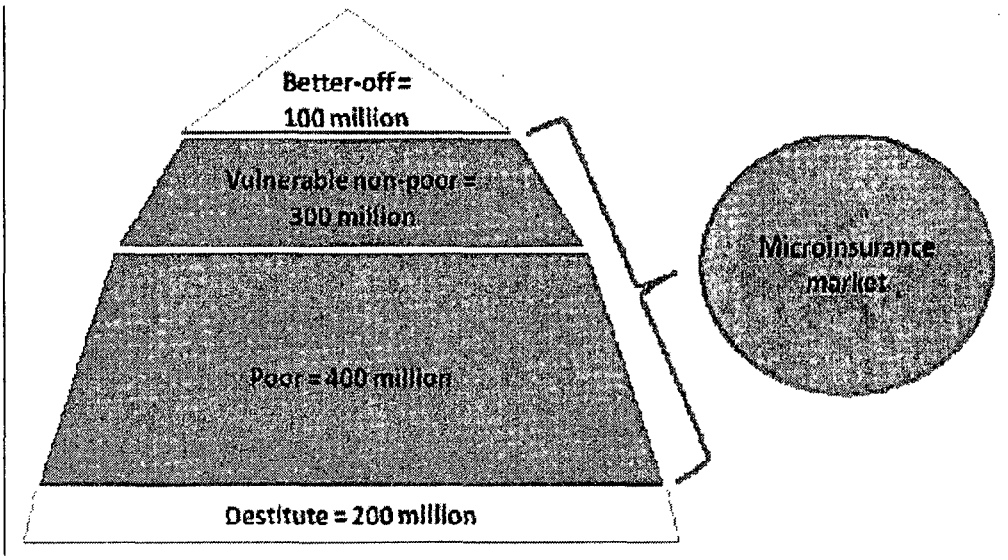
[195] Carrin, G. et. al 2005, *op cit*

[196] Tabor, S. 2005, *op cit*

[197] Chandani, T. 2008, '*Lessons Learned and Recommendations for Donors Supporting Micro insurance*', USAID/CGAP Working Group on Micro insurance, USA

membership cost around 5 - 10 % of annual household expenditure, in Burundi 27% of the community people could not afford the CBHI scheme as they cannot pay the premium[198]. Designing special schemes to the poor means more management cost and require financial security for the schemes which may not be possible for the schemes to provide[199]. So for making the schemes viable the poor are generally excluded.

Figure13: Scope for Micro Insurance in Africa



Source: The Landscape of Micro Insurance in Africa 2010

The premiums collected by the CBHI schemes are very low. The rising cost of health care is not possible to meet only by the premium collected by the CBHI. Though most of the CBHI claims to reduce the out of pocket expenditure many paid services are not covered in the CBHI schemes. The out of pocket expenditure of the CBHI members are in the range of 40% the total expenditure in health and in many cases this reduction of the out of pocket expenditure is because the CBHI uses the public health facilities

[198] Bennett, S. et. al.1998, *op cit*

[199] Matul, M. et. al. 2010, *'The Landscape of Micro insurance in Africa'*, International Labour Office. - Geneva

which are already subsidies by government. If CBHI uses the private facilities the out of pocket expenditure for the members will increase manifold[200].

The low level of membership base, non predictive nature of subsidies and external assistance and low level of revenue generation raises the question of sustainability of the CBHI schemes. Achieving self sufficiency in meeting the cost of operation and service purchasing is the key to a successful CBHI. Non generation of enough resources may lead to limit the benefit package, inclusion of only those who can pay or closedown.

[200] Berkhout, E. and Oostingh, H. 2008, '*Health Insurance in Low-income Countries: Where is the Evidence that it Works?*' Joint NGO Briefing Paper. Oxford: Oxfam.

DISCUSSION

DISCUSSION

Availability of Literature

The literature or the evidences available on CBHI schemes in Asia are limited as compared to the literature available for the same in Africa. The way CBHI has been implemented in both the continents might be a reason for this. As stated above the CBHIs in Africa were basically promoted by the donor or international developmental agencies whereas the CBHIs in Asia are generally offshoot of the micro finance institutes, cooperative movements and community interventions. Over dependence of African countries on the external assistance for the health service and high international debt of these nations makes them a perfect ground for international experiments. The international organizations and development agencies experiment more often in these countries in the name of ensuring health equity and bringing efficiency to the health service system. In case of Asian countries the ratio of external resources in financing health service system is very low. The existence of a public health service system assures some kind of health security for population. The non availability of studies from Asian countries especially on CBHI makes it difficult to compare the Asian CBHI with the African CBHIs in a very broad way. Most of the studies available in Asian context are analysis of single schemes (except India) where in case of Africa the multi country and multi scheme reviews have been done by many researches.

It is not only the Public Failure but Market Failure too

The most prominent arguments for the implementation of CBHI schemes are that the failure of the public health service system is the root cause of inequity in health. The public health service system in most of the low and middle income countries portrayed as system which in inefficient in effective and have no accountability for the services it provides. The arguments provided for privatization of services is that since private services are more efficient thus there will be less wastage of resource resulting in low treatments cost. Moreover it is argued that private sector is more capable of providing

quality of care and ensures accountability in the entire management of the health services system. The IMF and World Bank led health sector reforms put these arguments for reduction in government health expenditure and opening up the health service system for private player. And in many cases the CBHI was viewed as a step to build the prepayment mechanism and prepare population for private insurance scheme, large or small scale. But till date 51% of poorest of poor in sub-Saharan Africa has practically no medical coverage not even CBHI coverage. In Lebanon where the health service system is almost run by private sector the per capita cost on health care is more than double than that of Sri Lanka where the health care sector is mostly publicly financed but the coverage of Lebanese health care sector is half of what Sri Lankan health service system address. The concentration of private health care is mainly in urban areas and the health services provided by the private sector are mainly curative care at a secondary or tertiary setup. The failure of market to offer services to the poor and in the rural areas due to economic reasons is equally responsible for health inequity and reduced access to health. It is necessary to recognize that the markets too have also failed to provide medical care to all specially, to the poor and marginalized. Interestingly in most of the literature the success of public health service system providing better access and health care facilities are not documented. Study shows that most of the members of the CBHIs are generally the better of people of the community and the really poor are often left out[201,202]. It is important that the health care needs of this section is addressed and included in the health care coverage of the schemes. The designing of special package for the people who may not afford to pay the premium is the key to achieve universal coverage for the schemes.

Donor Influence in CBHI and Sustainability

The spread of CBHI has certain similar pattern across the Asia and Africa. Although the CBHIs are predominantly found in low and middle income countries, they are mainly concentrated in the former British, French and Dutch colonies. The development of CBHI in these regions especially in Africa was initiated by large development agencies

[201] Carrin, G. et. al. 2005, *op cit*

[202] Ahuja, R. Jutting J. 2003, *op cit*

from these colonizing countries. In recent years, World Bank and other international organizations like WHO, ILO, USAID, GTZ, and DFID have shown increasing interest in the CBHI schemes. The USAID document also discusses the strategy for transforming CBHI into a profitable micro insurance venture. The excessive dependency on external donors may lead uncertainty of operation of the schemes as the donor cross subsidies the financial burden of the schemes. The guideline (USAID) on the donor role on CBHI virtually gives managerial control and designing of the schemes in the hand of the experts from these organizations. Another problem with the donor supported schemes is that the donors promote certain kinds of models which have been successful in certain countries without taking into consideration that each and every community is inherently different. The homogenization of the schemes leads to low membership, restricted package designing and total failure in some time.[203] Moreover looking at the CBHI as a bridge to promote market led insurance is a serious issue of concern. The same document gives a clear understanding of the intention of donors pushing for certain kind of CBHI model by stating " Market forces alone will not close the gap for Insurance services needed by the poor, and neither will state-administered social protection. Donors are well positioned to find common points of intersection between these worlds and push the boundaries around each."

Nature and Biases of the Evidence

Another important issue which emerged from the review is the nature of evidences available. Most of the review of the schemes follows a specific pattern. These reviews generally try to explore two major areas of CBHI schemes. Those are –

Coverage: Most of the review, studies the coverage level achieved by CBHI schemes. The coverage studies calculate the number of people covered by these schemes in a specific region. However the studies do not tend to probe deep into the reason for opting out from the memberships.

[203] Berkhout E. and Oostingh H. 2008 op cit

Health equity, Access and Financial Protection: The other major kind of the studies available on CHI tries to estimate the increment in the access and impact on the financial protection and how health equity can be achieve through CBHI.

The literatures on social economic profile of the members are very limited. The available literature also does not compare the access of health facility by general population in compared to the insured population in a large geographical area. Understanding the trend of health facility utilization is important while comparing the success of the increase access by the members over the non members. If the general trend of the health facilities utilization is on rise then it becomes necessary to attribute other causes that resulted in the increase and actual increase in the utilization by the CBHIs. Again, most of the CBHI schemes are very small in size as stated above therefore reviewing them and extrapolating the result of a small sample size to larger population may not show the true picture. Most of the comparative study takes sample from different countries to show the performance of the CBHIs and these cross country studies have the samples standardized to make it scientifically correct. But while comparing the different socio economic factors has to be taken in to consideration. A CBHI in Africa with similar numbers of members cannot be possibly compared with a CBHI in South Asia as culture, health services, governance, political orientation of the states, and other socio economic factors are very different. The normalization of these factors is not seen in the evidence reviews.

Most of these reviews are being done by a specific group of people belonging to, affiliated or financed by World Bank and its partner organization or the organizations with a significant interest in the CBHI implementation and operation. Therefore the evidence these studies are producing is likely to be influenced by organizational mandate of the organization on CBHI. It may also produce the evidences which may promote a certain kind of CBHI.

Tracing the True Sense of CBHI

CBHI is an instrument for ensuring access to health service to the population which is for any given reason left out from the health security network. It is the duty of the state,

as per many universal declaration and covenants to ensure health care services are made available to all. Therefore the states should ensure that appropriate allocation of resources for purchasing of the health services which can cover its entire population and also decrease the out of pocket expenditure. CBHI cannot be a substitute nor is it a mechanism to prepare people to transit to the insurance based schemes. CBHI should be essentially taken as an ad-hoc mechanism to ensure health service security for a intermediate period until the dominant health service system ensures health security to all. Treating CBHI as a substitute to a bigger health service may create more health inequity as the schemes are varied in nature. The benefit package, membership contribution and the financial protection of each and every CBHI is different which in a larger context increase community based health inequity. Therefore it is necessary to study the impact of CBHI in long term in ensuring equitable health for all.

Finally the CBHI schemes should be able to adapt to changing demographic patterns, disease patterns, costs, political will, expectations and technology as all these factors have immense influence on the operation of any health service system. It is important that CBHI should be able to provide health security to the poor and the marginalized which are left out of the health services safety net because of whatever reason and bring health equity in its truest sense.

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