CURRENT CONCERNS
ARA Paper number 16

HEALTH INSURANCE SCHEMES FOR PEOPLE OUTSIDE FORMAL SECTOR EMPLOYMENT

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CORRIGENDA

Errors occurred in renumbering the schemes from the database to the sequence in which they occur in this document.

1. The scheme numbers in the first column of Tables 5.2 and 5.4 are incorrect. The correct number for each scheme is found in the text and in Annex 2.

2. In Annex 2 - List of Schemes and Source Material, pages 95 and 96, after reference number 74 these schemes should be numbered from 75 to 82.
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ACKNOWLEDGEMENTS

An earlier version of this document was discussed at the WHO consultation "Health Insurance for the Non-formal Sector", held 20–22 October 1997, in Geneva, Switzerland. Material presented by participants at the meeting, discussions during the meeting and participants' written comments have strengthened this document immeasurably. A full list of meeting participants can be found in Annex 1. The authors would like to acknowledge the extensive and insightful comments received from Joseph Kutzin and helpful suggestions from the external reviewer, Dr Catriona Waddington.

A very preliminary version of this document, reviewing 36 prepayment schemes, was published by the World Bank as Innovations in health care financing in 1997.
EXECUTIVE SUMMARY

Large groups among the world’s rural population and many people working in the urban non-formal sector are vulnerable to the financial costs of illness. This is because government risk sharing, via subsidy, of the costs of health care, and private or social (employment-based) health insurance continue to elude significant numbers of people in poorer countries.

This paper brings together and analyses 82 schemes that seek to promote risk sharing of the costs of health care for persons outside formal sector employment.

The schemes reviewed are very diverse. They cover a broad spectrum of contingencies: from essential drugs for routine first-contact episodes of primary care to catastrophic illness and were organized and implemented by various different groups, including community representatives, governments and nongovernmental organizations (NGOs).

The paper attempts to categorize the schemes on the basis of their degree of risk sharing, type of ownership, and whether they are voluntary or compulsory. Additionally, it demonstrates that assessment of a scheme should include consideration of factors such as the political and economic situation, the structure and performance of the health care system, and links between the scheme and other community development activities. No particular type of scheme is argued to be better than others. Rather, it is suggested that what matters most is how well the design of a scheme responds to local conditions. A short glossary of selected technical terms follows the main text.

The 82 schemes are reviewed in terms of their membership and coverage, financing, administration and fund management, how providers were paid and the mechanisms for providing health care. With the important exception of China’s late rural medical scheme, few of the schemes reviewed cover very large populations or even high proportions of the eligible population. Many schemes had encountered substantial adverse selection problems, particularly if at their outset they had not included design features to guard against these. All of the schemes depended on continuing access to some form of external subsidy. Yet very few reached the poorest households. Indeed, most of the health insurance schemes reviewed appeared to be targeted at the rural middle class.

Purchasing functions under the schemes tended to be weak, with scheme managers commonly focusing on raising revenue rather than ensuring efficient delivery of quality health care. The schemes’ administrative systems varied immensely. Some schemes concentrated on the provision of primary care services and operated in a very simple manner. Others, particularly those concerned with providing coverage against the costs of hospital care, had developed quite sophisticated administrative and management systems.
Discussion of small-scale health insurance schemes often focuses on the schemes themselves, and fails to consider the relationship between the schemes and the broader health care system. Evidence is therefore presented in this paper to demonstrate the problems that are likely to arise when an adequate regulatory and policy framework for small-scale health insurance schemes is lacking. Without such a framework, schemes may avoid responsibility for chronic or severe patients (leaving it to the public sector instead), attract unduly high levels of government and international subsidy, and introduce inefficiencies into health care delivery by ignoring referral structures. Moreover, unless government funding is targeted wisely, schemes may actually generate greater inequity between different population groups with respect to health care financing. Many of these problems appeared greater in schemes where purchaser and provider of care were one and the same. For example, hospital-owned insurance schemes seemed most likely to ignore issues concerning referrals and to pay little attention to improving quality of care. Lessons learned are thus presented for both government and managers of health insurance schemes for people outside formal sector employment.

However, although the review highlights the multitude of problems associated with existing health insurance schemes, their potential benefits are also acknowledged: they can enable individuals and households to regularize their health care expenditure and can serve to improve quality of care through appropriate purchasing. In order to ensure that these benefits are captured to the full extent possible, existing knowledge about appropriate design of schemes must be distributed more widely. Furthermore, governments should recognize that these initiatives can be an important means of furthering public the policy objective of ensuring equitable and accessible health care. To attain this goal, governments must develop rational and considered policy on health insurance schemes, and the capacity to implement such policy.

Governments have an important role to play both in facilitating the creation of schemes — by encouraging information exchange between schemes — and regulating schemes to prevent them from having adverse impacts on the broader health care system.
1. **Why Focus on Health Insurance for the Non-formal Sector?**

Few developing countries currently provide protection against health care costs for the whole, or even most, of their population. Even worse, recent and widespread trends in health policy, such as increased user charges and an increased role for private providers, have often resulted in a greater financial burden for those who do use health services. Moreover, a large percentage of the population in low-income countries remains without effective financial or physical access to local health services of good quality. This is especially true of those outside formal sector employment. In this report, "outside formal sector employment" refers to a number of distinct groups, including those working in the informal labour market, persons engaged in small-scale agricultural production and certain vulnerable population groups such as widows, orphans, the landless and the unsupported elderly.

People in formal employment are generally more financially secure than average, and also more easily organized into health insurance schemes since their income is readily identified and can often be taxed at source. Indeed, the size of the formally employed sector, and its rate of expansion or contraction have been cited as important background factors in the success or demise of national health insurance schemes (Preker and Feachem, 1995; WHO, 1995).

In most developing countries, however, those in formal sector employment are a small minority. This factor, combined with growing recognition of central government's limited ability to adequately finance and manage the health sector, is resulting in new forms of health care finance and organization, including various types of health insurance scheme.

Appropriately designed and managed health insurance schemes for people outside formal sector employment may be a means of improving health care services. By allowing communities to contribute to health care, and spreading their contribution over time between sick people and healthy people, extra resources for health care can be mobilized. These can be used to improve quality of care and promote accessibility. In addition, the accountability generated through community participation may enhance efficiency and further improve quality. Ultimately, well-designed health insurance schemes may have a broad positive impact on the organization and delivery of health care.

Numerous initiatives have been taken in recent years, by governments and international agencies, and NGOs in particular, to extend protection against health care costs to those not in formal employment. These initiatives include community financing innovations, such as those promoted in many countries under the Bamako Initiative, the establishment of community credit or revolving funds for the purchase of pharmaceuticals, and the development of different types of prepayment schemes to spread financial risk over time or between individuals. Many of these schemes have
been designed specifically to improve health care access for rural populations or for the growing number of urban people whose occupations fall outside the formal employment sector. The last major review of community financing was that of Stinson (1982).

1.1 Objectives and Scope of Review

Analyses of the health insurance prospects of developing and transitional countries often move quickly from brisk conceptual definition to analysis or recommendation of design and performance characteristics of particular schemes.* Seldom is insurance considered in broad terms as a function of health care systems, and an overall policy objective. Yet the pooling of risks among people of different income groups and with different levels of risk is a policy objective, and all health care systems are characterized by some risk sharing arrangements. Overall risk sharing arrangements can include publicly-financed health care, community-based health insurance schemes, employment-based schemes, and even private health insurance.

Like many of its predecessors this paper also focuses upon analysing particular health insurance schemes. It aims to deepen readers' understanding of the diversity of such schemes and to indicate which design features work best in which contexts. However, the analysis is not based solely upon the features and achievements of schemes in isolation. It also explores the links between the schemes and the overall objectives of the health care systems in which they are situated. Consideration is therefore also given to how schemes have contributed to (or detracted from) overarching government objectives (including risk sharing) and to improving the efficiency, equity and sustainability of health care systems.

Over 100 health insurance schemes were reviewed but reasonably detailed descriptions were found for only 82 of these. The 82 schemes are in no way representative of the totality of experience of rural and urban non-formal health insurance. Inclusion in the review was based on whether adequate documentation was available. The sample is therefore probably biased towards more "successful" schemes. "Failed" schemes, although equally instructive, are less likely to have been documented. Rwanda's Konage scheme is a notable exception (Kaddar et al., 1997).

The names and location of the 82 schemes on which data were collected are given in Annex 2. Throughout this paper, numbers in superscript are used to identify schemes according to the sequence on this list. A very large set of information** was collected on the 82 schemes, using

* As, for example, at the International Conference on the Economics of Health Insurance in Low- and Middle-income Countries, Antwerp, 17–18 January 1997.

** This information was entered into an Access database which is available on diskette on request from the authors. During 1998 it will also be made available on the websites of WHO and ILO.
WHY FOCUS ON HEALTH INSURANCE FOR THE NON-FORMAL SECTOR?

a standard descriptive template which is reproduced in Annex 3. A number of examples of actual schemes, taken directly from the database, are included in Annex 4. The schemes examined spread risks to different degrees and in different ways. Evidently, the level of risk sharing depends on what risks are included in an insurance benefit package, and the size and diversity of the risk pool. The sample includes simple prepayment schemes without risk sharing, where an individual pays in advance for a set of defined, non-transferable health care benefits (such as five outpatient visits). In this instance, the individual’s risk of financial costs of health care are distributed over time, but no risk pooling between individuals occurs. At the opposite end of the spectrum, social health insurance schemes providing insurance coverage across a large and diverse risk pool for a wide range of risks were included, if they succeeded in extending coverage to people outside formal sector employment. Section 2 discusses degrees of risk pooling and uses these as a basis for developing typologies of risk sharing schemes. Sections 3, 4 and 5 review the schemes, considering the context in which the schemes evolved, their design features and impact on key elements of health system performance. Section 7 outlines some initial lessons and Section 8 presents general conclusions.
2. BACKGROUND: TRADITIONS OF RISK SHARING AND IMPLEMENTATION CONDITIONS

2.1 LONG TRADITIONS OF RISK SHARING

The risk sharing schemes analysed in this paper represent only a fraction of risk sharing experience in protecting people outside the formal sector against the cost of unpredictable events including bereavement, disability and illness. In fact, numerous traditional structures that spread financial risks among groups of people or that are linked to non-specific savings schemes have been documented. Some schemes both indemnify members against the costs of unpredictable and expensive events, such as marriage or death, and allow non-specific saving. Relatively few recent schemes of this type have been documented, however, and they should therefore be seen as a subset of the older, more diverse traditional structures for financial risk sharing.

Given that these older schemes have scarcely been analysed in terms of their potential expansion into health insurance funds, the lessons that can be drawn from them are limited. But their history shows that people have organized and managed cash-based risk sharing mechanisms for high-expenditure ("catastrophic") events, often with quite complex contribution and benefit arrangements schedules. Membership is typically tightly limited, though. Indeed, "kinship" and "trust" feature in descriptions of these schemes, membership of which is usually by individual (rather than by household) and voluntary. Additionally, such schemes depend on a high degree of social homogeneity among participants and their trust in one another. As a result, the scope for such schemes to serve as a basis for national schemes is limited, unless they were to be supported as a set of initiatives in which other actors, government and non-government, were also to participate in a coordinated manner. Of the schemes reviewed in this paper, the mutual funds of Yaounde, Cameroon⁴ and Yoffe, Senegal⁵ are closest to older, traditional arrangements.

Examples of small risk sharing schemes that did successfully evolve into national insurance systems can be found in Germany, Japan and Korea. In these countries, small schemes for people employed in the same craft, town or industry were gradually expanded to cover the whole population in line with the move towards full or high employment and industrialization of the economy. Concurrently, employment in agriculture fell sharply (albeit over different periods in the three countries), although agricultural productivity and earnings rates rose, enabling a larger proportion of agricultural workers to organize themselves into insurance schemes, or to buy into industrially-based insurance funds. In Korea, government subsidized such rural participation. In more recent years, a reverse trend has been identified in Central and Eastern Europe. In countries such as Kazakstan, Kyrgyzstan, Russia, Bulgaria and the Slovak Republic, a combination of falling total employment and shrinking tax revenue are hindering attempts to use employment-based coverage as a basis for national health insurance.
2.2 Implementation Conditions for Health Insurance Schemes

People outside formal sector employment can be problematic for health planners because of frequent fluctuations in and the unpredictability of their income flow, and difficulties in assessing their income. Additionally, their income is often untaxed, making it difficult to collect premium payments at source. Making membership compulsory, which has substantial advantages in terms of the size of the risk pool and control of adverse selection, is also much harder in the case of non-formal sector workers. It must also be remembered that groups outside the formal sector differ significantly from each other. So in order to succeed, health insurance schemes for the non-formal sector must take the particular conditions and circumstances of their target groups into account.

Implementation conditions for risk pooling vary markedly between urban and rural populations. Industrialization, high and rising per capita income and population density — typically urban characteristics — all facilitate the growth of insurance (Ensor, 1997). Writing 20 years ago, Lipton (1976) assembled evidence to show that earnings and leisure — in brief, welfare — are both substantially higher in urban areas. In advancing his thesis of "urban bias" he also argued that the gap between urban and rural areas is most evident in health care:

"The townsman has nine times as good a prospect of medical attention as the villager in India, eleven times in Ghana, thirty-three times in Ethiopia. The poorer, the larger in area and the less densely populated a country is, the greater in general is this disparity" (pp. 265–266).

But although access to health care services is better in urban than in rural areas, recent and rapid growth in the size of the urban informal sector is complicating the picture. In fact, in many developing countries, informal urban employment has been growing more quickly than formal urban employment. In Latin America, where comparable data exist, the informal sector now accounts for most urban employment, as shown in Table 1 (ILO, 1996). Similar growth trends are reported for countries in South Asia and sub-Saharan Africa. Furthermore, workers in the urban informal sector can be extremely heterogeneous. Some self-employed workers may be relatively affluent whereas others have very low incomes and a vulnerable existence. In other words, establishing risk sharing mechanisms can be as difficult for the urban informal sector as for the rural informal sector. That said, although many urban communities are characterized by heterogeneity and a lack of solidarity, this is not always the case — some informal sector workers may be well-organized, making it easier to establish and administer insurance schemes.

* In this document the term "non-formal sector" is used interchangeably with the term "outside of formal sector employment". "Non-formal sector" is hence much broader in coverage than the term "informal sector".
Despite recent rapid urban growth, however, the rural sector remains the dominant sector in developing countries as a whole. In 1995, 74% of South Asia's population, 69% of the population of East Asia and the Pacific, and 69% of the population of sub-Saharan Africa were rural (World Bank, 1997). In 1988, 69% of the rural population in least developed countries was estimated to fall below the poverty line (Jazairy, Alamgir & Panuccio, 1993). On the basis of UN projections, more than half of Africa's population will be rural until well into the third decade of the next century (UN, 1993). Overwhelmingly, agricultural employment dominates in the rural sector, and much of this is seasonal, family or self-employment. Cash income is seasonal and also subject to significant fluctuations from year to year. In poorer countries, much of the rural population faces cash liquidity constraints for much of the year.

**Table 2.1. Percentage (%) of Informal Sector in Non-agricultural Employment, Latin America**

<table>
<thead>
<tr>
<th>Country</th>
<th>1990</th>
<th>1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>47.5</td>
<td>52.5</td>
</tr>
<tr>
<td>Bolivia</td>
<td>56.9</td>
<td>61.3</td>
</tr>
<tr>
<td>Brazil</td>
<td>52.0</td>
<td>56.4</td>
</tr>
<tr>
<td>Chile</td>
<td>49.9</td>
<td>51.0</td>
</tr>
<tr>
<td>Colombia</td>
<td>59.1</td>
<td>61.6</td>
</tr>
<tr>
<td>Ecuador</td>
<td>51.6</td>
<td>54.2</td>
</tr>
<tr>
<td>Peru</td>
<td>51.8</td>
<td>56.0</td>
</tr>
</tbody>
</table>
3. Concepts and Typologies of Risk Sharing Schemes

Broadly speaking, insurance, risk sharing or risk pooling may be defined as the reduction or "elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member" (ILO, 1996).

Risk sharing or risk-pooling strategies for health do not concern ill health itself, but its financial impacts. Health care costs are very commonly assigned to the individuals using the relevant services, and may be reassigned, shared or pooled via prepayment arrangements or insurance mechanisms.

Insurance or risk sharing varies between health care systems. Probably the highest level of risk pooling occurs in tax-funded, compulsory national health service systems that provide a full range of accessible services to the whole population. At the opposite extreme, the single individual makes out-of-pocket payment for care.

One of the common criticisms of health insurance schemes for people outside formal sector employment is that they only pool risks between similar individuals and that under certain conditions the poor simply cross-subsidize the health care costs of other poor members of the population. However, the truth of this claim depends on how the scheme in question relates to the rest of the health care system. If services provided under the health insurance scheme are largely subsidized by government, two simultaneous levels of risk pooling occur: one between members of the scheme, and another broader risk pooling via the subsidy generated across the entire population.

The various schemes that meet the loose criterion of pooling risks to provide health insurance for the non-formal sector can be typologized in numerous ways. But in this paper, the primary typology used focuses on the extent of risk pooling.

3.1 A Typology Based on Degree of Risk Sharing

Most of the schemes reviewed focused on providing cover for either high-cost, low-frequency events, or low-cost, high-frequency events (designated Type I and Type II schemes respectively in Table 3.1). Schemes such as those in Chogoria, Kenya, Nkoranza, Ghana, Taiwan and Korea are clearly Type I schemes. Type II schemes include the Dana Sehat scheme in Indonesia and the Lalitpur Medical Insurance Scheme in Nepal in Nepal. An large number of Type II schemes also contained referral services in their benefit package. They are listed as "Type II + referral" in Table 3.2. (The regional distribution of schemes according to the level of insurance
provided is also presented in Table 3.2.) Several schemes covered both high-cost, low-frequency events and low-cost, high-frequency events, often without setting premiums on an actuarial basis.

**Table 3.1. Two Ends of the Risk Sharing Spectrum**

<table>
<thead>
<tr>
<th>Type I Schemes</th>
<th>Type II Schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-cost, low-frequency events</td>
<td>Low-cost, high-frequency events</td>
</tr>
<tr>
<td>Tend to be hospital-owned or -based</td>
<td>Tend to be community-owned or -based</td>
</tr>
<tr>
<td>Tend to set wide geographical boundary</td>
<td>Tend to be based at the village level</td>
</tr>
<tr>
<td>May use actuarial basis or variable costs for calculating premium</td>
<td>Premium set mainly according to ability to pay</td>
</tr>
<tr>
<td>May be committed to meeting certain designated costs</td>
<td>Committed only to raising extra revenue for services, some only concerned with availability of and payment for drugs</td>
</tr>
</tbody>
</table>

It is tempting to see Type II schemes as not being "proper" insurance schemes since they did not cover the risk of high financial (i.e. catastrophic) loss associated with hospitalization. Furthermore, Type II schemes were often implemented in situations where the cost of higher levels of care (if available) were borne by government. In poor communities, though, where cash flows are unreliable, even the small co-payments necessary to access primary-level government services can represent a catastrophic cost. So in covering the costs of access to such services, Type II schemes may indeed have had a real insurance element to them as far as beneficiaries are concerned.

Distinguishing between schemes in terms of levels of risk pooling is important. This is because the types of conditions they require in order to be successful vary between schemes. In particular, Type I and Type II schemes differed with respect to:

- degree of social cohesiveness
- level of demand for insurance
- administrative complexity.
Personal risk aversion (see Glossary) was more likely to form the basis of demand for membership of Type I schemes than for membership of Type II schemes. Membership of Type II schemes appeared instead to relate more to a commitment to secure joint benefits for the community. Lack of a cohesive community was thus much less of an issue for Type I schemes than for Type II schemes. Moreover, beneficiaries of Type I schemes tended to be distributed over a wide area, relatively heterogeneous and therefore less likely to experience strong feelings of solidarity. Some Type I schemes appeared (mistakenly) to emphasize community solidarity. For example, the evaluation report for the Nkoranza Community Financing Health Insurance Scheme in Ghana states:

"The concept of risk sharing in the community must be well explained for the people to understand that if you insure and do not benefit directly, your neighbour will benefit from your contribution" (Somikang et al., 1994).

**Table 3.2. Regional Distribution of Schemes by Type of Insurance Protection**

<table>
<thead>
<tr>
<th>Scheme Type</th>
<th>Africa</th>
<th>South Asia</th>
<th>SE and E Asia</th>
<th>LAC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE I</td>
<td>8</td>
<td>2</td>
<td>8</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>TYPE II</td>
<td>20</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>34</td>
</tr>
<tr>
<td>TYPE II + REFERRAL</td>
<td>3</td>
<td>9</td>
<td>14</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>TOTAL</td>
<td>31</td>
<td>16</td>
<td>29</td>
<td>6</td>
<td>82</td>
</tr>
</tbody>
</table>

**TYPE I:** basically hospital inpatient care  
**TYPE II:** basically primary care  
**TYPE II + REFERRAL:** primary care scheme with referral coverage  
**LAC:** Latin America and the Caribbean  

* In some countries such as Indonesia a large number of similar but slightly different schemes operate under the same umbrella name (Dana Sehat in Indonesia). Because of the similarities between these schemes they have been counted as only one scheme.

Such an appeal to social solidarity may be effective at village level but seems unlikely to succeed at district level. Generally, Type I schemes placed less emphasis on altruism and community development. This and the nature of the benefits they offered meant that the financial impacts of adverse selection affected such schemes more severely. On the other hand, moral hazard may have been more of an issue in Type II schemes that covered costs associated with treatment of
relatively minor conditions and where decisions to utilize services were driven by the client (rather than the health care provider).

The level of effective demand for insurance in developing countries has been hotly debated. For Type I and Type II schemes, it appeared to have been influenced by very different contextual factors. Many of the Type I schemes evolved in circumstances where user fees for hospital services were high, which meant that people were interested in purchasing insurance primarily for its risk sharing benefits. In contrast, demand for Type II schemes did not necessarily stem from desire for risk sharing. Instead, these schemes focused far more on improving the availability and quality of care, particularly through extending services to previously unserved communities. Improved access to pharmaceuticals seems to have been a common motivating factor in the development of many Type II schemes.*

Much of the debate about risk sharing has also focused on the administrative feasibility of such schemes. Again, there was a critical difference between Type I and Type II schemes. Type I schemes that aim to cover certain variable costs may require actuarial estimates of premiums in addition to information on those costs, and are more difficult to manage than Type II schemes. Management structures for Type I schemes reflected this. They tended to be more complex and their management problems more substantial. The availability of specialist management skills may be crucial to Type I schemes but are probably less of a constraint for narrowly defined Type II schemes. That said, if Type II schemes include access to referral facilities, then covering the costs of this service, contracting for higher level care and controlling the utilization of such services will call for significant management capacity.

Within Type II schemes, a small but interesting subset did not provide any risk pooling across individuals but rather allowed an individual’s risk of health care costs to be spread over time. Most simply, prices for health care were set on a “fee per episode” basis, allowing the patient any number of visits until a defined illness episode was over. More ambitious inter-temporal risk sharing was offered by schemes that allowed the patient to pre-purchase a defined set of benefits (such as a number of outpatient visits or admissions). An interesting variant operated whereby small groups of individuals were encouraged to purchase a prepaid card jointly, thus allowing some risk sharing. The most systematic inter-temporal risk-redistributing mechanisms were offered by schemes such as Singapore’s Medisave. An individual earmarked medical care savings

* Hsiao and Sen (1995) have proposed a formal model — which they call Cooperative Health Care — for Type II schemes. In this, strong social bonds and mutual trust indicate the community’s ability to undertake the financing and provision of health care. Based on experiences in rural China and India, Hsiao and Sen show how such a system would work: a mix of annual premiums and co-payments would be operated, membership would ideally be compulsory and referrals would be covered through “packaged fees” or capitation. Government would provide complementary finance.
account available over a lifetime, it allowed people to build up credit for health care when they are healthy and to cushion or cover the increasing costs of care in old age.

3.2 Ownership

Schemes were also classified according to fund ownership and management.* Fund ownership was important for several reasons. First, it often revealed a scheme's initial motivation and objectives. These varied substantially. Some facility-based schemes were primarily driven by the need to raise revenue, for example. Others sought to combine revenue-raising with improved utilization of services. Thus hospital-based schemes may have paid little attention to meeting a population's needs for services at different levels (as in Chogoria, Kenya*), focusing instead on the quality of those services that were provided. Conversely, the initial motivation of a community-based scheme was likely to have been just how to meet such needs (albeit with the focus on only one level of the health care system, or one benefit item, such as pharmaceuticals). Yet other schemes were established for purposes of demonstration. The Sichuan Rural Health Insurance Experiment† was set up to show other communities and local authorities how to manage health insurance for those outside the formal sector.

A second reason for typologizing schemes according to fund ownership was that fund ownership often determined the scheme's design details. (Design is an important factor. As will be seen below, the design of several schemes did not incorporate satisfactory, sustainable risk sharing mechanisms.) Thirdly, ownership can be an important determinant of the overall trust and confidence a population has in a scheme and the services it provides. Finally, ownership can significantly influence government's opportunities for complementing and supporting a scheme.

Table 3.3 shows the distribution of schemes according to ownership classification and region and illustrates the variety of fund ownership arrangements. It also draws attention to the substantial role of NGOs. NGOs are, of course, a mixed group, and include private sector agencies, religious missions, and both international and local charitable movements. The small number of Latin American schemes somewhat underestimates experience in that region, although it does seem that the general trend in Latin America is to bring people outside the formal sector into existing social health insurance schemes through cross-subsidies from formal sector workers or government tax revenues. Difficulty in collecting contributions from this group frequently means that its membership is entirely subsidized by formal sector workers and the government.

* This phrase has not necessarily been used in a juridical sense, but to signify the location of control and decision-making regarding the use of resources and collection of contributions in the scheme.
### Table 3.3. Schemes by Ownership of Fund and Region

<table>
<thead>
<tr>
<th>Ownership</th>
<th>Africa</th>
<th>S Asia*</th>
<th>SE &amp; E Asia</th>
<th>LAC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Facility</td>
<td>8</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Community</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Cooperative &amp; Mutual</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>NGO</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>Government</td>
<td>4</td>
<td>0</td>
<td>9</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Joint Ownership</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>16</td>
<td>29</td>
<td>6</td>
<td>82</td>
</tr>
</tbody>
</table>

- Bangladesh, India, Nepal

LAC: Latin America and the Caribbean

In Table 3.3 "facility-owned" means that the scheme was principally initiated by hospital staff, and offered protection primarily against the substantial or catastrophic health care costs associated with hospital care. Such schemes had geographically defined beneficiary groups based on the hospital catchment area, often covering both rural and urban communities. Examples include the Kasturba Hospital\(^{13}\) scheme in India and the Masisi Hospital Scheme\(^{14}\) in former Zaire.

Community-owned schemes usually focused on primary-level benefits, especially drugs, but may also have included referral services, and often had a broad community development orientation. Examples include the Abota Health Insurance Scheme\(^{15}\) in Guinea Bissau, and Dana Sehat\(^{9}\) in Indonesia and Farmer's Health Insurance\(^{7}\) in Taiwan.

Cooperative schemes are often linked to the local labour market and based on individuals' place of work. Contributions to the health fund may be paid for from the sale of cooperatively produced goods. Examples here included the former cooperative medical\(^{16}\) system of China, the Tribhovandas Foundation\(^{17}\) in India and the Mutuelle de Yoffe\(^{6}\) in Senegal.

NGO-owned schemes varied, reflecting the origin and purpose of the NGO in question. They included facility, community and cooperative schemes. The ORT Health Plus Scheme\(^{18}\) in the Philippines, the SSSS scheme\(^{19}\) run by a local NGO in West Bengal, the Bwamanda Hospital\(^{20}\) in the Democratic Republic of the Congo and Nkoranza Community Scheme\(^{8}\) in Ghana schemes were just some examples.
Government-owned schemes also varied. Some consisted of subsidies for the poor or non-formally employed, paid directly into an existing fund for formal sector employees. Examples included the Rural Social Insurance Programme 23 in Ecuador and Bao Hiem Y Te 22 in Viet Nam, and on a much smaller scale, the Tarlac Health Maintenance Programme 23 in the Philippines. Others began as cooperative or small employment-based schemes and came to form the basis of a national system, as in Korea. Some others, such as Thailand's Health Card 24 and Bao Hiem Y Te 29 in Vietnam were intended to provide much wider coverage within a national framework, but actually covered only a small minority of the eligible population.

Several problems were encountered when classifying schemes by ownership. For example, ultimate legal responsibility for the insurance fund sometimes resided with a body other than the actual decision-making group that managed the scheme. For instance, legal ownership of the Nkoranza Community Scheme 8 in Ghana resided with the Bishop of Sunyani and this was therefore classified as an NGO scheme. However, management arrangements for this scheme were complex so that day-to-day control was not exercised by the owner. A similar situation existed with respect to the Chogoria Hospital Scheme 7 in Kenya and the SEWA Integrated Social Security Scheme 25 in India. In both cases, fund-holding was arranged with a private insurer.

It should be noted too that the ownership categories are not mutually exclusive: some health facilities were owned by NGOs or government, and the borderline between a community organization, a cooperative and an NGO was often unclear.

In all but six schemes, ownership of the fund lay with a single party. In India, SEWA's fund was owned jointly by the SEWA (NGO) Bank and the United India Insurance Company. Clients were not satisfied with the service provided by the insurance company, however, and the NGO decided to run the scheme itself. The schemes collectively known as Medicare II in the Philippines were owned tripartly by local government, the Department of Health and the Philippines Medical Commission. Others schemes such as that of the Social Work and Research Centre 26 in India and the Bajada Medical Cooperative 27 in the Philippines were owned jointly by the community and an NGO. UMASIDA 28 in Tanzania was owned jointly by its five constituent informal associations.

3.3 Voluntary versus Mandatory Schemes

All but twelve of the schemes examined were voluntary, i.e. people chose whether or not they wished to join the scheme, and if they preferred not to join could still access health care facilities (although they would normally incur a user fee in so doing).
Of the mandatory schemes, only a few, such as the scheme\(^2\) in Boboye District, Niger, Farmer's\(^2\) and Labour Insurance\(^3\) for the self-employed in Taiwan, and the NH\(F\) for the rural and self-employed in Korea made membership compulsory for all individuals within a defined catchment population (whether defined geographically, or by occupation or employment). The regulations of the other mandatory schemes were much weaker, simply requiring that anyone choosing to use a particular health facility join the scheme.

Mandatory schemes such as the scheme in Boboye, which ensured membership of the entire catchment population, had many advantages. They avoided adverse selection problems (thus guaranteeing substantial subsidy from the healthy to the sick), and problems relating to poor demand. Yet in most developing countries, weak tax collection systems make implementation of mandatory schemes very difficult. But if economic growth occurs, fiscal systems are generally strengthened, making it increasingly easy to mandate health insurance coverage for workers outside the formal sector and to move towards universal health insurance coverage. The experience with mandatory health insurance in Boboye, Niger was made possible precisely because the country's local fiscal system was unusually strong (for a country at Niger's level of economic development).
An understanding of the context — local, national, economic, political and social — is fundamental to any analysis of the purpose and performance of a risk sharing scheme, and essential to identifying barriers to or opportunities for replicating that scheme elsewhere. The health system is another important aspect of context that should be considered since it may have influenced the scheme's objectives, design and operation. Finally, other development activities should be taken into account since they may have increased the scheme's potential for success.

The individual schemes covered by this paper are described in more detail in the fact sheets that make up the database. Most of the schemes were rural (although five had an urban focus) and most received external financial and/or technical support.

4.1 Economic, Political and Social Context

The economic, political and social contexts of the risk sharing schemes considered differed widely. The Bwamanda Hospital scheme\(^{20}\) and other schemes in the Democratic Republic of the Congo were initiated partly in response to the near collapse of government and government-funded and organized health care delivery. National policy on cost sharing, or indeed any other aspect of health policy was virtually non-existent, so the issue of how the schemes were integrated into overall health policy was not relevant. Similarly, the Abota Health Insurance Schemes\(^{15}\) in Guinea Bissau were established in conditions where government funding for health care was minimal (although it was possible to integrate community-supported primary care with government-funded referral services).

As might be expected, risk sharing is often supported by economic growth. In East and South-East Asia, rapid expansion of health insurance in the non-formal sector has coincided with rapid economic growth. Thus the Korean class II rural schemes were initiated at a time of accelerating economic growth and urbanization, with the aim of extending health protection to rural dwellers under what was becoming an increasingly national insurance system. Extension of health insurance to those outside formal sector employment in Taiwan likewise occurred when the economy was booming.

China's Cooperative Medical System (CMS) in particular demonstrates how closely entwined economic and political structures and health system organization may be. The CMS was developed during a time when communal agricultural production was seen as key to economic development. When the focus of macroeconomic policy shifted to the "socialist market" concept and centralization, and provincial government subsidies were cut and redirected, the CMS collapsed (Hsiao, 1995). Several efforts are now being made in China to reinstate certain aspects
of the old CMS, such as the Rural Cooperative Medical Care System. However, given the considerable changes in cultural values and health staff attitudes that have occurred, this is proving to be less than straightforward.

Specific characteristics of the local culture and economy may favour or facilitate the creation of certain types of risk sharing mechanism. The schemes reviewed were located both in areas such as Nepal and Guinea Bissau where the majority of beneficiaries were subsistence farmers, and in areas such as Urmal, India where a large number of farmers were organized in cooperatives. However, cooperative and mutual schemes were more likely to evolve if cash crops were produced and marketed through cooperatives, such as the Coffee Growers Association of Colombia and the milk marketing cooperatives in India.

It has been suggested that strong traditions of community initiative and management, or very cohesive communities, may also encourage the development of community-based insurance schemes. Some of the schemes reviewed did indeed operate with in small, close-knit communities, but others covered large districts with diverse communities. In Guinea Bissau, the small size of local villages and their cohesiveness due to opposition to colonial powers has been seen as contributing to the success of health insurance schemes (Chabot, Boal & Da Silva, 1991). And the Yoffe Mutuelle in Senegal was started by and provides insurance cover to a small number of closely-knit families engaged in fishing in one particular suburb of Dakar. However, the extent to which community solidarity is important depends partly on ownership and scheme type. If funds are community-owned, trust within the community is critical. Most of the schemes covering larger areas were facility- or government-owned Type I schemes. For these schemes, the emphasis was on the accountability within management systems rather than trust in the community.

4.2 The Health Care System

Many of the reports examined provided only scant description of the health care system. In some instances, particularly when the relevant scheme was operated by NGOs and government was weak, links to the broader health care system appeared not even to have been considered. Nonetheless, some aspects of health care systems did seem to shape the design of health insurance schemes and to influence whether or not they were successful.

The configuration, quality and price of existing health service provision are particularly important contextual factors. If physical availability and the quality of existing health services, particularly government services, are inadequate, health insurance may be perceived as a means of improving or extending them. Additionally, the price of existing health services may be an enabling or
inhibiting factor with respect to the development of risk sharing. User fees for government services, for instance, may be essential if the potential role of insurance is to be recognized or broad popular demand for insurance created (Bennett & Ngalande-Banda, 1994). In virtually all of the schemes examined, people had been accustomed to paying fees for health services before risk sharing was introduced, or had had no real access to health care. This was the case with schemes in Nepal, Bangladesh, India and Senegal.\textsuperscript{10, 33, 34, 35}

Moreover, fee levels had often been prohibitively high for a large proportion of the population, particularly for facility-based health care. High fees discourage utilization, however, and can ultimately result in low revenue. (This scenario was sometimes the starting-point for considering the introduction of health insurance schemes.) For example, in former Zaire, health zones were intended to be self-supporting and — with the exception of funds received from external donors — expected to recover full operating costs. Fees were accordingly high and revenue uncertain. Likewise in Africa generally, mission hospitals* have been forced increasingly to set high fees since government subsidies and overseas support are no longer available (Gilson et al., 1994).

Elsewhere, in Taiwan, Korea and Japan, for instance, the health care sector is dominated by private sector providers and high fees are standard. The availability, price and quality of private provision may largely determine which services are covered in the benefit package. In Korea and Thailand the scale of private provision made it essential that insurance covers not only services provided by government clinics and hospitals, but also those provided by private practitioners.

Many of the schemes examined were initiated and/or run by NGOs, and therefore independent of government. But schemes planned and implemented without coordination with government had sometimes experienced major problems. In India, for example, the Bengali scheme\textsuperscript{34} began to collapse when a government hospital was opened nearby. Similarly in Mexico, the NGO CIMIGEN\textsuperscript{11} failed to generate the necessary and anticipated demand for its services because a new government facility was opened close by. Other schemes were initiated with active participation by central or local government. They include the Tarlac Health Maintenance Programme and Medicare II in the Philippines, Health Card in Thailand and Dana in Indonesia.\textsuperscript{23, 36, 37, 39}

Decentralization of financial and management roles is another contextual factor that may influence a scheme's success or lack of success significantly. However, many of the schemes examined were non-government schemes and operated with only limited reference to the broader health care system.

* In Ghana and Kenya, and also in Papua New Guinea, much organized health care was initiated by missionaries or mission hospitals.
Decentralization was therefore not as critical a factor as initially thought. Furthermore, although an element of decentralized financial management seems critical (as in the Thai Health Card scheme), clear central guidelines on how to operate the scheme appear to be of almost equal importance for schemes initiated with government support. In other words, successful schemes are often characterized by a judicious combination of local control and central guidance.

4.3 LINKS TO OTHER COMMUNITY DEVELOPMENT ACTIVITIES

Many of the schemes reviewed were initiated by or created with the help of NGOs involved in community development activities other than health service delivery. In general, links to these other types of activities appear to have strengthened schemes. The means through which this strengthening occurred evidently varied according to the nature of the NGO's non-health activities.

Several of the schemes were initiated by NGOs involved in broad community development activities. Examples include the ORT Health Plus Scheme in the Philippines, the Pallisa Community Development Trust in Uganda, BRAC in Bangladesh, the Barpali Village Scheme in India, the Socio Economic Development Project in Irian Jaya (Indonesia) and the Bwamanda Hospital scheme in the Democratic Republic of the Congo. By being linked to broad development activities, the health insurance component of a scheme may be more likely to achieve its aims. For instance, development activities often help raise the income level of local households, thereby increasing the amount of cash available to pay premiums. In Bwamanda, a donor-funded rural development project had boosted the local economy, creating the conditions essential to the success of the health insurance scheme, with which it was also linked (Moens, 1990). In such circumstances, communities may be more willing to participate actively in health insurance schemes since they consider that their priority needs (for a stable income, for instance) are also being addressed.

Health insurance integrated with rural development projects may benefit too in more practical respects from existing facilities, management systems and management skills. Under the ORT project, primary health care services were provided at existing pre-school day-care centres and the scheme was administered by the ORT Multi-purpose cooperative, which had already acquired significant management expertise. In Bwamanda, one of the strategies used to beat inflation consisted of investing funds in a foreign currency account: this was only possible because the scheme was linked to agricultural activities that produced coffee for export.

A health insurance scheme may also benefit in more subtle ways from its association with a pre-existing community development project or activity. If a health insurance scheme is linked to the
A health insurance scheme may also benefit in more subtle ways from its association with a pre-existing community development project or activity. If a health insurance scheme is linked to the community development project with which they are already involved, many households may feel they should support the scheme's membership drive. This was the case with the ORT scheme: early registrants were predominantly members of the ORT Cooperative. Such a membership pattern is also advantageous because it is likely to include many healthy households, thereby reducing adverse selection problems.

Conversely, some development activities have incorporated health insurance to increase the participation of target populations. The Grameen Health Programme in Bangladesh and the SEWA Integrated Social Security Scheme in India were initiated by banks specializing in micro-credit for poor families. Both organizations found that the main cause of loan default was illness of a borrower or family member of a borrower and thus developed a social insurance scheme that included health insurance. Mutuals that initiated health insurance were often found to have had similar motivations: they recognized that the well-being of their members depended upon a social insurance package, including health insurance. By offering a range of types of insurance, including benefits for death and disability, membership can be made more attractive. Members are also financially protected against really catastrophic events (such as long-term disability) that otherwise might cause them to drop out of the health insurance scheme.

Banks and mutuals also demonstrated some of the more innovative approaches to financing health insurance. For example, the SEWA scheme has developed special fixed deposit savings accounts, the interest on which can be used to cover the insurance premium.
5. Overview of Schemes

This section provides a brief overview of the design of the schemes reviewed. The schemes examined were predominantly insurance rather than personal prepayment schemes and membership of all but twelve of the schemes was voluntary.

5.1 Membership and Coverage

Membership

Potential beneficiaries of schemes were defined both by geographic location (particularly catchment areas for hospital-based schemes, and village, ward or district of residence for community-owned schemes) and by nature of work (whether this be occupation, place of work, or how produce is sold). Four of the schemes reviewed, the Smokey Mountain Cooperative in the Philippines, SWHI in Thailand, and the Kasturba Hospital scheme and SEWA in India were targeted at "the poor".

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/household</td>
<td>40</td>
</tr>
<tr>
<td>Individual</td>
<td>15</td>
</tr>
<tr>
<td>Individual and family</td>
<td>7</td>
</tr>
<tr>
<td>Village or cooperative</td>
<td>3</td>
</tr>
<tr>
<td>Other/unknown</td>
<td>17</td>
</tr>
</tbody>
</table>

Forty of the schemes took the household as the unit of membership (Table 5.1). Schemes that had initially allowed individuals to enrol often rapidly faced problems of adverse selection and had switched to enrolment by household. In Nkoranza, Ghana, premiums were set individually but the whole household had to join the scheme. If a family had not enrolled all its members it was obliged to pay a double premium for each non-enrolled member. Indeed, the failure of insurance scheme workers to sign up every member of each enrolled household was contributing to the scheme's failing financial viability when assessed in 1994 (Somkang et al., 1994). In Vietnam, households joining the country's health insurance scheme voluntarily were required to enrol at least two-thirds of their household (Ensor, 1995). Conversely, in Taiwan, enrolment was per individual under both the Farmers Health insurance scheme and Labour insurance, since only workers and not their dependants could be enrolled. However, the Farmers scheme appears to
have been compulsory (thereby reducing the risk of adverse selection) and the Labour insurance scheme probably attracted few self-employed (thereby minimizing the scale of risk of adverse selection).

Schemes can help prevent adverse selection by requiring that a minimum number or proportion of households in a village or members of a cooperative joins. In the Kasturba Hospital scheme at least 75% of poor households in a village must join the scheme, otherwise it is withdrawn from that particular community. Under the Palmomal Health Centre Scheme in Papua New Guinea, premiums have been set for a whole village. In the Kisiizi Hospital Plan in Uganda, the membership unit is the traditional Engozi (mutual benefit) society.

If a scheme includes some element of risk sharing and if enrolment in a scheme is permitted over a fairly long time and there is no waiting period, people will tend to enrol only if and when they need care. At least a quarter of the schemes reviewed had not set a fixed enrolment period and did not operate a prescribed waiting time that members must undergo before qualifying for insurance benefits. This may be less important for Type II schemes. But the lack of these conditions in Type I schemes, for which health services needs are more unpredictable and of higher financial impact, can lead to severe adverse selection problems since people are likely to enrol only when they are sick. At the VHS hospital in Madras, India, for example, where enrolment was allowed throughout the year and a waiting period was not applied, less than a quarter of subscribers had renewed their membership. The remaining three-quarters had most probably joined only at the time of illness, eroding the insurance effect of the scheme (Dave & Berman, 1990). Several schemes planned to have a limited enrolment period but had extended it because enrolment rates were low.

A variety of enrolment and waiting period practices were used by other schemes to prevent adverse selection if it was potentially a major problem. The ORT scheme (Philippines), which allows group or individual membership, operates a waiting period of two months for individuals but only two weeks for group members. Gonoshathi Kendra in Bangladesh imposes no waiting period for the use of clinic services, but a week for hospital care. The Raigarh Ambikapur Health Association in India has a general waiting period of two months before entitlement, while in the Philippines, some of the Medicare II schemes impose a three-month waiting period. Also in the Philippines, the Tarlac Health Maintenance Programme imposes a one-month wait for members paying the full annual premium and three months for those paying in instalments.

**Coverage**

Table 5.2 summarizes the proportion of the eligible population actually insured, based on the most recent information available.
### Table 5.2. Coverage of Schemes

<table>
<thead>
<tr>
<th>No.</th>
<th>Name of Scheme</th>
<th>Country</th>
<th>% Pop. Covered</th>
<th>Number of Beneficiaries</th>
<th>Eligible Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>ASSABA</td>
<td>Guatemala</td>
<td>&lt;1%</td>
<td>40 HHs</td>
<td>local population</td>
</tr>
<tr>
<td>80</td>
<td>CASP</td>
<td>Dem. Rep./Congo</td>
<td>&lt;1%</td>
<td>6700</td>
<td>entire population</td>
</tr>
<tr>
<td>61</td>
<td>UMASIDA</td>
<td>Tanzania</td>
<td>&lt;1%</td>
<td>6000</td>
<td>informal sector groups</td>
</tr>
<tr>
<td>19</td>
<td>Bokoro</td>
<td>Dem. Rep./Congo</td>
<td>4.5%</td>
<td>4000</td>
<td>-</td>
</tr>
<tr>
<td>43</td>
<td>Barpali</td>
<td>India</td>
<td>8%</td>
<td>-</td>
<td>local population</td>
</tr>
<tr>
<td>22</td>
<td>St Alphonse</td>
<td>Dem. Rep./Congo</td>
<td>8.2%</td>
<td>620</td>
<td>population in urban Matete pop. in catchment area</td>
</tr>
<tr>
<td>1</td>
<td>Chogoria</td>
<td>Kenya</td>
<td>1.8%</td>
<td>1700</td>
<td>-</td>
</tr>
<tr>
<td>29</td>
<td>Bao Hiem Y Te</td>
<td>Viet Nam</td>
<td>9%</td>
<td>130 000</td>
<td>entire population</td>
</tr>
<tr>
<td>81</td>
<td>REMEF</td>
<td>Dem. Rep./Congo</td>
<td>10–14%</td>
<td>700–1000</td>
<td>local community</td>
</tr>
<tr>
<td>2</td>
<td>ORT</td>
<td>Philippines</td>
<td>11%</td>
<td>2000</td>
<td>local community</td>
</tr>
<tr>
<td>71</td>
<td>Dana Sehat</td>
<td>Indonesia</td>
<td>13%</td>
<td>-</td>
<td>primarily rural population</td>
</tr>
<tr>
<td>37</td>
<td>Fed PHC Mother's club</td>
<td>Philippines</td>
<td>14%</td>
<td>12 000</td>
<td>members of local clubs</td>
</tr>
<tr>
<td>28</td>
<td>Smokey Mountain</td>
<td>Philippines</td>
<td>14%</td>
<td>250 HHs</td>
<td>families on Smokey Mtn members of milk coop</td>
</tr>
<tr>
<td>11</td>
<td>Tribhovandas</td>
<td>India</td>
<td>16–20%</td>
<td>800 000</td>
<td>small-scale farming HHs</td>
</tr>
<tr>
<td>57</td>
<td>SSC</td>
<td>Ecuador</td>
<td>17.5%</td>
<td>812 000</td>
<td>-</td>
</tr>
<tr>
<td>46</td>
<td>KSS</td>
<td>India</td>
<td>18%</td>
<td>34 000</td>
<td>pop in catchment area</td>
</tr>
<tr>
<td>13</td>
<td>Kongolo</td>
<td>Dem. Rep./Congo</td>
<td>19.3%</td>
<td>976</td>
<td>preg women in catchment</td>
</tr>
<tr>
<td>30</td>
<td>CIMIGEN</td>
<td>Mexico</td>
<td>20%</td>
<td>-</td>
<td>Entire population</td>
</tr>
<tr>
<td>58</td>
<td>CAM</td>
<td>Burundi</td>
<td>20–25%</td>
<td>1.2 million</td>
<td>People from 1 particular village in Yaounde</td>
</tr>
<tr>
<td>15</td>
<td>MFB de Yaounde</td>
<td>Cameroun</td>
<td>22%</td>
<td>455</td>
<td>Catchment population</td>
</tr>
<tr>
<td>3</td>
<td>Nkoranza</td>
<td>Ghana</td>
<td>23%</td>
<td>22 890</td>
<td>Non-poor villagers</td>
</tr>
<tr>
<td>62</td>
<td>Health card</td>
<td>Thailand</td>
<td>24.7%</td>
<td>1.2 million</td>
<td>-</td>
</tr>
<tr>
<td>42</td>
<td>SWRC</td>
<td>India</td>
<td>25%</td>
<td>20 000</td>
<td>Urban catchment pop</td>
</tr>
<tr>
<td>55</td>
<td>Masisi</td>
<td>Dem. Rep./Congo</td>
<td>26.8%</td>
<td>3530</td>
<td>Poor in catchment area</td>
</tr>
<tr>
<td>17</td>
<td>GK</td>
<td>Bangladesh</td>
<td>27.5%</td>
<td>45 600</td>
<td>-</td>
</tr>
<tr>
<td>41</td>
<td>BRAC</td>
<td>Bangladesh</td>
<td>30%</td>
<td>36 000</td>
<td>Villagers</td>
</tr>
<tr>
<td>33</td>
<td>PHACOM</td>
<td>Madagascar</td>
<td>30%</td>
<td>42 700</td>
<td>Rural pop in 14 counties</td>
</tr>
<tr>
<td>69</td>
<td>RCMS</td>
<td>China</td>
<td>31–100%</td>
<td>545 000</td>
<td>Population of 17 villages</td>
</tr>
<tr>
<td>6</td>
<td>Molodo</td>
<td>Mali</td>
<td>33%</td>
<td>532 HHs</td>
<td>Health centre catchment</td>
</tr>
<tr>
<td>4</td>
<td>Ala/dowa</td>
<td>Nigeria</td>
<td>40%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>79</td>
<td>SWHL</td>
<td>Thailand</td>
<td>45%</td>
<td>27 million</td>
<td>Low-income + elderly</td>
</tr>
<tr>
<td>65</td>
<td>National HI</td>
<td>Philippines</td>
<td>47%</td>
<td>600 000</td>
<td>Entire pop</td>
</tr>
<tr>
<td>9</td>
<td>Gaubin</td>
<td>Papua New</td>
<td>50%</td>
<td>19 000</td>
<td>Health centre catchment</td>
</tr>
<tr>
<td>59</td>
<td>Lalitpur</td>
<td>Guinea</td>
<td>50%</td>
<td>7574 HHs</td>
<td>People in 6 villages</td>
</tr>
<tr>
<td>14</td>
<td>Grameen</td>
<td>Nepal</td>
<td>52%</td>
<td>107 250</td>
<td>Poor who bank at Grameen</td>
</tr>
<tr>
<td>67</td>
<td>Swamanda</td>
<td>Bangladesh</td>
<td>66%</td>
<td>80 000</td>
<td>Health district population</td>
</tr>
<tr>
<td>26</td>
<td>Kasturba Hospital</td>
<td>Dem. Rep./Congo</td>
<td>74%</td>
<td>19 450</td>
<td>Hospital catchment pop</td>
</tr>
<tr>
<td>27</td>
<td>Goalpara</td>
<td>India</td>
<td>86%</td>
<td>1250</td>
<td>-</td>
</tr>
<tr>
<td>31</td>
<td>Abota</td>
<td>India</td>
<td>90%</td>
<td>200 000</td>
<td>Entire rural pop</td>
</tr>
<tr>
<td>70</td>
<td>Sichuan RHI</td>
<td>Guinea Bissau</td>
<td>90+%</td>
<td>40 440</td>
<td>District population</td>
</tr>
<tr>
<td>60</td>
<td>Boboye</td>
<td>China</td>
<td>90+%</td>
<td>250 000</td>
<td>Entire rural pop</td>
</tr>
<tr>
<td>75</td>
<td>CMS</td>
<td>Niger</td>
<td>90+%</td>
<td>700 000</td>
<td>Health centre catchment</td>
</tr>
<tr>
<td>8</td>
<td>Palmalmal</td>
<td>China</td>
<td>90+%</td>
<td>4440</td>
<td>Self-employed + rural pop</td>
</tr>
<tr>
<td>78</td>
<td>NHI Class II+IV</td>
<td>Papua New</td>
<td>90+%</td>
<td>19.7 million</td>
<td></td>
</tr>
</tbody>
</table>

HH: households
Only 12 of the 82 schemes reviewed claimed "mandatory" or "universal" membership within their area. But even within this group, effective membership — dependent on people paying premiums — was often low. At Boboye in Niger the whole population was included by means of a mandatory poll tax. But where "compulsory" membership meant paying the premium on attendance at the health centre, coverage levels tended to be much lower — for instance, 33% at Molodo in Mali, and 25% for SSWRC in India. Schemes that became compulsory as employment levels rose, as in Japan, Korea and Taiwan, evidently had close to full coverage.

With the exception of the schemes in China, coverage of the target population tended to be low for the non-compulsory schemes (Table 5.2). Bwamanda Hospital in the Democratic Republic of the Congo, the Kasturba Hospital scheme and the Goalpara Cooperative Health Society in India, and the Abota Health Insurance Scheme in Guinea-Bissau stand out as having strikingly high coverage in comparison to the other schemes. Many of the community-owned schemes (such as ASSABA in Guatemala and Dana Sehat in Indonesia) and even those that were relatively successful (such as Thailand's Health Card scheme) failed to cover more than a quarter of the total target population, although coverage among certain communities was obviously much higher.

Evidence from several schemes indicated that the very poor are seldom well represented in voluntary schemes, unless subsidized (usually by government, or another group such as those in formal sector employment). It also revealed that — and this is a related factor — if a scheme incorporated both rural and urban membership, rural participation was frequently lower than urban participation, as demonstrated by the Masisi Referral Hospital Pre-payment Scheme in the Democratic Republic of the Congo.

Examination of the histories of long-standing schemes shows that maintaining a given level of coverage requires continuous monitoring and adjustment of premium levels, co-payments and benefit packages, and a sustained information and sales policy. Marketing and information, education and communication strategies (IEC) to promote coverage varied immensely, depending partly on a scheme's catchment area. The HEWSPECS project in the Philippines, established in 1987, spent 9% of its 1994 budget on marketing and in Nkoranza, Ghana, substantial efforts were devoted to marketing and IEC, with a series of district-wide meetings, campaigns and distribution of information sheets. In the Philippines, the ORT scheme ran a registration campaign. In Chogoria, Kenya, a major marketing campaign was held to launch the new-style scheme (McFarlane, 1996).
5.2 FINANCING: PREMIUMS, CO-PAYMENTS AND COST RECOVERY

Premiums of the schemes reviewed were generally flat-rate and paid annually. Very few schemes used proceeds from cooperative sales to subsidize an insurance fund. Ten schemes operated some form of income-related premium. For instance, two hospital-based schemes in India (Kasturba Hospital and VHS) and one scheme in Bangladesh set premiums on a sliding scale according to income (Box 5.1). The more sophisticated schemes in Japan and Taiwan generally set premiums as a percentage of earnings. In Korea, premiums were set according to a complex assessment of income and assets.

Schemes based in urban areas were more likely to allow monthly or quarterly premium payments in order to accommodate the income patterns of those working in the urban informal sector. Examples included the UTH Prepayment Scheme in Zambia and several schemes in the Philippines. In rural areas, annual premium payments were more usual. However, a flexible payment schedule was adopted under the ORT scheme allowing monthly, quarterly or semi-annual payments since it was considered that many households would not be able to afford to pay the annual premium in one lump sum. Nonetheless, a number of families dropped out of the scheme over the Christmas period since they had failed to keep up payments (Ron & Kupferman, 1996). During 1993–1994, the Nkoranza Community Financing Health Insurance Scheme in Ghana allowed families who could not afford to pay the premium all at once to pay in instalments. Few households took this option, though, and it was later dropped.

In some instances, no attempt appeared to have been made to adjust the frequency of premium payment to local conditions. For example, the Dana Sehat scheme in Indonesia, which was a predominantly rural scheme, required monthly payment of premiums.

Payments in kind were generally not accepted. The exceptions were some villages in Guinea Bissau, the Lalitpur Medical Insurance Scheme in Nepal, the Bolivian Caja the Kasturba Hospital scheme in India and the Bangladesh Rural Advancement Committee in Bangladesh. Interestingly, very few among the poor agricultural communities in Nepal chose to pay in kind (Donaldson, 1982).
**Box 5.1. Gonoshthaya Kendra: Providing Insurance Coverage for the Poor**

Gonoshthaya Kendra (GK) is a Bangladeshi NGO that provides health care services to the population of a rapidly industrializing area about 40km from Dhaka. GK established a health insurance scheme in 1975 with the aim of increasing the access of the poor to the health care system and recovering the majority of the recurrent costs of services provided.

GK divides the population into four groups:

- **The destitute**: including neglected widows, widows from landless families, women abandoned by their husbands and the disabled.
- **The poor**: made up of households that cannot afford two meals a day for all family members.
- **The middle-class**: including households that can meet the essential costs of day-to-day living but that have no savings.
- **The rich**: including households that can meet all basic needs and have savings.

Premiums are set on a sliding scale according to the socioeconomic category the household falls into. Premiums for the destitute and poor groups range from 5–15 Taka per annum, whereas for the middle-class and rich groups the premiums range from 40–50 Taka per annum. The co-payments also vary according to socioeconomic status, and while the destitute and poor households receive all medicines free of charge, middle-class and rich households are expected to pay for them.

In 1995, GK estimated that over 80% of destitute households and 46% of poor households, but only 20% of middle class and 10% of rich households, were covered by the scheme. It should be noted that GK operates with a substantial subsidy from other sources which covers 64% of operating costs (see Table 5.3).

Only thirteen of the schemes had built-in exemption policies. Given the emphasis on serving the poor of many of the schemes this seems quite low. In Boboye, Niger the indigent could apply for special waivers (Diop, Yazbeck & Bitran, 1995) and under the Abota Scheme in Guinea Bissau, villagers could decide to allow the indigent access to drugs despite the fact that they had not paid their premium (Chabot, Boal & Da Silva, 1991). Under the ORT scheme, project staff would try to seek supplementary funds to subsidize the premiums of poor families (Ron and Kupferman, 1996), while in Lalitpur district, Nepal, poor households could obtain a free health card upon production of the appropriate letter from a community leader (Donaldson, 1982). In many instances, those who could not afford the premiums payable under the scheme would simply pay user fees when using the service or not seek care.
Table 5.3. Sources of income for Gonoshathya Kendra in 1995–1996

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepayments</td>
<td>12</td>
</tr>
<tr>
<td>Co-payments (insured)</td>
<td>8</td>
</tr>
<tr>
<td>Co-payments (uninsured)</td>
<td>16</td>
</tr>
<tr>
<td>GK commercial venture subsidy</td>
<td>14</td>
</tr>
<tr>
<td>International subsidy</td>
<td>50</td>
</tr>
</tbody>
</table>

Some South-East Asian countries have responded to the issue of how to provide coverage for the poor by creating a special-low income card or scheme for the poor, rather than integrating them into the main health insurance system. In Vietnam, a separate scheme was operated for very poor people under which 100% of the premium was paid from the provincial government budget directly into the health fund. In Korea, the poor were instead theoretically integrated into the system through subsidized premiums. The same practice was being followed locally by the Tarlac Programme in the Philippines; households requiring subsidies were identified by local government. Such mechanisms are essential if universal coverage is to be achieved.

All of the schemes relied on funds other than those received from premiums. Table 5.4 shows what costs schemes attempted to cover from prepaid premium collection and cost-recovery rates where available.

The schemes with highest cost recovery from prepayment were generally those concerned with the drugs cost component of health care (for example, the Mutuelle NSALASANI scheme in Congo-Brazzaville). The experience of other schemes seems to underscore the often important contributory role of prepayment to revenue raising. Yet there is little evidence that voluntary prepayment schemes for those outside the formal sector can be “self-financing”, for anything other than the very short term. In fact, schemes such as that of the Bwamanda Hospital in the Democratic Republic of the Congo and Gonoshathya Kendra in Bangladesh had mixed sources of total revenue, with important elements of prepayment, co-payment, prepayment and operating subsidy. Table 5.3 summarizes sources of income for Gonoshathya Kendra in 1995/96.
## Table 5.4. Cost Recovery from Insurance Premiums under the Schemes

<table>
<thead>
<tr>
<th>No.</th>
<th>Scheme</th>
<th>Country</th>
<th>Cost Recovery from Prepayment</th>
<th>Last Date Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>SWRC</td>
<td>India</td>
<td>10% of recurrent expenditure</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>RAHA</td>
<td>India</td>
<td>10–20% off community costs &amp; 100% referral costs*</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>SSSS</td>
<td>India</td>
<td>15% of recurrent expenditureb</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Caja-Tiwanaku</td>
<td>Bolivia</td>
<td>18% of recurrent expenditurec</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Abota</td>
<td>Guinea Bissau</td>
<td>23% of recurrent expenditured</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Bajada</td>
<td>Philippines</td>
<td>30% of recurrent expenditure</td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>CAM</td>
<td>Burundi</td>
<td>34% of outpatient drug costs*</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>GK</td>
<td>Bangladesh</td>
<td>12% of recurrent expendituref</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Grameen</td>
<td>Bangladesh</td>
<td>24.7% of recurrent expenditureg</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>BRAC</td>
<td>Bangladesh</td>
<td>50% of recurrent expenditure</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Health Card</td>
<td>Thailand</td>
<td>50.0%h</td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>Bwamanda</td>
<td>former Zaire</td>
<td>65–70% recurrent excl. personal allowances</td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>SWHI</td>
<td>Thailand</td>
<td>50–60%i</td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Lalitpur</td>
<td>Nepal</td>
<td>51% of recurrent expenditurej</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Kisilzi</td>
<td>Uganda</td>
<td>72% of recurrent expenditurek</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>KSSS</td>
<td>India</td>
<td>88% of recurrent expenditure</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Boboye</td>
<td>Niger</td>
<td>89% of drug and management costsl</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Kasturba Hospital</td>
<td>India</td>
<td>96% of community health prog. costs</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Medicare II</td>
<td>Philippines</td>
<td>100% of recurrent expenditurem</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>PHACOM</td>
<td>Madagascar</td>
<td>100% of drug costsn</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>UMASIDA</td>
<td>Tanzania</td>
<td>100% of costs</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ORT</td>
<td>Philippines</td>
<td>100% excluding professional salaries</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>Nsalasani</td>
<td>Congo-Brazzaville</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Bao Hiem Y Te</td>
<td>Viet Nam</td>
<td>130%</td>
<td></td>
</tr>
</tbody>
</table>

### Notes
- a Non-member fee collections covered roughly 60% of community cost.
- b Co-payments covered 31% of costs and balance financed from fund-raising activities.
- c Without the costs associated with expatriate assistance the insurance fund contribution would have been 48% of budget.
- d In a study of 18 village schemes, cost recovery ranged from 3–123% based on assumption that all communities consumed a given amount of drugs as estimated by government.
- e There was no link between pre-payment revenues collected and financing of services since revenues reverted to government. A study in Muyinga province showed that the revenue from premiums was sufficient to fund approximately 34% of drug costs.
- f The remainder was covered by user fees (24%), subsidies from GK commercial ventures (14%) and international solidarity (50%).
- g The remainder was covered by user fees (41.3% members and non-members) and a long-term loan from Grameen Bank (34%).
- h The scheme is currently half financed by government budget and half by card holders. This is a relatively recent reform; previous estimates show recovery of approximately 35% of recurrent costs.
- i Balance from cross-subsidy from richer households.
- j Cost recovery from prepayment ranged from 30–56.6%.
- k Average cost recovery for the hospital as a whole was 48%.
- l 149% of drug costs only.
- m Fund utilization was relatively low, ranging from 38–78% of total collections. Only in 1992, after a large drop in membership did disbursement exceed collection under the Unisan, Quezon pilot scheme.
- n Drugs were bought with membership fees but often only lasted three months of the year.
- o The 130% included a cross-subsidy from formal sector workers to non-formal sector workers.
Table 5.4 suggests that a handful of schemes did achieve self-financing, but it is actually rather deceptive. For instance, under the Les Pharmacies Communataires scheme in Madagascar, 63 100% of drug costs were apparently covered, but more usually, drug stocks lasted for three months of the year only. The scheme could therefore not be considered truly self-financing. And under the Bao Hiem Y Te scheme 22 in Vietnam substantial cross-subsidy occurred: from those in formal sector employment to those who were members of the scheme and without formal employment.

However, at the time this review was undertaken, the UMASIDA scheme 28 in Tanzania had been fully self-financing for two years. A number of the scheme’s characteristics may help explain this success. First, the scheme covered those working in the informal sector in Dar Es Salaam who did not have stable incomes but did have cash incomes. Second, adverse selection problems were minimized since entire groups of informal sector workers (such as all the hawkers working in a particular market) were enrolled. Third, the scheme developed quite strict gatekeeping mechanisms: members had to obtain approval from the group chairperson before seeking care and care had to be sought from a defined list of providers.

The Bwamanda Hospital scheme in former Zaire again stood out as an exception, with a cost recovery ratio of approximately 65–70%. For most other schemes, the cost recovery ratios appeared to be much lower. For instance, approximately 35% of costs only were estimated to be recovered in Thailand. However, this needs to be placed in the context of Thailand’s generally high government-cost recovery (roughly 50–60% of recurrent costs at district hospitals). In short, cost recovery was lower under the Health Card scheme than under the user-fee system.

The Abota scheme in Guinea-Bissau is generally considered a success. Yet the scheme can really only be considered a modest success since the drugs stocked at the community level were very basic (just twelve essential drugs), and approximately 90% of the cost of essential drugs sold to health posts was donor-subsidized; (Eklund and Stavem, 1996).

The Voluntary Health Services scheme in Madras 45 charged premiums on a sliding scale, leading to very different cost recovery rates for different groups of patient. Predictably too, most (73.6%) of those joining the scheme had a low income and the scheme accounted for less than 10% of hospital patient revenues (Dave & Berman, 1990).

In Taiwan 23 and Korea, 4 government paid a substantial proportion of the premium for non-formal sector workers (70% and 50% respectively). Moreover, co-payment rates were very high, so ultimately only about 25% of the total charge of services was met from premiums paid by members.
5.3 Administration, Fund Management and Information Systems

Administration

Successful operation of a health insurance scheme requires efficient performance of several administrative functions, including premium collection, rate setting (for both premiums and rates of reimbursement and co-payment), marketing, fund management and possibly utilization review, and contracting with health care providers. The importance of these different functions varies according to the design of the scheme in question. So for Type I schemes, utilization review, including regular review of medical records to identify excess provision or unusual medical practices, may be necessary to ensure the scheme's continued financial viability. For Type II schemes, though, where gatekeepers control access to higher, more costly levels of health care, utilization review may be less pressing. Similarly, for Type I schemes that set premiums and reimbursement rates on an actuarial basis, quite complex calculations may be required if appropriate rates are to be set. But for Type II schemes where premiums play a contributory role, and are substantially supplemented by government and/or donor funds, rate setting is likely to be less complex.

Considerable variation in the complexity of administrative and management structures was therefore observed among the schemes reviewed. Management structures were sometimes very simple. In Guinea Bissau, administrative simplicity was one of the prime reasons for implementing a prepaid as opposed to a user-fee system. A village leader simply visited each household once a year and requested payment of a fixed amount. After an initial learning period, villagers managed the scheme well, although increasing economic pressures finally led to some misuse of funds, threatening the scheme's credibility. Elsewhere, very complex management structures were established. The Nkoranza scheme in Ghana drew heavily on unpaid committee members, such as the insurance management team, the insurance advisory board and the Diocesan health committee, in addition to running a small salaried management team. The scheme had six management levels.

Chogoria Hospital in Kenya and the SEWA Hospital in India contracted risk management out to a private for-profit insurance company. The hospitals retained only billing functions. However, Chogoria Hospital experienced major administrative problems during the first three or four years of its scheme, with claims to the insurance company often being submitted a year late (Enright et al., 1994). Similarly, SEWA received complaints from beneficiaries. The latter pressed for improved benefits and faster reimbursement. SEWA responded by withdrawing management of the health insurance aspects from the insurance company in 1995, although it continued to manage other aspects of the social insurance package.
The high administrative costs of managing health insurance schemes are often cited as an argument against expanding health insurance to those who work outside the formal sector. In support of this argument, administrative structures do sometimes appear to be disproportionate to the functions performed. The administrative costs of the Dana Sehat scheme in Indonesia seemed very high compared to the amount of funds handled and the level of coverage provided (World Bank, 1991). Volunteer staff collected monthly premiums of a limited value (approximately US$ 0.05). Village health workers wrote referral letters for all insured persons seeking care at the health centre level. Health centres recorded all insured persons on separate registers and at the end of the month presented claims to the fund-holders who then paid them. This entire procedure accounted for no more than approximately 3% of recurrent costs, and the same level of revenue would otherwise have been collected through user fees.

Similarly, accounts for the Nkoranza scheme suggested that in 1994, 17% of scheme revenue was spent on administration (although this ignored the high input of voluntary labour noted above) and for Gonoshathya Kendra and Bwamanda Hospital, administrative costs amounted to about 12% and 5% respectively of income. However, administrative costs vary according to the complexity of the administrative structure and the different functions performed by a scheme’s management. Moreover, only limited data are available for examining this issue. Drawing a firm conclusion is therefore difficult.

At the same time, if insufficient attention is paid to administration and management capacity, a scheme may soon find itself in jeopardy. For schemes run by banks, mutuals or cooperatives, management capacity is probably not a major concern since such bodies are likely to be accustomed to managing funds and administrative systems are commonly already in place. However, if schemes are to be operated by communities or health staff who are unaccustomed to managing funds, extra training will be required. In Nepal’s Lalitpur scheme it was observed that the village committees running the scheme made some very good decisions, particularly relating to exemptions, but were poor at communicating their plans to the rest of the village and in accounting for funds.

Accountability for fund management was not much discussed in the documentation of the schemes reviewed. If schemes were community-owned, fund managers were sometimes held accountable to the local community through community meetings, as in the Kasturba Hospital scheme in India or through simple accounting procedures, such as showing receipts to the community (Mogedal, 1984; Chabot, Boal & Da Silva, 1991). The Nkoranza Hospital scheme in Ghana incorporated an Insurance Advisory Board that included members of the hospital management team and 25 community members (Somkang et al., 1994). On the whole, though, systems for ensuring accountability to the beneficiary communities appeared weak.
Some programmes such as the Thai Health Card were centrally-driven and therefore operated within quite tight government guidelines. In Indonesia, however, although guidelines on the use of funds exist, they are not very tight. Elsewhere, complete autonomy reigned. Examples include several schemes in the Philippines and the hospital-based schemes of former Zaire.

**Fund management**

If premiums are collected only once a year and are intended to cover financial commitments for the whole of that year, the funds must obviously be invested, particularly if inflation is high. The Nkoranza scheme learnt this lesson during its first year of operation when it ran into difficulties through lack of an investment policy and high inflation rates rapidly eroded the fund's value. Thereafter, the scheme bought treasury bonds to counteract this problem.

Other schemes found innovative ways to combat inflation. In Masisi, funds were held by the district pharmacy which immediately converted revenues into drugs; income was later generated through sales of those drugs. For the Bwamanda Hospital scheme capital for the funds was constituted by the NGO. In more stable economic environments, particularly where safe and accessible investment opportunities exist, such as Korea, Taiwan and Japan, fund management was not problematic. Under the Thai Health Card scheme fund-holders did not have to pay providers until the end of the year and could invest the funds during the year. Investment often took the form of interest-bearing loans to community members (Myers, 1989; Supachutikul, 1996).

**Information systems**

Few of the studies reviewed provided much background on management information systems. Most schemes focused primarily on developing adequate financial management systems in order to be able to account for financial transactions and ensure that only insured people could access benefits. Unfortunately, protecting the scheme against fraudulent claims often proved difficult since checking the identity of the person seeking care was itself often difficult (Somkang et al., 1994; McFarlane, 1996).

Thereafter, systems were sometimes expanded to cover utilization (which provides useful information for premium setting). Only once these basic systems were in place would attention turn to more complex aspects of monitoring such as quality of care and only the most developed of the schemes, such as the NHI Schemes in Korea, had gathered information on these aspects. Some of the schemes (notably the Thai Health Card scheme, and the prepayment scheme in Boboye) had collected information on quality of care from special evaluations, but not from routine data. In Taiwan, under the Farmers' Health Insurance scheme, routine patient data provided to the fund now includes fees charged by category, diagnosis, surgery and length of stay.
5.4 PROVIDER PAYMENT MECHANISMS

The most common form of provider payment mechanism under the schemes reviewed was direct salary and budget subsidy. This was used in over 50% of schemes, and particularly in those schemes with direct service provision (Table 5.5). In most instances, funds collected were used to cover the salaries and budgets of the nearest health care facility.

Under the Thai Health Card scheme, though, access was open to any level of care, provided the patient had been referred. More sophisticated methods for allocating funds therefore had to be devised. Initially, a fixed formula was applied to allocate funds across different levels of the system. For example, in Chiang Mai, northern Thailand, 15% of funds were allocated to the village committee, 20% to the health centre, 33% to the community hospital and 32% to the provincial hospital (Supachutikul and Sirinirund, 1993). These allocations varied between provinces, but could nevertheless be estimated. However, under this payment system, higher service levels, particularly district hospitals, often felt that they received an unfairly low share of funds. Furthermore, referral became more lax. Accordingly, there has been discussion within Thailand’s Ministry of Health about linking allocation to actual utilization of facilities. To institute such a payment mechanism successfully, though, stronger information systems would be required.

<table>
<thead>
<tr>
<th>PAYMENT MECHANISM</th>
<th>NUMBER OF SCHEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and budget</td>
<td>42</td>
</tr>
<tr>
<td>Fee for service reimbursement</td>
<td>11</td>
</tr>
<tr>
<td>Mixed payment systems</td>
<td>3</td>
</tr>
<tr>
<td>Fee per visit</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Unknown</td>
<td>21</td>
</tr>
</tbody>
</table>

The second most common form of payment was fee-for-service reimbursement. This was particularly common for Type I schemes or schemes with a significant hospital care component. Additionally, fee-for-service was frequently used to pay private health care providers at both primary and secondary levels (see). Under a fee-for-service system, the insurance scheme can operate by directly reimbursing the provider. Alternatively, the patient can pay out-of-pocket and seek reimbursement later, as illustrated by the SEWA scheme. Evidence from elsewhere in India (Ellis, Allam & Gupta, 1996) suggests that in such circumstances demand may be considerably reduced because of the necessity of finding cash to make the initial payments.
Variations upon fee-for-service, including fee-per-visit and a points system for reimbursing physicians were also observed.

Mixed payment strategies were used by some schemes. The ORT scheme in the Philippines and the ASSABA scheme in Guatemala both provided direct salary and budget subvention to primary providers, but for the hospital level, both schemes sought to pay a capitation fee. In the Philippines, several pilot schemes provided salaries and budget subvention to publicly-owned providers, but paid private providers under contract, using a variety of payment mechanisms.

5.5 Health Care Provision

Benefits package

Benefits packages were generally weakly defined. In numerous cases, benefits were redefined when a scheme encountered difficulties in balancing revenue with expenditure. Some schemes applied exclusions (e.g. dental services under the ORT scheme), but otherwise they tended to cover all the services available at the participating facilities. The main problem with this approach was that enrolment rates among those with pre-existing conditions, particularly chronic illnesses, were high. Initially, for instance, the Chogoria Hospital scheme had a very broad benefit package covering all such conditions. However, when the scheme was reviewed recently, the decision was taken to define the benefit package much more tightly in order to exclude the elderly and those with pre-existing conditions (see Box 5.2).

Very few of the schemes used revenue to provide non-personal services. Those that did were smaller, Type II schemes that offered health education and limited preventive care. In some cases it was not recognized that a scheme could not financially sustain a generously defined benefit package unless it was accompanied by tight referral practice or gatekeeping. The UTH Prepayment Scheme in Zambia in its first version was an example of this problem. Conversely, under the Bwamanda Hospital scheme, patients could qualify for the insured benefits only if referred by a (fee-for-service) primary health centre. This gatekeeping strategy helped maintain financial viability.
Box 5.2. Chogoria Hospital Health Insurance Scheme: Exclusions and Limits

- If a disease was diagnosed before the patient joined the scheme or within the waiting period, it is not covered.
- Once a person reaches 65 years of age insurance cover is discontinued.
- Treatment of patients with AIDS is provided up to a maximum of Sh. 36.00 per year.
- Treatment of psychiatric illness is limited to Sh. 68.00 per policy per year.
- Expenses associated with normal or abnormal pregnancy are not covered, but the operation fee for a first caesarian section is covered.
- Reading glasses, eye and ear tests, and hearing aids are not provided under the scheme.
- Self-inflicted injuries are not covered.
- Birth defects and cosmetic surgery are not covered.
- Dental procedures are not covered.
- Medical examinations are not covered.
- Procedures carried out for non-medical reasons are not covered (e.g. circumcision).

Source: McFarlane, 1996.

Integration of health care services

Of those schemes reviewed for which the relevant information was available, utilization was permitted as follows: public facilities only (25); private not-for-profit facilities only (15); public and private facilities (8); private-for-profit providers only (2).

Hospital-based schemes tended to focus exclusively on the hospital level and to have limited connections with the primary care level, although there were some exceptions. Thus the Chogoria Hospital scheme covered primary-level providers and used them as gatekeepers for the hospital level. Under the Kasturba Hospital scheme, the principal benefit was hospital care, but premiums were used to pay for primary care (Jajoo, 1992). Community-owned and cooperative schemes tended to have clearer and stronger referral structures than hospital-based schemes.
In Taiwan\(^2\),\(^6\) and Korea\(^4\) providers are predominantly private and referral systems extremely weak (if not non-existent). Lack of a gatekeeper has also contributed to rapid escalation of overall health costs in these countries.

**Quality of care**

Several of the community-owned and NGO schemes had used revenues to increase the accessibility of health services, but very few had sought to improve other aspects of quality of care (the exceptions being the prepayment scheme in Boboye, Niger,\(^29\) and the prepayment for perinatal care scheme in Mexico\(^11\)). In none of the facility-owned schemes had introduction of the scheme been explicitly linked to attempts to improve quality of care. In Mexico, quality improvements focused upon the hotel aspects of care.

A number of features of managed care (Kane, 1995), as demonstrated by health maintenance organizations in the US and many health care systems in Europe, could be investigated and adapted for their own use by health insurance schemes for the non-formal sector in developing countries. Kutzin (1995) has discussed the following:

- structuring financial incentives for providers (notably through the form of payment mechanism);
- physician profiling, i.e. tracking individual physician treatment patterns;
- selective contracting, i.e. channelling patients to those providers who agree to certain conditions and are contracted to provide care;
- utilization review and quality assurance;
- development and use of standard treatment protocols, including drug formularies.

The more successful schemes did, over time, take on a more effective purchasing role. That is, they started to act as financial managers rather than remaining merely financial intermediaries. For example, both UMASIDA in Tanzania\(^28\) and SEWA in India\(^22\) adopted selective contracting with providers and use of essential drug lists, to help ensure quality of care. (Box 5.3 explains UMASIDA’s purchasing element in more detail.) However, very few of the schemes had adopted special pharmaceutical policies, although the ORT scheme\(^1\) in the Philippines had managed to negotiate favourable prices for essential drugs purchased from local suppliers.
BOX 5.3. PURCHASING PRACTICES UNDER UMASIDA

UMASIDA is a health insurance scheme owned and run by a group of cooperatives covering informal sector workers in Dar Es Salaam, Tanzania. The scheme aims not only to assure access to quality health care services for its members and their dependants but also to encourage the delivery of preventive health services to insured members.

Before seeking care the insured person must obtain approval from the chairperson of his or her group. Thus the scheme has a gatekeeping element built into it.

The scheme purchases services from both public and private health care providers in Dar es Salaam. Private providers are used predominantly for primary care and public providers for hospital services. Before contracting with a provider, the scheme surveys the facilities, services and prices at the provider, and checks that the provider is willing to be paid retrospectively on a monthly basis. All four government hospitals in Dar Es Salaam will treat scheme participants and have agreed to be paid on a monthly basis.

The scheme contracts care from providers who:

- have access to the services of a qualified medical officer;
- offer maternal and child health services;
- maintain acceptable laboratory services;
- undertake appropriate record-keeping;
- agree to restrict drug use to the WHO-approved essential drug list;
- agree to prescribe only by generic name;
- agree to provide health education to clients, including occupation-based workshops.

When a provider violated the agreement on essential drugs it was not paid for the services it provided.

Provider behaviour is monitored by the technical advisor to the scheme (a local medical doctor). Before a provider is paid, invoices and patient medical cards are checked for any irregularities. Patterns of disease and prescribing habits are monitored as are comparative data on costs of the services supplied by different providers and between different membership groups. The information on disease patterns is used to tailor health education programmes to the particular needs of scheme members. The scheme has also trained two primary health care workers in each cooperative group. These individuals can provide first aid and health education services to members.
Box 5.4. The Evolution of SEWA's Health Insurance Scheme

The Self-Employed Women’s Association (SEWA) was initiated in Ahmedabad, India in 1972, and a sister organization, the SEWA Bank, was started in 1974. SEWA’s main aims are to help women organize themselves and create collective strength, and to help them increase their control over their income and assets. SEWA does this by helping to establish cooperatives and providing supportive services such as banking. But it was not until 1992 that SEWA established its integrated insurance scheme. The scheme includes sickness benefits, death benefits, insurance against loss (riot, fire, flood, etc.) and maternity benefit, and covers approximately 8% of SEWA’s 212,000 members. Since its inception it has evolved in several respects:

- Initially all elements of the insurance plan were managed by the United India Insurance Company. Members complained about the excessive bureaucracy they encountered when making claims for health care, however, and in 1995 SEWA opted to administer the scheme itself. SEWA is also planning to decentralize management of the scheme to the districts in order to improve promptness of payment.

- The benefits provided under the scheme have been expanded. The initial benefit package covered hospitalizations only. Yet access to hospitals in India’s rural areas is very poor and family demands make it difficult for women to spend time in hospital even if they are seriously ill. Furthermore, the initial benefit package did not include occupational health benefits and gynaecological care. The scheme has now been extended to cover ambulatory care, occupational health care and gynaecological care. The premiums were increased in order to cover the cost of providing these services.

- SEWA bank has set up a separate savings scheme so that members can afford the premiums more easily. Once they have accumulated Rs 500 in their account members can pay their premiums from the interest accrued. However, SEWA found that premiums remained out of reach of their poorest members. It therefore established a loan fund: women borrow Rs 500 which is placed in a savings account. Interest from the savings account is then used to pay premiums and the loan is paid back over time.

- SEWA is increasingly using its purchasing power to improve the quality of services for members. Through routine processing of claims SEWA has learnt which clinics provide reasonable medical care at affordable prices and encourages their members to use these. Fraudulent doctors are blacklisted. Some doctors have agreed to offer services to SEWA members at reduced rates. Additionally, SEWA now operates cooperative drug stores in two municipal hospitals in Ahmedabad that provide members with essential drugs at low cost. Finally, SEWA has come to play an increasingly active role in educating members about their medical rights, enabling them to question the care which they receive more critically and to negotiate with providers.
5.6 Adaptation of Schemes

Several schemes have undergone major design shifts during their history. The Chogoria scheme\(^7\) in Kenya effectively re-started in 1995 after several years of difficulty in controlling highly adverse selection and abuse of entitlement cards that had resulted in a loss of over US$ 100 000. Similarly, the ORT scheme\(^18\) changed its hospital provider after two years of functioning when it became apparent that the scheme could not afford the remuneration levels expected by private physicians. In former Zaire, the Kongolo Health Centre scheme\(^67\) was stopped less than six months after it had begun because the prepayment scheme did not succeed in substantially improving access, utilization or revenues. And the ASSABA Community Health Financing Scheme\(^57\) in Guatemala, Bokoro\(^68\) in former Zaire, RAHA\(^46\) in India and the Federated PHC scheme\(^69\) in the Philippines all changed their benefit levels. The main reasons for design change were: financial loss;\(^14, 24\) growth;\(^69\) misuse;\(^7\) misunderstandings between providers and users;\(^18, 24, 57\) efforts to increase membership and access, and consequent higher membership levels and increased demand for access.\(^42, 46\)

Some of the more successful schemes progressively adopted a more active purchasing role and regularly sought feedback on their performance. The SEWA scheme, in particular, made considerable efforts to adapt in order to meet members' needs (see Box 5.4). Bolivia's Caja scheme\(^61\) also underwent much change. Several attempts made during 1984–1986 to start a prepayment scheme were unsuccessful. Planners then changed their strategy, placing the burden of designing a scheme upon local community leaders. Through a long process of negotiation, a relatively successful scheme was then designed.
6. ASSESSMENT OF PERFORMANCE

Assessment of the schemes incorporated two important dimensions. Internal assessment of performance was undertaken to assess how successful a scheme had been in providing efficient, equitable and high-quality health care services. Additionally, assessment was made of a scheme's contribution to the overall efficiency, equity and quality of the health care system of which it was a part. These two aspects of performance may of course be in direct conflict with each other. A scheme may be very efficient internally but if it does not fit into standard government structures it may be very problematic for system-level regulators.

6.1 HEALTH STATUS IMPROVEMENT

None of the schemes reviewed had been evaluated with respect to their impact on health status. This is probably to be expected: it is commonly very difficult to judge the health impact of such interventions.

6.2 EFFICIENCY

Administrative efficiency

Data on administrative costs presented in Section 5.4 show that the documented proportion of income spent on administration ranges from 5–17%. If the opportunity costs of volunteer time had been included in computing administrative costs some of these figures might well have been higher. Although these figures are high compared to Western European insurance funds — whose administrative costs generally amount to about 5% of income — they are not unreasonable compared to some administrative costs associated with social health insurance schemes in Latin America and Africa (WHO, 1993).

Administrative efficiency should not be judged on the basis of costs alone, however, but rather on what has been achieved through use of the resources available. It is clear that in most instances the schemes reviewed were not acting as active purchasers and therefore not as effective as they might have been in their use of resources. For schemes such as UMASIDA 28 and SEWA 29, which did have basic purchasing roles, it would be useful to know what extra resources would be required to enable the schemes to become more active purchasers.

In the long run, the key question for policy-makers regarding administrative costs is whether or not the overall cost of running a system based on multiple small insurance schemes is more or less than running an integrated health financing system, whether funded by social health insurance or
government tax revenues. It is of course usually accepted that the administrative costs associated with pluralistic health care financing systems, particularly when there is substantial consumer choice (as in the US), are higher than those of more integrated systems.

Based on this review, however, very little evidence appears available for addressing this issue with respect to developing countries. Furthermore, predicting how the small insurance schemes reviewed here could develop into national financing systems is difficult. Much would depend upon policies the adopted by government. Given that many of the schemes reviewed had been initiated in contexts where government supervision and regulation was weak, the prognosis would not appear to be good. Active support by government could encourage convergence of small schemes into a more integrated system (Hsiao, 1995).

*Allocative and technical efficiency: do schemes spend their money on the right kinds of services, and are costs controlled?*

It has already been stated that most of the scheme were not acting as active purchasers. In fact, few had defined cost-effective packages for care, few implemented strong referral and utilization control systems to optimize efficient use of different levels of the health care system, and few operated a management information system that monitored cost-effectiveness or appropriateness of care delivered. Moreover, the schemes sometimes introduced inefficiencies of their own into the health care system. For example, many of the hospital-based schemes largely ignored primary care, while some of the primary care-based schemes certainly underestimated the costs of referral services. Unfortunately, the available documentation did not include assessment of the impact of hospital-based schemes on primary care. But it seems likely that it leads to under-utilization of health centres, resulting in facilities operating at low capacity and rising unit costs. Meanwhile, patients are probably treated less efficiently at hospital level. The Bwamanda Hospital scheme proved to be an exception, though, since access to the hospital required a referral from a health centre. Referral costs of the latter were not covered by the scheme, however.

As discussed in Section 5.5, many of the hospital-based schemes involved fee-for-service payment. Fee-for-service has a number of well-known shortcomings: it provides little incentive for efficiency on the part of the hospital; it does not guard against problems of cost escalation, and administratively it is relatively complex. Additionally, fee-for-service payment gives providers incentives to over-service and over-prescribe. In Masisi, former Zaire, part of the hospital revenue was used as incentive payments for the doctors (Noterman, 1996). Under such circumstances fee-for-service must be subject to strong administrative mechanisms to prevent over-servicing.

However, when fee-for-service is paid to a government or mission facility where staff are employed on a salary basis (as was actually the case in most of the hospital schemes reviewed),
medical officer in charge at Chogoria hospital, where staff had no direct incentives to treat insured patients differently from uninsured patients, noted:

"It has taken some time to educate our prescribers to treat patients on the scheme in a similar manner to other patients, keeping in view the cost of treatment" (McFarlane, 1996).

The hospital-based schemes in Nkoranza, Ghana⁴ and Masisi, former Zaïre¹⁴ experienced rapid cost escalation, at least in their early years due to their fee-for-service system. In Korea⁴ and Taiwan,²,³ where fee-for-service payment also exists, such problems have persisted despite efforts to contain costs through co-payment. Lack of a gatekeeper has also contributed to rapid cost escalation in these countries.

Problems with over-utilization of services and cost escalation appear to have been a problem in Type I schemes especially. But if a scheme incorporates strong primary care and community orientation — as do many Type II schemes — effective primary-level gatekeepers are more likely to be in place and these problems avoided or minimized.

Financial efficiency

Regrettably, scheme managers had not always adequately planned means of investing the revenue raised from the insurance scheme before implementation. Yet this is an important aspect of scheme management since heavy financial losses during the first year of a scheme can adversely affect financial efficiency for a long period.

6.3 Equity

- In financing

Risk sharing has been promoted as a means of encouraging more equitable financing of health care. All of the insurance schemes examined set premiums according to a community rating, in principle entailing a subsidy from the healthy to the sick.¹ The extent of such subsidy depended on the extent of adverse selection. In schemes with high levels of adverse selection, cross-subsidy from the healthy to the sick was limited. Very few schemes had adopted sliding scales. Instead, they relied on flat-rate premiums, implying regressivity in financing.

* Obviously with the exception of the few schemes for which there was no risk pooling and that involved prepayment.
Probably the key equity issue within schemes is affordability. Yet very few schemes applied exemptions to those who could not afford to pay the premiums. In most cases, those who could not afford premiums were required to pay user fees instead. The effectiveness of insurance in protecting the poor is therefore linked to the effectiveness of exemption mechanisms.

Several of the schemes that had examined the issue of affordability acknowledged that it could be a problem. For moderate to large, lower-income households in Nkoranza district, Ghana, the estimated cost of premiums amounted to 5–10% of the annual household budget, which may well be a financial barrier to membership (Somkang et al., 1994). In Muyinga, Burundi, 27% of the respondents of a household survey stated that financial inability to purchase a card was one of the main reasons for not participating in the scheme (Arhin, 1994). And in Mexico, about 20% of those enrolled in the perinatal prepayment scheme dropped out. This was attributed mainly to financial inability to keep up payments (Ensor, 1995).

More important, perhaps, is the question of whether the schemes made financing of health care systems more, or less, equitable. While flat-rate premiums are likely to be less regressive than user fees, they may be more regressive than general tax revenue financing. In a number of developed countries, work to measure the progressiveness or regressiveness of the financing of health systems has established that social insurance is more regressive than general tax. But evidence to this effect is lacking for developing countries.

Another equity issue relates to subsidy. In virtually all the schemes reviewed, the level of external subsidy, be it from government, donors or NGOs, was fairly high and essential to the functioning of the schemes. If, however, the small-scale schemes reviewed managed to attract higher levels of subsidy than those received by the general population outside the scheme, this could be seen as inequitable.

- In utilization

Only the pilot project in Boboye district, Niger, analyzed how utilization patterns varied by income group. Use rates among the poor were found to have risen since the start of the scheme, and if payments by the poor who used government facilities were compared for before and after the scheme, it could be seen that total payment had decreased (Diop, Yazbeck & Bitran, 1995). Additionally, the compulsory (tax-based) system in Boboye performed better than a user-fee experiment in a comparison district. Yet, given that it was possible in Boboye to mandate contributions to the scheme, the Boboye project was quite dissimilar from schemes implemented elsewhere. Thus although the Boboye experience suggests that it is possible to design an insurance scheme that has positive equity effects in terms of who benefits from the service, it by no means demonstrates that this is always the case.
Several of the case studies discussed utilization enrolment patterns according to household geographical location. Fairly substantial evidence suggests that utilization increases far more among insured households located close to a health care facility and that these households are also more likely to join such a scheme (Donaldson, 1982; Criel, 1992; Noterman et al., 1996). Since under most schemes, people pay the same premium wherever they live, those distant from the facility (who might in any case belong to poorer, more remote, rural communities) in effect cross-subsidize those who live close to the health facility. Such circumstances might also lead to a form of adverse selection whereby more remote households drop out of the scheme since the premiums are so high that it is not worth their while to join the scheme. In which case, average utilization rates rise even higher and more people drop out.

The RAHA scheme in India and the Bwamanda Hospital tried to implement a sliding scale based upon geographical proximity to the facility. Under the RAHA scheme, members referred to any of the three hospitals affiliated with the scheme paid co-payments inversely related to the distance travelled (Rs 200 for less than 25 km, Rs 150 for 25–100 km and Rs 100 for more than 100 km). In Bwamanda the level of co-payment was based for one year on a sliding scale based on distance from the hospital. The group nearest to the hospital was subject to a co-payment of 20% while the group furthest away from the hospital was subject to a co-payment of only 5% (Criel, 1992). It was observed that although enrolment increased among the group furthest away, its utilization of the hospital did not. Furthermore, the implementation team thought that enrolment among this group might have increased anyway due to the scheme having become better known. The sliding scale was therefore dropped as it appeared to have no impact on utilization and was administratively complex.

Most of the schemes in sub-Saharan Africa permitted access to public health care facilities (which were generally in poor supply) only and were thus unlikely to witness a "market response" (whereby people "shop around") to the establishment of insurance in remote areas. However, in Korea, where private providers were the main mode of service delivery, establishing insurance schemes was not enough to encourage providers to relocate to rural areas. The Korean Government was also obliged to initiate separate programmes to finance remote health care centres, subsidize insurance societies in rural areas and use tax incentives to encourage the development of clinics and hospitals (Peabody, Lee & Bickel, 1995).

Finally, limiting the benefits of schemes and applying exclusions may affect equity in utilization of services. Admittedly, setting certain exclusions may be essential for schemes that cover the catastrophic costs of care, in order to prevent adverse selection. However, these exclusions are likely to affect more vulnerable groups, such as the elderly and people with AIDS. This has been seen in Tanzania's UMASIDA scheme (Box 5.3), the objectives of which appear to conflict with those of the country's health care system. Additionally, exclusions are likely to lead to "dumping"
those chronic and severe conditions that are not covered by the insurance scheme.

*Equity between schemes*

In the few countries where coverage through rural risk sharing is considerable — in Thailand, for example — equity between schemes has become a major issue. It was also a major issue in China before the breakdown of the country's Cooperative Medical System. Here, the type of care to which people had access varied substantially according to their community's financial resources; poorer communities could often only afford to cover primary care services and therefore did not cover inpatient services at county hospitals (World Bank, 1996).

Coverage is also extensive in Korea which now has more than 600 insurance funds. However, although government subsidy and regulation of the funds are considerable, it is unclear whether such intervention promotes equity between schemes. Government regulates reimbursement rates and subsidizes 50% of the premiums charged to farmers, the self-employed, workers in small businesses and government workers. Premiums are set by the individual insurance society, though, implying that schemes covering more affluent groups can buy bigger and better benefit packages, and that government subsidy of such benefit packages will accordingly also be higher (Yu & Anderson, 1992; Peabody, Lee & Bickel, 1995).

Few countries covered by this paper provided information with which to compare equity between formal and non-formal schemes. In Korea, Japan and Taiwan the schemes covering the non-formal sector are now fully integrated into the national health insurance scheme so that such a comparison is not now possible. In many of the other countries, formal schemes are non-existent or very limited. Thailand is an exception, and here questions are being posed about the different benefits and government subsidies provided to those in formal and non-formal schemes (Khoman, 1997). It was estimated that in 1994 total expenditure per capita under the Civil Servants' Medical Benefit Scheme was 9.4 times higher than that under the Health Card scheme, and 3.7 times higher under the Social Security Scheme than under the Health Card Scheme. Differences become even more marked when the level of government subsidy to the schemes is examined. In 1994, government subsidy per capita for the Civil Servants' Medical Benefit Scheme and the Social Security Scheme was respectively 27 times and 4.4 times that for the Health Card Scheme (Supachutikul, 1996).

6.4 Consumer Satisfaction

During their design phase, most of the schemes paid little attention to the issue of consumer satisfaction, or even to what consumers wanted. Few had carried out marketing surveys before implementation and none of the studies reported having carried out surveys of consumer
satisfaction. Judging by demand for the schemes — which over a period of time can be an excellent indicator of satisfaction — consumer satisfaction was in fact often low.

6.5 Sustainability

Sustainability has a number of different elements. Within any particular scheme, financial sustainability and administrative or managerial sustainability are important. However, if it is accepted that most of the schemes reviewed were designed to contribute to sources of finance for health care, rather than to their being entirely self-sustaining, the issue of financial sustainability is relevant only within the context of broader issues concerning the availability of subsidy and finance. Furthermore, in common with other dimensions that have been assessed, some conflict may arise between the sustainability of a specific scheme and that of the overall health care system. For example, a system of tight exclusions may help to secure the financial viability of a scheme, but at the expense of the broader health care system which will be obliged to bear a heavier load of severe cases than otherwise. In which case, cost recovery levels may be an inappropriate measure of financial sustainability.

The review highlighted a number of weak design features that could contribute to poor financial viability. These included:

- the small scale of most of the schemes examined;
- adverse selection leading to progressively smaller risk pools and higher costs;
- heavy administrative structures and costs.

As described in Section 5.1, the weak design of many schemes, particularly failure to ensure that the whole of a household joined a scheme, or to enforce an adequate waiting period before granting access benefits, meant that adverse selection was often a considerable problem. Adverse selection problems tended to be far greater for Type I schemes than for Type II schemes since the care that was involved tended to more expensive. Adverse selection is of course only a problem in voluntary schemes.

It has been argued that in developing countries, compulsory schemes for non-formal sector workers are unlikely to be feasible owing to insufficient knowledge of the number and location of rural households — for which identification, income assessment and contribution collection can rapidly become expensive processes. However, authorities in Boboye, Niger managed to implement such insurance scheme through an earmarked tax. Further investigation of the prospects for implementing mandatory schemes in developing countries would be helpful.
Clearly, the more highly developed and more extensive local government taxation systems are, the easier it is to make risk sharing mandatory.

Perhaps one of the most telling pieces of evidence concerning sustainability would be the lifespan of the schemes reviewed. Unfortunately, no information was available on the current status of 45 of the schemes. Of the remaining 37 schemes, 6 had terminated, 27 were ongoing and 4 had evolved into different forms of health care financing. It is probable that many of the schemes on which data were not available are no longer operating. Of the ongoing schemes, the average lifespan was about eight and a half years. This average was skewed upwards by some very long-lived NGO schemes such as Gonoshthya Kendra (23 years) and the VHS scheme (25 years).
7. Lessons from Rural Risk Sharing

7.1 Context

The first lesson must be that context matters. The contexts of the schemes reviewed varied considerably. Some schemes came into existence in response to economic and political crisis, as illustrated by the Bwamanda Hospital in the Democratic Republic of the Congo. Elsewhere, economic factors had facilitated the success of schemes (as in Korea). But economic factors had also caused the collapse of some schemes (as in China). The external environment is evidently a major influence on whether a risk sharing initiative will function effectively and on its replicability within a country or transferability between countries. Furthermore, different schemes in different contexts address different problems. In brief, if the success or otherwise of a scheme is to be assessed, not only its context, but also its objectives must be taken fully into account.

This complexity undermines attempts to create rigid categories for the different types of context. Nevertheless, a rough categorization might be as follows:

• **Weak government or complete government failure:** This was typified by countries such as former Zaïre where government involvement in the health care sector, in terms of finance, policy-making and regulation, was minimal. In other country contexts, government-subsidized health services may not have been entirely absent, but were inaccessible, rundown and perceived to be of poor quality. In such cases, health insurance schemes for people outside formal sector employment can make a critical contribution to health care delivery. In such instances, the lack of (or very weak) overarching health care system, means that issues relating to linkages between individual schemes and the broader health system are less significant.

• **Established health care system but lack of government policy on health insurance schemes:** This situation was common in many countries including India, Kenya and Ghana. While insurance schemes for those outside formal sector employment may provide valuable services to those insured, they can be disruptive to the system as a whole.

• **Established health care system and government policy on schemes:** This is perhaps the ideal situation, where the ability of small-scale insurance schemes to contribute to the overall health system, but not supplant it, is recognized. By providing a clear policy on schemes, governments can prevent or mitigate some of the adverse effects that occur when a scheme's individual objectives conflict with those of the broader health care system. Thailand and the Philippines fall into this category.
The possibility of linking schemes covering people outside the formal sector with those covering people within formal sector employment confers significant benefits. For example, under Vietnam's health insurance scheme, those in formal sector employment considerably cross-subsidized those outside the formal sector. The scheme benefited too from administrative economies of scale. However, few countries appeared to be actively seeking to improve linkages among existing insurance schemes as part of current health policy.

7.2 The Role of Government

The role of government is to ensure that society's health objectives are met. Many agencies finance and provide health services, and in these roles government is typically one among numerous actors. But the overall definition of national health policy objectives and the responsibility for defining the rules of engagement of all health actors — whether they are concerned with the formal sector or the non-formal sector — is that of government. As part of their overall regulatory function, governments have an important role to play in promoting the good design and practice of health insurance schemes for people outside formal employment. A number of different aspects of this government role are identified here.

Developing a clear policy framework for schemes

Few governments appeared to have developed explicit policy positions to guide and monitor health insurance initiatives for people outside formal sector employment. Yet a policy framework can be a valuable tool for supporting the growth of schemes that complement and reinforce overall national health policy objectives. Countries that have had the most success in increasing rural insurance coverage (such as China, Thailand, Korea and Indonesia) have established relatively clearly defined policy frameworks and schemes have often benefited from specific operational guidelines (see Box 7.1). In the Philippines, pilot projects have been used to help develop national policy and legislation on rural insurance.

A policy framework should consist of a public statement of the roles and responsibilities of the major participants in a health scheme, including communities, insurance organizations, government and health care providers. Such a framework should not seek to be a master-plan, but rather a flexible and consultative vehicle allowing scope for innovation at local level. Thus any policy framework will need to be adapted in the light of accumulating national and international experience.

If a consultative process is adopted, and the knowledge of policy-makers and people within the country who have experience in operating such schemes is brought together, the resulting framework is more likely to reflect the current state of knowledge and to successfully guide the
development of schemes. Successful development of insurance schemes for people outside the formal sector is dependent upon continuous adaptation of those schemes.

**Box 7.1. Guidelines for Establishing Dana Sehat in Indonesia**

- The Dana Sehat is run by the community itself for the health benefit of its members. Local institutions (such as the family welfare movement, the village cooperative and religious organizations) can undertake to manage the Dana Sehat.
- Premium payment is supported by local economic activities such as cooperatives based on sale of crops or handicrafts, or moneylending.
- The vision, mission, objectives and programme identification should be based upon deliberation and agreement among community members.
- The Government provides tools and guidelines on how the Dana Sehat should operate, but the prime control mechanisms of Dana Sehat should operate through its members, with community members monitoring procedures.
- Three different levels of development of Dana Sehat are identified: from simple community management of small-scale schemes to large-scale, complex, professionally managed schemes.

*Source: Suwandono, Brahim & Malik, 1995.*

**Facilitating scheme development**

Governments should ensure that:

- *schemes have the necessary legal status for them to function as official entities.* Schemes in some countries operated without legal recognition. Governments should review current legislation to ensure that approved schemes have the protection, security and accountability conferred by legal existence.

- *those responsible for existing schemes have the opportunity to share experiences and discuss strategies.*
• **technical support, advice and training are available to groups wishing to establish such schemes, and groups already operating schemes.** The development of an active purchasing role is a particularly important area and one in which most scheme managers have only limited experience and for which they require extra guidance.

• **there is scope for strategy development, so that schemes can evolve over time.** For example, schemes can use their purchasing power more actively to contain costs and improve quality and accessibility.

An umbrella body, including government and representatives of schemes may serve as a useful partnership forum in countries where several schemes are already functioning. Such an umbrella body operates in the Philippines.

**Monitoring and regulating schemes**

Ideally, government should monitor and regulate schemes so that they are not only accountable to their beneficiaries but also serve the interests of the broader community.

If funds are owned by government, mutuals or cooperatives, or communities themselves, the design of the scheme should ensure adequate accountability to communities. However, if funds are facility-owned, lines of accountability to the beneficiaries may be extremely weak. Government must then ensure that fund managers are accountable. Accountability had been dealt with satisfactorily in only a few of the schemes reviewed.

**Financing and system-wide equity considerations**

Policy-makers should recognize that the revenue-raising potential of rural risk sharing schemes, particularly in very poor countries, is likely to be limited. They should not, therefore, set ambitious cost recovery targets under such schemes. Some of the literature appears over-optimistic in its description of the potential revenue to be generated through health insurance of sub-Saharan Africa, one recent publication argues:

"Health insurance is virtually the only practical instrument governments can use to get out of the expensive business of providing across-the-board subsidies for hospital care" (Shaw and Griffin, 1995).

Like user fees, insurance should therefore be seen rather as a means of "topping-up" existing government budgetary funding and of introducing or strengthening health system management. In countries where rural schemes have spread widely and been integrated into fully-fledged national health insurance programmes, substantial government contributions are still often made.
to schemes covering people outside formal sector employment.

Government subsidy can be:

- **made direct to the provider**: as in most of the community-owned schemes, whereby government continues to fund the bulk of the provider running costs and revenue from the insurance scheme provides a top-up.

- **directed to the insurance fund itself**: as in Japan, Korea, Taiwan and Thailand.

Preferred government strategy depends principally on ownership of service providers. In instances where the private sector dominates, government subsidizes either poor households so that they can buy into the fund, or the fund itself. By contributing directly to the fund, rather than to the provider, governments can also help develop effective purchasing power and strengthen fund management.

Additionally, general tax revenue can be used to help solve some of the particular problems associated with health insurance for people outside the formal sector. If schemes are expected to be self-financing, substantial inequities can develop since richer communities will be able to pay higher premiums than poorer communities. But if general tax revenue is used to enable the poor to buy into schemes, which otherwise would be unaffordable for them, such inequity can be avoided. Governments should also structure their contributions to health care financing so as to help offset regional inequities that are likely to arise owing to the fragmented nature of multiple geographically-based, health insurance schemes.

### 7.3 The Importance of Appropriate Design

Many insurance schemes appeared to have run into difficulties that could have been avoided had they been planned and structured differently, and allowed to evolve flexibly. Getting the initial architecture of the scheme right is part of the challenge, but adapting it as circumstances change is at least as important. In retrospect, many of the design flaws of the schemes reviewed appear to have been obvious. Yet they were clearly not so to the people designing and implementing the schemes. A number of aspects of scheme design should therefore be stated clearly and made widely known. That said, it must be stressed that appropriate design of a scheme cannot be assured by applying a set formula. On the contrary, different designs will be appropriate in different contexts, for addressing different problems. The points made below are thus mostly very general.
Preventing adverse selection

Adverse selection was found to affect Type I schemes in particular. Even for Type II schemes, though, adopting the first of the measures noted below is probably advisable. For prepayment schemes without risk sharing (i.e. savings type schemes) adverse selection is not an issue.] Several mechanisms can be used to help prevent adverse selection, including:

- making the household or even the village the unit of membership and enforcing this rule strictly;

- application of a waiting period after joining, so that people do not join the scheme solely when they are ill;

- stipulating that if a village is to be allowed to enter a scheme a certain proportion of households in the village must join (as under the Thai Health Card project and the Kasturba Hospital scheme in India);

- making the scheme compulsory, although this does not seem to be feasible in many contexts;

- preventing people with pre-existing conditions from registering, or limiting the benefits available for such conditions.

The first mechanism is probably desirable in all schemes that risk adverse selection. The enforcement of a waiting period after joining a scheme is a particularly important if enrolment is permitted throughout the year, and particularly for Type I schemes. Many of the schemes reviewed initially planned to have only a limited enrolment period. However, if at the end of the registration period, enrolment was lower than anticipated, the period was often extended in the hope that more people would join up. It was under these circumstances that lack of a waiting period became a particular problem.

The third mechanism described is probably not feasible in many contexts but has few disadvantages. The fourth mechanism is probably the most difficult of all to implement, but if it can be guaranteed that every member of a defined community will join and contribute to the scheme's cost, this approach has much to recommend it.

The last mechanism described is probably not suitable in many contexts. While it may confer financial advantages upon the scheme itself, it is likely to conflict with health system-wide equity objectives. Furthermore, if it leads to "dumping" of chronically ill patients it may also adversely affect the sustainability of the broader health care system.
**Fund management**

Some insurance schemes failed or very nearly failed because they did not invest funds as soon as they were received. In high-inflation environments, delays of even a couple of months can sorely deplete insurance funds. Developing an investment strategy before receipt of funds is essential to guard against this erosion.

**Using health insurance to organize health service delivery**

Recent health sector reform literature from both industrialized and developing countries emphasizes the importance of the presence of informed purchasers in the health care sector (Saltman, 1995). But most health insurance funds for people outside formal sector employment serve as nothing more than financial intermediaries and have only very limited capacity to influence the organization of health service delivery. This is unfortunate since risk sharing schemes can be not only a source of finance, but an effective means of organizing health services financing and delivery.

The potential for developing an active purchaser role will vary according to the ownership and design of the scheme. Facility-owned schemes — where there is no purchaser–provider split — will almost inevitably play a more limited role in structuring health service delivery than schemes where responsibilities are divided between purchasers and providers. Perhaps the greatest potential for an active purchasing role exists in urban areas where there is a substantial number of providers to choose from (although the quality of care offered by these providers is often inadequate). Schemes such as UMASIDA \(^{28}\) appear to have performed a particularly successful purchasing role under these conditions (Box 5.3). Since government often has neither the capacity nor the access to reliable information necessary for effective regulation of private sector providers, insurance schemes can help meet a critical, broader health sector need in this respect.

In order to become effective purchasers, insurance schemes must:

- negotiate special prices with providers;

- define benefits packages so as to ensure delivery of cost-effective services;

- define benefits packages so as to ensure that preventive and promotive services are included;

- monitor the quality and appropriateness of care through techniques such as utilization review;
HEALTH INSURANCE SCHEMES FOR PEOPLE OUTSIDE FORMAL SECTOR EMPLOYMENT

- encourage adoption of quality assurance principles by health care providers, by, for example, contracting only with providers that adopt such principles;
- use appropriate payment mechanisms to encourage an efficient, quality service;
- develop strong essential drugs policies.

Even if there is no purchaser–provider split, there are some design principles that health insurance schemes should follow in order to promote suitable delivery structures. In particular, many Type I hospital-owned schemes, paid little attention to the impact of the scheme on other levels of the health care system. Such a segmented approach adversely affects not only the providers excluded from the scheme, but also the providers within the scheme who may be inundated with relatively simple cases who could be treated at lower cost at lower levels of the health care system. Referral systems should therefore be used to ensure that patients are treated in the most appropriate and cost-effective manner and to protect the financial viability of hospitals.

Given that facility-owned schemes are less able to effectively perform the critical purchasing role of health insurance schemes, governments may find it worthwhile to give preference to or encourage more schemes operated by other types of organization.

Responsiveness to consumers

There is substantial debate in the health insurance literature concerning whether demand for health insurance exists among non-formal sector workers and rural populations. In view of this uncertainty, a clear understanding of people’s preferences and needs would appear to be vital if an appropriate insurance scheme is to be designed and demand for it created. However, several of the health insurance schemes reviewed, particularly facility-based schemes, effectively ignored the demand issue during the design period, simply assuming that the product would be bought once available.

Efforts to market schemes that have been designed without consultation are likely to be unsuccessful. Several of the project documents examined seem to assume that simply explaining the principles of health insurance via marketing techniques is sufficient to convince people to join health insurance schemes. Yet it is evidently far more effective to consult consumers during the design phase and convince them that the scheme will be managed in their interest, and that it will continue to ensure that they have access to services of good quality when they need them.

Indeed, responsiveness to clients or beneficiaries should be an ongoing concern, leading to periodic improvements in the scheme’s design. Ideally, health insurance schemes should be flexible and provide a prompt service (both in terms of health care provision and administration)
and should not place a heavy bureaucratic burden on clients. SEWA's efforts to streamline procedures in order to meet clients needs (see Box 5.4) are an excellent example of such responsiveness.

Risk sharing and the poor

Section 7.2 discussed some of the issues relating to the role government must play to ensure equity between insurance schemes, and between those covered by insurance schemes and those outside insurance schemes. Internal design issues and their impact upon equity can be just as important. The design of the schemes reviewed suggest that they were targeted not at the rural poor, but at the rural middle class for they:

- seldom allowed payment in-kind;
- tended to operate flat-rate premiums only, with no sliding scale;
- rarely operated an exemption policy;
- frequently entailed substantial co-payments.

All of these design features tend to limit access of the poorest of the poor to the scheme.

Geographical and income inequities in financing can be reduced by applying a sliding scale. In principle, implementing a sliding scale should be easier for payment of an annual premium than for multiple user-fee-type charges. However user-fee literature has highlighted the problems involved in successfully targeting exemptions based on income (Parker & Knippenberg, 1991; Willis & Leighton, 1995). Sliding scales based on geographical location would be much less liable to targeting errors and are probably worth experimenting with.
8. Conclusions

Debate about the potential for health insurance for the non-formal sector has encouraged the adoption of quite extreme positions. The diversity of the schemes and experience observed during this review means that many of these positions can be supported. Thus while some schemes have operated with extremely complex administrative structures, the reverse has been true of others. Some schemes have had substantial problems with adverse selection, others have avoided them almost completely. Some schemes have successfully devised incentives to promote efficient use of the health care system but others have probably increased inefficiencies in the system. However, in order to pursue evidence-based discussions about the role that health insurance for the non-formal sector can play, and as part of a broader strategy of health care financing and delivery, more precise terms must be found. Distinguishing more carefully between different types of schemes and objectives will then be possible. The policy framework presented here is a first step along this path.

The schemes reviewed in this paper were largely voluntary, hospital, community or NGO-owned schemes. Alternative options warrant further exploration. In particular, since many of the problems associated with the schemes stemmed from their voluntary nature, more information is required on both the feasibility and desirability of compulsory schemes. Cooperative and mutual insurance organizations might be thought to offer other possibilities too, particularly since they have formed the foundations of social health insurance systems in many Western European countries and Japan. This review unearthed little information on their operation in developing countries, however, perhaps suggesting that their transferability to these countries is limited.

Many of the schemes examined had been poorly designed and had encountered a range of problems as a result. Wide distribution of the basic principles of scheme design and the lessons learned from experience could prevent many such problems in future.

The few success stories that stand out, such as the Bwamanda scheme in former Zaire and the scheme in Boboye, Niger, demonstrate that designing and operating a successful health insurance scheme for the non-formal sector is possible. That said, each of these schemes was very dependent upon skilled external technical support. In fact, many of the schemes reviewed had benefited from extensive external technical assistance from well-informed experts. But provision of such intensive technical support would not be possible on a broad scale.

Well-designed insurance schemes may have even greater potential for improving health system performance, particularly quality and efficiency, than for raising substantial additional finance. This is particularly likely in poor communities where considerable additional money may simply not be available. Indeed, individuals often already spend substantial amounts of money on health care. But by combining these individual contributions and pooling funds, health insurance...
schemes may help to regularize expenditure, develop a significant purchasing power and facilitate expenditure on prevention rather than treatment (Ginneken, 1997). A well-designed and managed health insurance scheme may thus offer considerable advantages over a straightforward user-fee system, even if it does not raise significantly more money.

Organizational changes, such as tighter referral control, implementation of contracting arrangements between purchasers and providers, accreditation and improvement of service quality improvement, and performance-related pay can all be introduced into the health system as part of a shift towards health insurance. In particular, schemes in which there is a purchaser–provider split such as SEWA 25 and UMASIDA 28 appear more likely to develop active purchasing roles than schemes in which the purchaser and provider are more closely integrated, such as Nkoranza 8 and Chogoria 7.

Several features of the schemes revealed by the review suggest that the schemes are unlikely to be suitable for widespread "self-financing" of health care:

- the population coverage of schemes in low-income countries is generally limited;
- cost recovery rates under the schemes tend to be low;
- membership of schemes is often most limited among the poorest groups.

Insurance should thus be seen as a supporting strategy rather than as an exclusive “financing alternative”. In other words, if insurance is considered as a financing alternative, other options are likely to be closed off. Moreover, neither user fees nor voluntary prepayment strategies deal adequately with the needs of the poorest people. Some schemes therefore combine several elements. The Bwamanda 29 and CAM 30 schemes, for instance, combine prepayment, subsidy and fee-for-service. Specifically, subsidy from government tax revenue can help offset intra- and inter-scheme inequities and ensure broader risk pooling within the health care system.

Evidently then, health insurance for those outside the formal sector has to operate within a broader health financing policy framework. More thought should be given to how local insurance initiatives can best be integrated with a risk-pooling function for the system as a whole. The appropriate roles of local-level schemes and national government should take account of the local context and community preferences. For example, while in some instances it appears that people prefer to pay for primary care out of pocket and demand proper risk-pooling for secondary level care only, elsewhere insurance schemes have only proved successful if they include coverage of primary care services.

As this review has demonstrated, much experience with health insurance schemes for those outside formal sector employment has already accumulated, including how to make individual schemes viable and sustainable. The two greatest challenges ahead will be how to put existing
knowledge into practice and how to ensure that the types of small-scale schemes reviewed here contribute to the equity, efficiency and quality of health systems.
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Glossary of Selected Health Insurance Terminology

**Actuarial:** applied to calculation of insurance risks and premiums.

**Adverse Selection:** phenomenon associated with voluntary enrolment of individuals into health insurance schemes. It occurs when a disproportionate number of persons with a high probability of incurring high medical costs is covered by a scheme. Such "adverse selection" can jeopardize a scheme's financial viability.

**Allocative Efficiency:** in standard economic theory, allocative efficiency occurs when resources are allocated in such a way that any change — which might be beneficial to some — to the amounts or types of outputs, services or products currently being produced would be detrimental to others.

**Beneficiaries:** the individuals covered within a health care plan. In a publicly funded system, the beneficiaries are residents of a jurisdiction; in a private plan, they are enrollees of the insurance plan.

**Benefit Package:** services and the means of accessing services that are covered by the insurance scheme.

**Budget:** periodic allocation of funds to (or on behalf of) health facilities. The total amount of the allocation is determined in advance (i.e. prospectively).

**Capitation:** fixed payment to providers per person enrolled in the insurance scheme. Providers paid by capitation bear the financial risk of providing a defined package of services to the beneficiary population.

**Case-based Reimbursement:** retrospective payment of an administratively predetermined amount per case of episode of illness. Individual services are bundled into distinct case categories that are fairly homogeneous with respect to resource cost, and providers are reimbursed a fixed amount per case in each category.

**Catastrophic Cost:** cost arising from treatment of an illness that is extremely high relative to individual or household income. Usually associated with expensive referral hospital care.

**Community Rating:** a situation in which all members of an insurance pool are charged the same premium, irrespective of their risk status.

**Co-payment:** flat amount that covered individuals must pay out-of-pocket for each service used.

**Coverage:** the beneficiary population. This could refer to the percentage of persons who are covered by insurance, or to defined population groups (e.g. employees and dependants) who are covered.
EQUITY: fairness in the allocation of resources or treatments among different individuals or groups.

FUND: the institution responsible for accumulating and spending the (prepaid) contributions for insurance. Funds are usually third party payers (public or private) but can also be providers. In the latter case, some functions of insurer and provider are integrated in a single institution.

GATEKEEPER: the institution or individual responsible for determining access to referral services. The gatekeeper function is usually the responsibility of the provider of first-contact primary care.

MORAL HAZARD: impact on an individual's demand for care of an out-of-pocket payment that is less than the cost of providing that care. Since insurance (including centrally tax-funded services) covers some or all of the costs of service use, individuals tend to use more services when insured than when uninsured when they must pay the full cost of care.

OPPORTUNITY COST: the opportunity cost of a product or service is the value of the best alternative use to which those resources could have been put, the value of the productive opportunities foregone by the decision to use them in producing that commodity or service.

"OUTSIDE FORMAL SECTOR EMPLOYMENT": used in this paper to refer to a number of distinct groups, including those working in the informal labour market, persons engaged in small-scale agricultural production and certain vulnerable population groups such as widows, orphans, the landless and the unsupported elderly.

PROVIDER PAYMENT: the mechanism by which resources are allocated from the insurance fund(s) (or national health service) to institutional (e.g. hospitals) or individual service providers (e.g. doctors). Options include: budgets/salaries; capitation; fee-for-service reimbursement; case-based reimbursement, and different combinations of these options.

PURCHASER: the institution responsible for purchasing health services from providers. This always includes the insurance fund itself, but some schemes involve additional purchasers as well, including entities that are also service providers.

REGRESSIVITY: this occurs when the poor pay a larger fraction of their income than the rich for a product or service.

RISK POOL: group of people covered by the same insurance scheme.

RISK POOLING (INSURANCE): broadly speaking, may be defined as the reduction or "elimination of the uncertain risk+ of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member" (ILO, 1996).
Glossary of Selected Health Insurance Terminology

Salaries: similar to budgets, but applied specifically to health workers. Salaries are prospectively determined allocations.

Social (Health) Insurance: system of financing care through contributions to an insurance fund operating within a tight framework of government regulations. Social insurance usually involves mandatory, earnings-related contributions by employers and employees.

Sustainability: capacity to maintain at length without interruption, weakening or loss in power or quality.

Technical Efficiency: for any given amount of output, the amount of input required is minimized.

Utilization: the amount of health care services actually consumed. Utilization reflects the interaction of demand of patients, recommendations of providers and supplies of the services in question.
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ANNEX 2. LIST OF SCHEMES AND SOURCE MATERIAL

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5 **MUTUELLE FAMILLE BABA ANTOU DE YAOUNDÉ, CAMEROUN**


6 **MUTUELLE DE YOFFE, SENEGAL**


81
7 Chogoria Hospital, Kenya


8 Nkoranza Community Financing Health Insurance Scheme, Ghana


9 Dana Sehat, Indonesia


**SOURCE MATERIAL ON INDIVIDUAL SCHEMES**


10 **LALITPUR MEDICAL INSURANCE SCHEME, NEPAL**


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33 GONOSHATHYA KENDRA, BANGLADESH


34 BARPALI VILLAGE SCHEME, INDIA


35 THIES, SENEGAL


36 MEDICARE PROGRAMME II (SEVERAL PILOT SCHEMES), THE PHILIPPINES


37 PALLISA COMMUNITY DEVELOPMENT TRUST (PACODET), UGANDA


38 BANGLADESH RURAL ADVANCEMENT COMMITTEE (BRAC), BANGLADESH


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40 GRAIMEEN HEALTH PROGRAM (PILOT SCHEME), BANGLADESH


41 KOOPERATIBA NG BINHANG PANGKALUSUGAN SA SMOKEY MOUNTAIN, THE PHILIPPINES

42 Social Welfare Health Insurance (SWHI), Thailand


43 Palmamal Health Centre, Papua New Guinea


44 Kisiizi Hospital Plan, Uganda


45 Voluntary Health Services, Medical Aid Plan, India


46 Raigarh Ambikapur Health Association (RAHA) Medical Insurance Scheme, India


47 Molodo, Mali


48 Pomio Government Health Centre, Papua New Guinea


49 Tinsley Medical Insurance Scheme, Papua New Guinea


50 Fatick Project, Senegal


51 Borgou, Benin


52 Titiki, South Kabras and Bokoli Prepayment Scheme, Kenya


53 NATIONAL HEALTH INSURANCE PROGRAMME, PHILIPPINES


54 MUTUAL AID ORGANIZATIONS (AFTER NHI THESE WERE KNOWN AS "SPECIAL ASSOCIATIONS"), JAPAN


55 COMMUNITY AGRICULTURAL COOPERATIVE SOCIETIES (AFTER NHI THESE WERE KNOWN AS "SPECIAL ASSOCIATIONS"), JAPAN


56 GOALPARA COOPERATIVE HEALTH SOCIETY, INDIA


57 ASSABA — COMMUNITY HEALTH FINANCING SCHEME, GUATEMALA


58 HEWSPECS PILOT COMMUNITY BASED HMO, PHILIPPINES

Description of SHINE project in Philippines, GTZ, 1997.
59 UTH PREPAYMENT SCHEME, ZAMBIA

Trip reports: J. Kutzin (August 1997), S. Bennett (March/April 1997).

UTH Board of Management brochure. *Information on high-cost facilities and services available at UTH.*

UTH Board of Management brochure. *For your health.*

60 ARCHDIOCESAN NUTRITION PROGRAMME ON TARGETED MATERNAL AND CHILD HEALTH, PHILIPPINES


61 CAJA DE SEGURO DE SALUD CAMPESINA TIWANAKU, BOLIVIA


62 LA MUTUELLE "NSALASANI", CONGO — BRAZZAVILLE

Couverture du risque hospitalisation: expérience de la Mutuelle "NSALASANI" de Brazzaville, 1996.

63 LES PHARMACIES COMMUNAUTAIRES (PHACOM), MADAGASCAR


64 RE-ORIENTATION PROGRAM OF HOLY FAMILY HOSPITAL, PHILIPPINES

Description of SHINE project in Philippines, GTZ, 1997.

65 JESÚS NAZARENO COOPERATIVE, BOLIVIA

66 Perinatal package infant care tuberculosis package, China


67 KongoHealth Centre, Democratic Republic of the Congo

Criel B (1992) Community financing schemes: give them time...Discussion of two prepayment schemes conducted at district level in Zaire. Unpublished.


68 Bokoro, Democratic Republic of the Congo


69 Federated PHC Mother's Club — Surigao City, Philippines

Description of SHINE project in Philippines, GTZ, 1997.

70 Cart d'Assurance Maladie (CAM), Burundi


71 THE ALA/IDOWA COMMUNITY-BASED HEALTH INSURANCE SCHEME, NIGERIA


72 GAUBIN HEALTH CENTRE, PAPUA NEW GUINEA


73 ACCORD/ASHWINI INSURANCE SCHEME, INDIA


74 ST. ALPHONSE INSURANCE PLAN, DEMOCRATIC REPUBLIC OF THE CONGO


23 COMMUNITY HEALTH CARE FINANCING SYSTEM IMPLEMENTED IN MANOMPONA, MADAGASCAR

Community Health Care Financing System implemented in Manompona. Description of scheme received from AFRO, December 1996.

34 ASSOCIATIONS DES AMIS DE LA SANTÉ (AAS), MADAGASCAR


46 KOTTAR SOCIAL SERVICE SOCIETY (KSSS), INDIA

49 **Essential Drugs Tickets Prepayment Scheme, Lao People's Democratic Republic**

Correspondence with GTZ, Germany, 1997.

51 **"La Famille" — Aldo Health Centre, Benin**

Correspondence with GTZ, Germany, 1997.

53 **Prepayment Health Centre Scheme, Cote d'Ivoire**

Correspondence with GTZ, Germany, 1997.

80 **CASOP (Caisse de Solidarité et Paysanne) (One Scheme in Kinshasa), Democratic Republic of the Congo**


81 **Reseau Medecins de Familles (REMEF), Democratic Republic of the Congo**

| **Organization Name:** | - |
| **Country:** | - |
| **Region/Area:** | - |
| **Setting:** | - |
| **Total population in scheme area:** | - |

## History of the Scheme

- **Date of Inception:** -
- **Date of termination:** -
- **Scheme initiated by:** -
- **Role of Government in design of the scheme:** -
- **Role of community in design of the scheme:** -
- **Role of Donor/Technical Adv. in design of the scheme:** -
- **To what extent was implementation preceded by marketing and IEC strategies about the scheme?:** -
- **History - Changes of the scheme over time:** -

## Local Context

- **Health system in the scheme area:** -
- **Social conditions in the scheme area:** -
- **Economic conditions in the scheme area:** -

## Characteristics of the Fund

- **Objective(s) of the scheme:** -
- **Who owns the fund / scheme - (Government/ NGO/ Community/ Cooperative./ etc.):** -
- **Is the ownership pluralistic?:** -
- **Who manages the fund?:** -
- **Extent of autonomy of management of the fund:** -
- **Do scheme managers have special training or skills?:** -
- **How are funds held (bank/invested/under bed)?:** -
- **Can fund’s managers decide to invest to increase capital of fund?:** -
- **Subjected to Government accounting and reporting practices:** -
- **How is it accountable?:** -
- **Single purpose health care fund/Multi purpose fund:** -
- **Is the scheme focussed on one or more health facilities?:** -
- **Cost recovery rate of the scheme:** -
Membership and Coverage

Beneficiaries of the scheme:

Type of membership (ind./fam./village/oth.):

Voluntary / Mandated (If mandated, what level):

Does the scheme cover only contributors to the Fund or also non-contributors - If so Who?:

Can someone from outside the scheme area use health services covered by the scheme. If so how are such services financed?:

Defined enrollment period/waiting period:

Number of beneficiaries:

Proportion of population covered:

Operation of the Scheme

Frequency premium is paid:

Form of Premium: Flat rate/income related/risk related/mix:

Paid by:

Possibility of payment in kind:

Are some families/individuals exempt; how?:

What happens to those who cannot afford to pay the premium:

If a multi-purpose scheme, is a health care component ear-marked?:

Additional funds for the health care services received from who?:

Are there co-payments or other forms of cost sharing, at the time of use or at other times? List by level of health care system:

How are providers paid?:

Is payment of providers different from government budget allocation?:

How are revenues allocated between different levels of service providers?:

Is any form of contracting in use?:

Benefit Packages

Which services are included/excluded?:

Changes in benefit package:

Are non-personal services (eg. health education) funded?:

For which levels of health system is care covered:

Public and/or private providers covered by the scheme:

Direct or Indirect provision (could be hospital operated scheme-HMO style):

Existence of referral mechanism:
Health Insurance Schemes For People Outside Formal Sector Employment

Defined point of contact: -
Pharmaceuticals - drug list, policy and generics, etc. -
Management and information systems (monitoring of providers): -
Scheme typology: -

Role of Government

Role of Government in financing: -
Role of Government in regulation: -
Role of Government in protocols: -
Role of Government in Drug Lists: -
Are there clear government policy guidelines on such schemes and how they should relate to the broader health care system?: -
Technical assistance from outside agency (donor, NGO, etc.): -
Financial assistance from outside agency: -
Caja de seguro de salud campesina Tiwanaku (Caja)

Organization Name: Caja de seguro de salud campesina Tiwanaku (Caja)

Country: Bolivia

Region/Area: Highlands, near lake Titicaca and the Peruvian border

Setting: Rural

Total population in scheme area: 60,000

History of the Scheme

Date of inception: 1986

Date of termination: Ongoing.

Scheme initiated by: Community and NGO.

Role of Government in design of the scheme: No.

Role of community in design of the scheme: Yes (see history).

Role of Donor/Technical Adv. in design of the scheme: -

To what extent was implementation preceded by marketing and IEC strategies about the scheme?: Publicity on radio by a local NGO.

During 1984-86, several attempts were made to start a prepayment scheme. As it did not succeed it was decided to charge direct fees. The community was not happy with this initiative, but the planners did not see a need to seek their approval (since direct fees suggest the availability of services, which people then decide whether to use or not). Instead they tried to explain the concept of a revolving fund. After a year the planners had the impression that the community was not actively 'participating', even though this had often been invited. They looked for strategies to get local population more actively involved in decision making, and decided to challenge community members. They invited all heads of peasant trade unions, in their capacity as 'mayors', in the area to a meeting, and explained that the MOH would take over this project within a short time. The mayors did not find this an attractive option. They did not have confidence in the MOH, and expected the change would result in the existing equipment being moved to other places, and so forth. The planners asked them to suggest an alternative, but they were unable to do this. This time the planners, instead of providing one of their own, asked the mayors to look for a solution and come back in two weeks. When the mayors came back with the idea of creating a 'defence committee' for health - to deal with external relations with the MOH, and needs such as maintaining control over the health care equipment in the community - the planners confronted them with new questions: what such a committee would do; what to do if there were nothing to 'defend' (that is, how to keep up interest in the committee during a period when there were no problems). Again the mayors were asked to find a solution.
Health Insurance Schemes For People Outside Formal Sector Employment

**Caja de seguro de salud campesina Tiwanaku (Caja)**

This began a new process, broadening the issue: instead of, as usual, asking community members to give feedback on the planners' solutions - the planners gave feedback in the form of posing questions related to the solutions proposed; first by the mayors and later by the defence committee. One of the results was - in response to a question about who would have the power in the project, and why - community representatives themselves proposed a plan based on prepayment in kind. The initiative that was to become the Caja began in individual communities. The planners thought it would be more efficient, although very difficult, to unite the communities in one prepayment system. Nevertheless, such a union of communities 'spontaneously' appeared. This was presumably due to linkages - invisible to the expatriate planners - within and between federations of communities. A number of examples in the article suggest that the Caja brought out a number of traditional cultural concepts, which often still exist, though in a rudimentary form. The process approach used to organize community involvement may have been responsible: people organized the Caja in a way that was feasible for them, within their culture.

### Local Context

- Health system in the scheme area:
- Social conditions in the scheme area:
- Economic conditions in the scheme area:

### Characteristics of the Fund

| Objective(s) of the scheme: | - |
| Who owns the fund / scheme - (Government/ NGO/ Community/ Cooperative/ etc.): | Community. |
| Is the ownership pluralistic?: | No. |
| Who manages the fund?: | Health defence committee (community representatives paid by committees). |
| Extent of autonomy of management of the fund: | All decision making on resource allocation. |
| Do scheme managers have special training or skills?: | Committees received training courses organized by NGO. |
| How are funds held (bank/invested/under bed)?: | A trade committee is responsible for commercialization of potatoes. |
| Can fund's managers decide to invest to increase capital of fund?: | - |
| Subjected to Government accounting and reporting practices: | There is a vigilance committee which monitors administration. Every 3 months a general assembly, committee reports on activities and financial accounting. |
| How is it accountable?: | It was a single health care fund, but changed to include agricultural activities. |
| Single purpose health care fund/Multi purpose fund: | One health centre and one referral hospital. |
| Is the scheme focussed on one or more health facilities?: | - |
# Health Insurance Schemes For People Outside Formal Sector Employment

## Caja de seguro de salud campesina Tiwanaku (Caja)

<table>
<thead>
<tr>
<th>Cost recovery rate of the scheme:</th>
<th>18% of recurrent cost (1988). Without costs from expatriate assistance (thus no expatriate salaries) the caja contribution would have been 48% of budget.</th>
</tr>
</thead>
</table>

### Membership and Coverage

<table>
<thead>
<tr>
<th>Beneficiaries of the scheme:</th>
<th>Farmers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of membership (ind./fam./village/etc.):</td>
<td>Family.</td>
</tr>
<tr>
<td>Voluntary / Mandated (if mandated, what level):</td>
<td>Voluntary.</td>
</tr>
<tr>
<td>Does the scheme cover only contributors to the Fund or also non-contributors - If so Who?:</td>
<td>-</td>
</tr>
<tr>
<td>Can someone from outside the scheme area use health services covered by the scheme. If so how are such services financed?:</td>
<td>Pay user fees by cash.</td>
</tr>
<tr>
<td>Defined enrollment period/waiting period:</td>
<td>-</td>
</tr>
<tr>
<td>Number of beneficiaries:</td>
<td>-</td>
</tr>
<tr>
<td>Proportion of population covered:</td>
<td>-</td>
</tr>
</tbody>
</table>

### Operation of the Scheme

<table>
<thead>
<tr>
<th>Frequency premium is paid:</th>
<th>Annually.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form of Premium: Flat rate/income related/risk related/mix:</td>
<td>Initial contribution in form of seed potatoes and labour by one family member for work on the community lot for production of potatoes.</td>
</tr>
<tr>
<td>Paid by:</td>
<td>Family member.</td>
</tr>
<tr>
<td>Possibility of payment in kind:</td>
<td>Yes. Payment is in kind (labour or potatoes).</td>
</tr>
<tr>
<td>Are some families/individuals exempt; how?:</td>
<td>Every community itself decides which members are exempted.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What happens to those who cannot afford to pay the premium:</th>
<th>Pay fee directly at the center.</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a multi-purpose scheme, is a health care component ear-marked?:</td>
<td>Single purpose scheme.</td>
</tr>
<tr>
<td>Additional funds for the health care services received from who?:</td>
<td>Proyecto de Salud Tiwanaku (PST, NGO running health care in scheme area).</td>
</tr>
<tr>
<td>Are there co-payments or other forms of cost sharing, at the time of use or at other times? List by level of health care system:</td>
<td>No co-payments.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How are providers paid?:</th>
<th>PST and a Bonus from the insurance scheme.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is payment of providers different from government budget allocation?:</td>
<td>-</td>
</tr>
<tr>
<td>How are revenues allocated between different levels of service providers?:</td>
<td>-</td>
</tr>
<tr>
<td>Is any form of contracting in use?:</td>
<td>-</td>
</tr>
</tbody>
</table>

### Benefit Packages

<table>
<thead>
<tr>
<th>Which services are included/excluded?:</th>
<th>Health care at Tiwanaku Health Centre and at hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in benefit package:</td>
<td>After 1 year access to Torax Hospital in La Paz.</td>
</tr>
<tr>
<td>Are non-personal services (eg. health education) funded?:</td>
<td>Yes, health promotion + community health service.</td>
</tr>
<tr>
<td>For which levels of health system is care covered:</td>
<td>Health centre and hospital.</td>
</tr>
</tbody>
</table>
## Caja de seguro de salud campesina Tiwanaku (Caja)

<table>
<thead>
<tr>
<th>Public and/or private providers covered by the scheme:</th>
<th>Private (NGO health centre) and public (?) (hospital).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct or Indirect provision (could be hospital operated scheme-HMO style):</td>
<td>-</td>
</tr>
<tr>
<td>Existence of referral mechanism:</td>
<td>Yes.</td>
</tr>
<tr>
<td>Defined point of contact:</td>
<td>-</td>
</tr>
<tr>
<td>Pharmaceuticals - drug list, policy and generics, etc.</td>
<td>-</td>
</tr>
<tr>
<td>Management and information systems (monitoring of providers):</td>
<td>-</td>
</tr>
<tr>
<td>Scheme typology:</td>
<td>II + Referral.</td>
</tr>
</tbody>
</table>

### Role of Government

| Role of Government in financing: | - |
| Role of Government in regulation: | - |
| Role of Government in protocols: | - |
| Role of Government in Drug Lists: | - |
| Are there clear government policy guidelines on such schemes and how they should relate to the broader health care system?: | - |

### Technical assistance from outside agency (donor, NGO, etc.):
- Local NGO acted in advisory role for organizational matters and publicity on radio.

### Financial assistance from outside agency:
- Local NGO created a guarantee fund.

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Health Insurance Schemes For People Outside Formal Sector Employment

Self Employed Women's Association - Integrated Social Security Scheme

<table>
<thead>
<tr>
<th>Organization Name:</th>
<th>Self Employed Women's Association - Integrated Social Security Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country:</td>
<td>India</td>
</tr>
<tr>
<td>Region/Area:</td>
<td>Ahmedabad</td>
</tr>
<tr>
<td>Setting:</td>
<td>Urban/Rural</td>
</tr>
<tr>
<td>Total population in scheme area:</td>
<td>20 million</td>
</tr>
</tbody>
</table>

**History of the Scheme**

Date of inception: 1992

Date of termination: Ongoing.

Scheme initiated by: Self Employed Women's Association (SEWA) and a female officer of commercial insurance company.

Role of Government in design of the scheme: -

Role of community in design of the scheme: -

Role of Donor/Technical Adv. in design of the scheme: SEWA.

To what extent was implementation preceded by marketing and IEC strategies about the scheme?: -

History - Changes of the scheme over time:

In a survey in 1977 of the SEWA Bank’s loan defaulters revealed that of 500 women who were not repaying their loans regularly, 20 had died, 15 of them at child birth. Others reported their own illness or that of a family member as reasons for irregular loan repayments. SEWA identified at that time the need for an insurance scheme. However, there was no interest from any insurance company. In 1992, a young women officer of the United India Insurance Company understood the need for health insurance and was determined to see that such a programme would Materialise. The insurance company was prepared to cover only those cases where the insured woman was hospitalized. This was mainly for their operational convenience. Union and co-operative organisers reported that members found the SEWA programme so appropriate and useful that they encouraged other women to join SEWA and the scheme. It grew from 40,000 in 1992 to 75,000 at the end of 1994.

**Local Context**

Health system in the scheme area: -

Social conditions in the scheme area: Members are women who work in non-formal sector and who live in poverty. Medical crises are one of the major costs borne for these women.

Economic conditions in the scheme area: -

**Characteristics of the Fund**

Objective(s) of the scheme: -
Health Insurance Schemes For People Outside Formal Sector Employment

Self Employed Women's Association - Integrated Social Security Scheme

Who owns the fund / scheme? - (Government/ NGO/ Community/ Cooperative/ etc.?):
Commercial Insurance Company and the SEWA.

Is the ownership pluralistic?:
Yes, the SEWA Bank and the United India Insurance Company.

Who manages the fund?:
The insurance company.

Extent of autonomy of management of the fund: Company decides what is covered and what isn't.

Do scheme managers have special training or skills?: Professional insurers.

How are funds held (bank/invested/under bed)?: Money is kept in SEWA Bank.

Can fund's managers decide to invest to increase capital of fund?: Yes.

Subjected to Government accounting and reporting practices:
No.

How is it accountable?: To it's members.

Single purpose health care fund/Multi purpose fund:
Multi purpose fund; death, partial or full disablement, loss of goods due to disaster). More facilities.

Is the scheme focussed on one or more health facilities?:

Cost recovery rate of the scheme:

Membership and Coverage

Beneficiaries of the scheme:
Members of SEWA.

Type of membership (Ind./fam./village/oth.):
Individual (Family members can't be insured, although members wish this to be possible).

Voluntary / Manadated (If mandated, what level):
Voluntary.

Does the scheme cover only contributors to the Fund or also non-contributers - If so Who?:
Only contributors.

Can someone from outside the scheme area use health services covered by the scheme. If so how are such services financed?: Yes, user fees.

Defined enrollment period/waiting period:

Number of beneficiaries:
- Proportion of population covered:

Operation of the Scheme

Frequency premium is paid:
Annually.

Form of Premium: Flat rate/income related/risk related/mix:
Flat (Rs.15 for health Insurance component, Rs. 45 for everything.) Maternity care is covered by SEWA directly (not by the insurance company ), if member has fixed deposit of Rs 500.

Paid by:
Member of SEWA direct or deducted from their SEWA bank account. Significant group pays membership from interest of bank account.

Possibility of payment in kind:
No.

Are some families/individuals exempt; how?: No exemption.

What happens to those who cannot afford to pay the premium:
Not covered.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a multi-purpose scheme, is a health care component ear-marked?</td>
<td>Yes.</td>
</tr>
<tr>
<td>Additional funds for the health care services received from who?</td>
<td>SEWA Bank + German Aid.</td>
</tr>
<tr>
<td>Are there co-payments or other forms of cost sharing, at the time of use or at other times? List by level of health care system:</td>
<td>No co-payment.</td>
</tr>
<tr>
<td>How are providers paid?</td>
<td>Fee for service. Members claim it back with receipt from the doctor. (problem is the delay in refunding).</td>
</tr>
<tr>
<td>Is payment of providers different from government budget allocation?</td>
<td>Women pay user fees.</td>
</tr>
<tr>
<td>How are revenues allocated between different levels of service providers?</td>
<td>Reimbursement is based on bills.</td>
</tr>
<tr>
<td>Is any form of contracting in use?</td>
<td>-</td>
</tr>
</tbody>
</table>

**Benefit Packages**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which services are included/excluded?</td>
<td>Hospital costs up to Rs. 1000. Chronic or long-term diseases like TB, cancer, piles, blood pressure, gynaecological problems and diabetes are not covered. In principle insurance company pays only for sudden risks. Women express to be prepared to pay more if gyn. problems are included.</td>
</tr>
<tr>
<td>Changes in benefit package</td>
<td>No. But women expressed wish to have out-patient care covered. Ins. Company refused because increasing administrative costs.</td>
</tr>
<tr>
<td>Are non-personal services (e.g. health education) funded?</td>
<td>-</td>
</tr>
<tr>
<td>For which levels of health system is care covered?</td>
<td>Hospitalization (has a minimum defined size) smaller centres are not covered. (Type I scheme).</td>
</tr>
<tr>
<td>Public and/or private providers covered by the scheme:</td>
<td>Both public and private providers are covered.</td>
</tr>
<tr>
<td>Direct or Indirect provision (could be hospital operated scheme-HMO style):</td>
<td>-</td>
</tr>
<tr>
<td>Existence of referral mechanism:</td>
<td>Yes, through a SEWA Health Cooperative.</td>
</tr>
<tr>
<td>Defined point of contact:</td>
<td>No defined point of contact.</td>
</tr>
<tr>
<td>Pharmaceuticals - drug list, policy and generics, etc.</td>
<td>-</td>
</tr>
<tr>
<td>Management and information systems (monitoring of providers):</td>
<td>-</td>
</tr>
<tr>
<td>Scheme typology:</td>
<td>I</td>
</tr>
</tbody>
</table>

**Role of Government**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of Government in financing:</td>
<td>None.</td>
</tr>
<tr>
<td>Role of Government in regulation:</td>
<td>-</td>
</tr>
<tr>
<td>Role of Government in protocols:</td>
<td>-</td>
</tr>
<tr>
<td>Role of Government in Drug Lists:</td>
<td>-</td>
</tr>
<tr>
<td>Are there clear government policy guidelines on such schemes and how they should relate to the broader health care system?:</td>
<td>-</td>
</tr>
<tr>
<td>Technical assistance from outside agency (donor, NGO, etc.):</td>
<td>The scheme was developed in cooperation with SEWA, SEWA Bank and the private insurance company.</td>
</tr>
<tr>
<td>Financial assistance from outside agency:</td>
<td>GTZ</td>
</tr>
</tbody>
</table>
**Health Insurance Schemes For People Outside Formal Sector Employment**

### Tarlac Health Maintenance Program

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Tarlac Health Maintenance Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
<td>Philippines</td>
</tr>
<tr>
<td>Region/Area:</td>
<td>Region III, Tarlac, Tarlac</td>
</tr>
<tr>
<td>Setting</td>
<td>Urban/Rural</td>
</tr>
<tr>
<td>Total population in scheme area</td>
<td>-</td>
</tr>
</tbody>
</table>

### History of the Scheme

| Date of inception                 | 1995                               |
| Date of termination               | Ongoing                            |
| Scheme initiated by               | Tarlac Health Maintenance Cooperative (THMP). |
| Role of Government in design of the scheme | Provided technical assistance in the preparation of THMP's benefit package and premium calculation and channelled foreign assistance in the preparation of Management and Information System. |
| Role of community in design of the scheme | Organizer of the scheme; beneficiaries in the scheme. |
| Role of Donor/Technical Adv. in design of the scheme | Technical assistance in preparation of a Management Information System. |
| To what extent was implementation preceded by marketing and IEC strategies about the scheme? | Recruitment done by THMP Health Counsellors include information dissemination of the program to individuals of the programme to individuals and organizations. |

### Local Context

| Health system in the scheme area  | -                                 |
| Social conditions in the scheme area | -                                 |
| Economic conditions in the scheme area | -                                 |

### Characteristics of the Fund

| Objective(s) of the scheme          | -                                 |
| Who owns the fund / scheme - (Government/ NGO/ Community/ Cooperative/ etc.)? | Tarlac Health Maintenance Cooperative. |
| Is the ownership pluralistic?       | No.                               |
| Who manages the fund?              | Tarlac Health Maintenance Cooperative. |
| Extent of autonomy of management of the fund | Full autonomy. |
| Do scheme managers have special training or skills? | -                                 |
| How are funds held (bank/invested/under bed)? | In bank. |
| Can fund's managers decide to invest to increase capital of fund? | -                                 |
| Subjected to Government accounting and reporting practices | -                                 |
| How is it accountable?             | -                                 |
| Single purpose health care fund/Multi purpose fund | Single purpose health care fund. |
Health Insurance Schemes For People Outside Formal Sector Employment

**Tarlac Health Maintenance Program**

Is the scheme focused on one or more health facilities?:
Cost recovery rate of the scheme:

**Membership and Coverage**

Beneficiaries of the scheme:
Type of membership (Ind./fam./village/oth.):
Voluntary / Mandated (If mandated, what level):
Does the scheme cover only contributors to the Fund or also non-contributors - if so Who?:
Can someone from outside the scheme area use health services covered by the scheme. If so how are such services financed?:
Defined enrollment period/waiting period:

Number of beneficiaries:

Proportion of population covered:

**Operation of the Scheme**

Frequency premium is paid:
Form of Premium: Flat rate/income related/risk related/mix:
Paid by:
Possibility of payment in kind:
Are some families/individuals exempt; how?:
What happens to those who cannot afford to pay the premium:
If a multi-purpose scheme, is a health care component ear-marked?:
Additional funds for the health care services received from who?:
Are there co-payments or other forms of cost sharing, at the time of use or at other times? List by level of health care system:
How are providers paid?:
Is payment of providers different from government budget allocation?:
How are revenues allocated between different levels of service providers?:
Is any form of contracting in use?:

**Benefit Packages**

Which services are included/excluded?:

More facilities (THMP accredited providers).

- Members and their dependants.

Individual and dependants.

Voluntary.

A municipality of Tarlac decided to enrol its indigents and pays for their premium.

THMP non-members who are Medicare members may avail of services from the PMCCV accredited hospitals.

1 month if premium is paid in full; 3 months if premium is paid in instalment.

1,444 (357 active members + 1,087 dependants, as of July 1996).

Quarterly, semi-annually or annually.

Flat rate.

Member.

No.

Subsidized indigents.

NA.

Single purpose scheme.

Support value 19%.

Claims by provider against the THMP fund.

Yes.

Fee-for-service; not applicable.

Benefit package is standard for all THMP members. Rates vary depending on hospital classification and type of illness benefits: outpatient with limit per family (annual): a) regular consultation; b) diagnostic services; c) inpatient benefit limits per confinement (per beneficiary) - benefits inpatient: a) room/board; b) medicine (with varying levels for different levels of health care); c) diagnostic (with varying limits for different levels of care); d) operating room fee (with varying
<table>
<thead>
<tr>
<th>Changes in benefit package:</th>
<th>levels for different levels of health care).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are non-personal services (eg. health education) funded?</td>
<td>No.</td>
</tr>
<tr>
<td>For which levels of health system is care covered:</td>
<td>Primary, secondary and tertiary hospitals covered.</td>
</tr>
<tr>
<td>Public and/or private providers covered by the scheme:</td>
<td>Both public and private providers are covered.</td>
</tr>
<tr>
<td>Direct or Indirect provision (could be hospital operated scheme-HMO style):</td>
<td>Indirect.</td>
</tr>
<tr>
<td>Existence of referral mechanism:</td>
<td>None.</td>
</tr>
<tr>
<td>Defined point of contact:</td>
<td>None.</td>
</tr>
<tr>
<td>Pharmaceuticals - drug list, policy and generics, etc.</td>
<td>-</td>
</tr>
<tr>
<td>Management and information systems (monitoring of providers):</td>
<td>Yes, THMP's Management and Information System was developed by USAID-HFDP similar to the Bukidnon system (Medicare II).</td>
</tr>
<tr>
<td>Scheme typology:</td>
<td>II + Referral.</td>
</tr>
</tbody>
</table>

**Role of Government**

| Role of Government in financing: | A municipality in the province has subsidized indigent premium. |
| Role of Government in regulation: | Hospital accreditation requirements are those issued by PMCC/PHIC. |
| Role of Government in protocols: | Technical support is provided through the channelling of support from various foreign technical assistance groups. |
| Role of Government in Drug Lists: | The Department of Health provides the essential drug list in the National Drug Formulary which is a listing of reimbursable drugs and medicines. |
| Are there clear government policy guidelines on such schemes and how they should relate to the broader health care system?: | - |
| Technical assistance from outside agency (donor, NGO, etc.): | Technical Assistance was provided by USAID Health Finance Development Project (HFDP) in the development of the Operations Manual and its Management and Information System. |

Financial assistance from outside agency:
<table>
<thead>
<tr>
<th><strong>Pilot project on cost recovery in the non-clinical sector - Boboye District</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organization Name:</strong> Pilot project on cost recovery in the non-clinical sector - Boboye District</td>
</tr>
<tr>
<td><strong>Country:</strong> Niger</td>
</tr>
<tr>
<td><strong>Region/Area:</strong> South Western Niger</td>
</tr>
<tr>
<td><strong>Setting:</strong> Rural</td>
</tr>
<tr>
<td><strong>Total population in scheme area:</strong> 250,000</td>
</tr>
</tbody>
</table>

**History of the Scheme**

| Date of inception: | 1993 (May) |
| Date of termination: | - |
| Scheme initiated by: | Ministry of Public Health. |
| Role of Government in design of the scheme: | Initiated and designed scheme. |
| Role of community in design of the scheme: | They were informed of the scheme. |
| To what extent was implementation preceded by marketing and IEC strategies about the scheme?: | Population in district were sensitized and local health committees installed. |

**History - Changes of the scheme over time:**

After years of debate on cost recovery policy and alternative modes of payments outside the health sector, the Ministry of Public Health (MPH) of Niger decided in 1989 to carry out pilot tests on two modes of payment, a pure fee-for-service financing mechanism and a type of local social financing mechanisms (tax + fee-for-service), in order to inform the choice of payment mechanisms for a national cost recovery health policy. With the financial and technical support of the US agency for International development (USAID) and the World Bank, the MPH implemented the pilot tests in three districts as a first step towards nation-wide implementation of cost recovery for primary care. The pilot test's interventions included a comprehensive package of quality and administrative improvements to accompany the changes in the finance policy. First, initial stocks of drugs were delivered to every facility to improve drug availability. Second, health facility technical personnel were trained in the use of standardized diagnosis and treatment protocols specially designed to rationalize the utilization of resources in general, and utilization of drugs in particular. Third, in both districts, management capacities of health facilities were strengthened through the installation of a drug stock and financial management system in every health facility and at the district level. Health personnel were trained in the administration of the management system. Finally, supervisory capacities were augmented in the two health districts in order to reinforce management and the administration of the standardized diagnosis and treatment protocols. The three districts which functioned as pilot area
Pilot project on cost recovery in the non-clinical sector - Boboye District

Local Context
Health system in the scheme area:

During the '80s and the beginning of the '90s, the Niger public health budget represented between 5% and 6% of the government budget. In a typical year, 1988, public expenditure per capita was as low as US$ 2-3. Not only are public health finances insufficient, but they are also ill-distributed, with hospitals and personnel absorbing the largest share. In the early '90s, central budget allocations for drugs and medical supplies were as low as US$0.30 per capita per year in health districts that comprise the rural areas. As a consequence, utilization of public health facilities has been deteriorating while alternative private sector services are still at an embryonic stage, even in urban areas. In Boboye district the health system consists of one medical centre, coupled with a maternal and child centre, and one medical post which served as referral points to a network of rural dispensaries (8). In 1993, the district had one physician who held medical as well as administrative responsibilities at the level of the district.

Ethnic group in Boboye district are the Zarma.

Rainfed agriculture based on millet is main source of income. The sale of cattle and petty trade activities constitute the main additional sources of cash income.

Characteristics of the Fund
Objective(s) of the scheme:

Objectives for the financing reforms of which scheme is a pilot test are: (1) To implement health care quality improvements which satisfy the perceived needs of the population and stimulate the demand for health care. (2) To guarantee access to target groups, such as children, women and the poor, and to populations living far from public health facilities. (3) To minimize recurrent costs of technical and administrative reforms. (4) To generate revenues that recover recurrent costs induced by the technical and administrative reforms, in order to guarantee the viability of the local health financing system.

Who owns the fund / scheme - (Government/ NGO/ Community/ Cooperative/ etc.)?

The government.

Is the ownership pluralistic?

No.

Who manages the fund?

Revenues from fees and taxes were managed at each facility. At district level the fund is managed by representatives of the population organized into local health committees.
Health Insurance Schemes For People Outside Formal Sector Employment

Pilot project on cost recovery in the non-clinical sector - Boboye District

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do scheme managers have special training or skills?</td>
<td>Managers at health facility level and district level were trained.</td>
</tr>
<tr>
<td>How are funds held (bank/invested/under bed)?</td>
<td>Revenues generated were pooled at the district level to finance a solidarity fund.</td>
</tr>
<tr>
<td>Can fund’s managers decide to invest to increase capital of fund?</td>
<td>No.</td>
</tr>
<tr>
<td>Subjected to Government accounting and reporting practices?</td>
<td>Yes.</td>
</tr>
<tr>
<td>How is it accountable?</td>
<td>-</td>
</tr>
<tr>
<td>Is the scheme focussed on one or more health facilities?</td>
<td>More facilities.</td>
</tr>
<tr>
<td>Cost recovery rate of the scheme:</td>
<td>Cost recovery of drugs is 149%. Cost recovery of drugs and management costs is 89%.</td>
</tr>
</tbody>
</table>

Membership and Coverage

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiaries of the scheme:</td>
<td>Entire population in Boboye district.</td>
</tr>
<tr>
<td>Type of membership (ind./fam./village/oth.):</td>
<td>Individual.</td>
</tr>
<tr>
<td>Voluntary / Mandated (If mandated, what level):</td>
<td>Mandatory.</td>
</tr>
<tr>
<td>Does the scheme cover only contributors to the Fund or also non-contributors - If so Who?:</td>
<td>-</td>
</tr>
<tr>
<td>Can someone from outside the scheme area use health services covered by the scheme. If so how are such services financed?:</td>
<td>Yes.</td>
</tr>
<tr>
<td>Defined enrollment period/waiting period:</td>
<td>No.</td>
</tr>
<tr>
<td>Number of beneficiaries:</td>
<td>250,000.</td>
</tr>
<tr>
<td>Proportion of population covered:</td>
<td>In principle, 100%. However, part of the population lives far from health facilities. Utilization among this group is significantly smaller. The coverage is limited to this group.</td>
</tr>
</tbody>
</table>

Operation of the Scheme

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency premium is paid:</td>
<td>Annually (US$ 0.36 after devaluation FCFA).</td>
</tr>
<tr>
<td>Form of Premium: Flat rate/income related/risk related/mix:</td>
<td>Tax, Flat rate.</td>
</tr>
<tr>
<td>Paid by:</td>
<td>Tax payers in district.</td>
</tr>
<tr>
<td>Possibility of payment in kind:</td>
<td>No.</td>
</tr>
<tr>
<td>Are some families/individuals exempt; how?:</td>
<td>Children under 14, adults with a handicap limiting their income generating activities, and the elderly are exempted from paying local taxes. Handicapped, schoolchildren, prisoners, soldiers and indigents are exempted from paying at public health facilities. Probably exempted (see above). Single purpose scheme.</td>
</tr>
<tr>
<td>What happens to those who cannot afford to pay the premium:</td>
<td>Yes. 50FCFA for 5 years and older, 25FCFA for Children under 5.</td>
</tr>
</tbody>
</table>
Pilot project on cost recovery in the non-clinical sector - Boboye District

How are providers paid?:
Government employees.

Is payment of providers different from government budget allocation?:
No.

How are revenues allocated between different levels of service providers?:
NA.

Is any form of contracting in use?:
No.

Benefit Packages

Which services are included/excluded?:
Public health facilities including drugs (non-clinical).

Changes in benefit package:
-

Are non-personal services (eg. health education) funded?:
-

For which levels of health system is care covered?:
Primary care.

Public and/or private providers covered by the scheme:
Public providers.

Direct or Indirect provision (could be hospital operated scheme-HMO style):
-

Existence of referral mechanism:
No.

Defined point of contact:
No.

Pharmaceuticals - drug list, policy and generics, etc.
Generic drug used in order to minimize drug costs.

Management and information systems (monitoring of providers):
Yes, there is a drug stock and financial management system. The scheme is furthermore carefully monitored as it is a pilot scheme.

Scheme typology:
II.

Role of Government

Role of Government in financing:
Main responsible actor.

Role of Government in regulation:
Yes.

Role of Government in protocols:
Yes.

Role of Government in Drug Lists:
Yes.

Are there clear government policy guidelines on such schemes and how they should relate to the broader health care system?:
Yes.

Technical assistance from outside agency (donor, NGO, etc.):
USAID, World Bank, Abt Associates.

Financial assistance from outside agency:
USAID, World Bank
Bao Hiem Y Te (Voluntary Component)

Organization Name: Bao Hiem Y Te (Voluntary Component)
Country: Viet Nam
Region/Area: National (However, in 1996, 15 provinces out of 53 had introduced the voluntary component.)
Setting: Urban/Rural
Total population in scheme area: 77,000,000 (country population)

History of the Scheme
Date of inception: 1992, official start. Pilot experiences were already on the way since 1989.
Date of termination: -
Scheme initiated by: Government.
Role of Government in design of the scheme: Implementing agency.
Role of community in design of the scheme: -
To what extent was implementation preceded by marketing and IEC strategies about the scheme?: Marketing, such as via newspapers, can be financed, in principle, by part of health insurance contributions.
History - Changes of the scheme over time: Since 1987, the economic and political climate has been changing rapidly with the move from a centrally planned to a market-based economy. However, reform was accompanied by a fiscal policy calling for reduction in public expenditure, including cuts in allocation for health care. Accordingly, the government recognized the need for cost-sharing with the population as a viable alternative and, in August 1992, issued a National Health Insurance Decree calling for compulsory health insurance for salaried workers in the public and private sector, for retired persons, civil servants, and for special group of population, who need social support, such as war invalids, veterans, etc. Voluntary membership of the scheme was made available from the start, in an attempt to improve access to health care for rural farmer populations and for the self-employed. This decree was immediately followed by the implementation of health insurance in all provinces. After intensified cooperation between WHO and the Ministry of Health (MOH), a plan of action dealing specifically with health insurance development was formulated in June 1993, as a MOH/WHO Project on Health Insurance Development. Seminars on the principles of health insurance were held at a central level in September 1993 and January 1994. Throughout the Project, discussions were held with SIDA and the MOH on ways to extend coverage to the very poor through the Vietnam Swedish Health Cooperation (VSHC) component dealing with health in disadvantaged areas and populations. As the component was eventually dropped from the VSHC, national policy on covering the poor was not developed and
different approaches evolved in some provinces. In several provinces, NGOs such as the Red Cross, sponsored membership cards for a limited number of poor families, on an ad hoc rather than institutionalized basis. At present, Vietnam Health Insurance (VHI) provincial offices have been established in all 53 provinces. There is a discussion between MOH and Ministry of Labour, Invalid and Social Affairs (MOLISA) of merging all social security branches under a single administration, within a structure outside both MOH and MOLISA.

Local Context
Health system in the scheme area:

In the provinces visited by the WHO team since 1992, the health service system is characterized by a resource pattern including several large (around 500-bed) provincial and central hospitals, with around 85% occupancy, and 1 doctor to 2-3 beds; 1-2 district hospitals per district with around 100 beds, with less than 50% occupancy, and 1 doctor to 4-5 beds; and at commune level, health stations with beds for normal deliveries and observation, with low use and staffed mainly by medical assistants, nurses and midwives. Physical conditions, medical equipment and training need improvement at all levels. All the above providers are obviously contenders for health insurance revenues. At the same time, several thousands of military doctors have been discharged in the recent years and tend to set up private practices in their home villages. These doctors are often prepared to accept payment in kind from villagers and play a role in the provision of primary health care and sometimes in order to avoid in-patient care. To some extent, they now constitute a form of deterrent to purchasing voluntary health insurance.

Social conditions in the scheme area:
Economic conditions in the scheme area:

Characteristics of the Fund
Objective(s) of the scheme:

Who owns the fund / scheme - (Government/ NGO/ Community/ Cooperative/ etc.):?
Is the ownership pluralistic?:
Who manages the fund?:

Provinces have different socio-economic conditions, which co-determine the speed of health insurance development.

Health insurance for the whole population to improve health and health care for the population of Vietnam.
Bao Hiem Y Te (Vietnam Health Insurance-VHI), a state company within the MOH.

No.
The Vietnam Health Insurance (VHI) was established as the operational unit within the MOH to implement compulsory and voluntary health insurance throughout the country, through a series of decrees related to contribution levels, collection, benefits, the use of contribution revenues and provider payment. From the beginning, the VHI adopted a management approach which included central control of policy, information systems and training activities, but decentralized (at provincial level) management of registration,
Health Insurance Schemes For People Outside Formal Sector Employment

Bao Hiem Y Te (Voluntary Component)

contribution collection, determination of benefits, contribution levels for voluntary health insurance, claims and reimbursement procedures. The Hanoi Central VHI Office serves as the national directorate. This office is responsible for all operational guidelines, monitoring of registration, contribution revenues and expenditures as well as training, promotion of the schemes and public relations. The provincial VHI offices typically have a Director (usually a physician or pharmacist), several physicians engaged in relation with providers, the information system and claims reviews, at least one accountant and several clerks. At provincial level, the vice chairperson of the Peoples' Committee serves as Chairman of the Provincial Health Insurance Board, while the Director of the Provincial Health Bureau serves as Vice-Chairman.

Extent of autonomy of management of the fund:

At provincial level, the People's Committee approves the proposed contribution amounts for voluntary insurance. A minor percentage of health insurance revenue is transferred to Hanoi to finance others training activities.

Do scheme managers have special training or skills?:

Regular training given by central Hanoi office.

How are funds held (bank/invested/under bed)?:

In bank.

Can fund’s managers decide to invest to increase capital of fund?:

Investment of surpluses is currently not permitted. In general, voluntary health insurance in all province has no surplus. Before 1992, surplus came only from compulsory health insurance.

Subjected to Government accounting and reporting practices:

Supervision is statutorily the responsibility of a Health Insurance Board, currently chaired by a Vice Minister of Health (different person from Vice Minister responsible for VHI) and with members from within the MOH and other ministries.

How is it accountable?:

Single purpose health care fund/Multi purpose fund:

Single purpose health care fund.

Is the scheme focussed on one or more health facilities?:

More facilities.

Cost recovery rate of the scheme:

The scheme is financially autonomous at both central and provincial level. 130% for compulsory and voluntary component together.

Membership and Coverage

Beneficiaries of the scheme:

The total population. However, the target population for health insurance coverage currently does not include military and police personnel, and children under 6 years of age. The target population also specifically excludes Mountain Area villages, most of which are in areas now termed "New Economic Areas", with special taxation and economic development benefits for three years, beginning in 1995.

Type of membership (ind./fam./village/oth.):

Community, village, school (class) or company (for dependants). Individual membership in special cases.
Health Insurance Schemes For People Outside Formal Sector Employment

Bao Hiem Y Te (Voluntary Component)

Voluntary / Mandated (if mandated, what level):
Does the scheme cover only contributors to the Fund or also non-contributors - If so Who?:
Can someone from outside the scheme area use health services covered by the scheme. If so how are such services financed?:
Defined enrollment period/waiting period:
Number of beneficiaries:

Voluntary (VHI has also a compulsory component).
Only members receive benefits.

Yes.

Generally one month.
The number of insured persons is 9.5 million (1997), including the compulsory, voluntary and school children schemes. The number of voluntary insured persons is still small in most provinces. However, in 1997, all 61 provinces have voluntary health insurance.

13% of the population (1997), including the compulsory, voluntary and school children schemes. In Hai Phong province, 17% of the self-employed and 10% of the farmers were members of the voluntary scheme.

Operation of the Scheme

Frequency premium is paid:
Form of Premium: Flat rate/income related/risk related/mix:
Paid by:
Possibility of payment in kind:
Are some families/individuals exempt; how?:

Annually or 2 times per year.
Flat rates, no defined amount, varying among provinces, class grade (for school children).
Member. For poor people, by the provincial budget.
No.
The following are categories of patients, for whose care government takes responsibility: invalids, children under 6, patients with specific mental diseases, epilepsy, TB, inhabitants of new economic areas and the very poor.
The provincial government of Hai Phong, purchased annual health insurance membership cards for distribution to recognized list of welfare recipients.
Single purpose scheme.
The government and donors.
According to the government circular, the VHI now covers the full charge for the services used. However, starting from 1 October 1997, there is a ceiling for in-patient expenditure and copayment for some special services, such as, MRI, hemodialysis, CT scan, cancer therapy, etc.
Billing by fee-for-service, plus fraction of user fees. The VHI has an interest in exploring a capitation system in certain provinces.
Salaries are still paid through central government funds.
By fee-for-service billing.
Agreement are made between hospitals and provincial Bao Hiem Y Te.

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Health Insurance Schemes For People Outside Formal Sector Employment

Bao Hiem Y Te (Voluntary Component)

Benefit Packages
Which services are included/excluded?:

In voluntary service, tendency in most provinces was to cover only in-patient care: drugs, blood and plasma, transfusion, laboratory tests, x-ray, accommodation in hospitals. With additional payment, members can insure for out-patient care: drugs, laboratory tests, x-ray, minor surgery, consultation fee, all types of surgery, accommodation in hospital (except meals), etc.

Changes in benefit package:

- No.

Are non-personal services (e.g. health education) funded?:

Primary (if additionally insured), secondary and tertiary.

For which levels of health system is care covered:

Public and/or private providers covered by the scheme:

Public providers. Contacts with private providers are being considered in certain provinces.

Direct or Indirect provision (could be hospital operated scheme-HMO style):

Defined point of contact:

- Bao Hiem Y Te established its list of reimbursable drugs.

Pharmaceuticals - drug list, policy and generics, etc.

Management and information systems (monitoring of providers):

Membership database in all 61 provinces. Claims system in 10 provinces. LAN is used in big cities and provinces for management and information system. A plan for nation-wide uniform software application has been set up for membership system.

Scheme typology:

Role of Government

Role of Government in financing:

Yes, via Provincial People's Committee (Hai Phong).

Role of Government in regulation:

Yes, via Bao Hiem Y Te agency and decrees.

Role of Government in protocols:

- MOH developed a drug list.

Role of Government in Drug Lists:

Yes, by the government circulars and decrees.

Are there clear government policy guidelines on such schemes and how they should relate to the broader health care system?:

France, SIDA, WHO, ILO.

Technical assistance from outside agency (donor, NGO, etc.):

France, Sweden, Luxembourg.

Financial assistance from outside agency:
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