

Community Health Insurance in India

An Overview

Community health insurance is an important intermediate step in the evolution of an equitable health financing mechanism such as social health insurance in Europe and Japan. Social health insurance in these countries, in fact, evolved from a conglomeration of small 'community' health insurance schemes. Historically, during the peak of the industrial revolution workers' unions developed insurance mechanisms which were eventually transformed. Community health insurance programmes in India offer valuable lessons for policy-makers. Documented here are 12 schemes where health insurance has been operationalised. The two following articles describe in some detail two successful community health projects.

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According to the World Health Organisation, greater than 80 per cent of total expenditure on health in India is private (figure for 1999-2001 [World Health Organisation 2004]) and most of this flows directly from households to the private-for-profit health care sector. Most studies of health care spending have found that out-of-pocket spending in India is actually progressive, or equity neutral; as a proportion of non-food expenditure, richer Indians spend marginally more than poorer Indians on health care. However, because the poor lack the resources to pay for health care, they are far more likely to avoid going for care, or to become indebted or impoverished trying to pay for it. On average, the poorest quintile of Indians is 2.6 times more likely than the richest to forgo medical treatment when ill [Peters, Yazbeck et al 2002]. Aside from cases where people believed that their illness was not serious, the main reason for not seeking care was cost. The richest quintile of the population is six times more likely than the poorest quintile to have been hospitalised in either the public or private sector [Mahal, Singh et al 2000]. Peters et al (2002) estimated that at least 24 per cent of all Indians hospitalised fall below the poverty line because they are hospitalised, and that out-of-pocket spending on hospital care might have raised by 2 per cent the proportion of the population in poverty [Peters, Yazbeck et al 2001]. Given this context, health insurance appears to be an equitable alternative to out of pocket payments.

In recent years, community health insurance (CHI) has emerged as a possible means of: (1) improving access to health care among the poor; and (2) protecting the poor from indebtedness and impoverishment resulting from medical expenditures. The World Health Report 2000, for example, noted that prepayment schemes represent the most effective way to protect people from the costs of health care, and called for investigation into mechanisms to bring the poor into such schemes (World Health Organisation 2000).

Various other terms are used in reference to community health insurance, including: 'micro health insurance' [Dror et al 1999], 'local health insurance' [Criel 2000] and 'mutuelles' [Atim C 2001]. We define CHI (along the same lines as [Atim 1998]) as "any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management." CHI schemes involve prepayment and the pooling of resources to cover the costs of health-related events.

They are generally targeted at low-income populations, and the nature of the 'communities' around which they have evolved is quite diverse: from people living in the same town or district, to members of a work cooperative or micro-finance groups. Often, the schemes are initiated by a hospital, and targeted at residents of the surrounding area. As opposed to social health insurance, membership is almost always voluntary rather than mandatory.

Internationally, there is a shortage of empirical evidence to assess whether or not CHI schemes have improved access and financial protection among the poor. Enthusiasm for such schemes was fuelled in part by studies showing disproportionate increases in utilisation among the poorest with the implementation of insurance [Yip and Berman 2001] or mandatory prepayment schemes [Diop, Yazbeck et al 1995] in developing countries. But studies of voluntary CHI schemes have yielded less promising results. The studies and reviews that have been undertaken suggest that many schemes are short-lived and fail even to meet the goals they set for themselves [Bennett, Creese et al 1998]. Often, the schemes enrol relatively small populations (of 1,000 people or less) thus limiting the extent to which there can be pooling and resource transfers (International Labour Office (Universitas Programme) 2002). Furthermore, CBHIs have tended to exclude the poorest among their target populations, in part because they generally charge a flat (or uniform) premium that is unaffordable to the poorest. Under the three schemes reviewed by Preker et al [Preker, Carrin et al 2001] in Rawanda, Senegal and India, even among the insured, low income remained a significant constraint to health care utilisation.

The purpose of this paper is to describe Indian CHI schemes, and where data are available, their impact – it is intended to serve as an update on earlier work by one of the authors [Ranson 2003]. In India, community health insurance has a long history. The earliest such scheme was started in Kolkata in 1952 as part of a student's movement. The Student's Health Home (SHH) caters to the students in the schools and universities of West Bengal. Currently there are more than 20 documented CHI programmes, of which five were initiated in the past three years. Based on visits to twelve of the schemes, the authors describe the context in which they are operational, their design and management, the administrative challenges faced by them, and their impact. The names and locations of the programmes included in this summary are given in the accompanying table.

Underlying Objectives

Most of the insurance programmes have been started as a reaction to the high health care costs and the failure of the government machinery to provide good quality care. The objectives range from “providing low cost health care” to “protecting the households from high hospitalisation costs.” BAIF, DHAN, Navsarjan Trust and RAHA explicitly state that the health insurance scheme was developed to prevent the individual member from bearing the financial burden of hospitalisation. Health insurance was also seen by some organisations as a method of encouraging participation by the community in their own health care. And finally, especially the more activist organisations (ACCORD, RAHA) used community health insurance as a measure to increase solidarity among its members – “one for all and all for one.”

Context

Almost all the 12 CHIs are based in rural or semi urban areas, working among the poor. This ranges from tribal populations (ACCORD, Karuna Trust, RAHA), dalits (Navsarjan Trust),

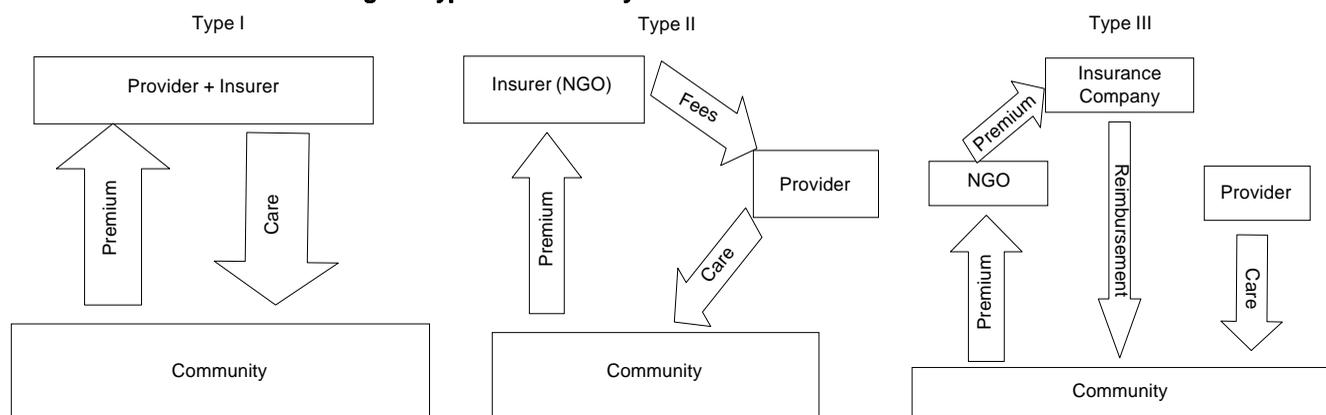
farmers (MGIMS, Yeshasvini, Buldhana, VHS), women from self help groups (BAIF, DHAN) and poor self-employed women (SEWA). The size of the target population (i.e., the population from which they aim to draw members) ranges from a few thousands to 25 lakh (Yeshasvini trust). Most of them (eight of the twelve) use existing community based organisations to piggyback the health insurance programme. While in some it is the existing self help groups (SHGs), e.g., DHAN, BAIF; in others it is a union (SEWA, ACCORD and Navsarjan). In two others it is the cooperative movement (Yeshasvini and Buldhana). These community-based organisations have been a useful platform to explain the principles of health insurance to the community, for collecting premium and for managing claims and reimbursements. And most important, they have instilled a sense of ownership of the insurance programme among the community.

In India, there appears to be three basic designs, depending on who is the insurer (see the Figure). In Type I (or HMO design), the hospital plays the dual role of providing health care and running the insurance programme. There are five programmes under this type. In Type II (or Insurer design), the voluntary organisation is the insurer, while purchasing care from independent providers. There are two programmes under this type. And

Table 1: 12 CHI Schemes in India

Name and Location of the CHI As Well As Year of Initiation	Target Population	Type	Remarks
ACCORD Gudalur, Nilgiris, Tamil Nadu 1992	Scheduled tribes of Gudalur taluk who are members of the Adivasi Munnetra Sangam (AMS) – the tribal union. (N = 13,070 individuals)	Type I	Linked with the New India Assurance Company
BAIF Uruli Kanchan, Pune, Maharashtra 2001	Poor women members of the community banking scheme and living in the 22 villages around Uruli Kanchan town. (N= 1,500 women)	Type III	Linked with United India Insurance Company
BULDHANA Urban Cooperative and Credit society. Buldhana, Maharashtra	Farmers living in Buldhana District (N = 175,000)	Type III	Linked with United India Insurance Company
DHAN Foundation Kadamalai block, Theni district, Tamil Nadu 2000	Poor women members of the community banking scheme and living in the villages of Mayiladumparia block. Total of 4,514 members and their families. (N = 19,049 individuals).	Type II	No linkages. The women operate the scheme by themselves
Karuna Trust T Narsipur Block, Mysore District, Karnataka 2002	Total population of T Narsipur block and Bailhongal block, with a focus on scheduled tribes and scheduled caste populations. (N=634,581 individuals)	Type III	Linkage with National Insurance company
MGIMS Hospital Wardha, Maharashtra 1981	The small farmers and landless labourers living in the 40 villages around Kasturba Hospital. (N = 30,000 individuals)	Type I	No linkages. The organisation operates the scheme.
Navsarjan Trust Pathan District, Gujarat 1999 (discontinued in 2000)	Select scheduled caste individuals in two blocks of Patan district, north Gujarat (N= ?)	Type III	Linkage with New India Assurance Company
RAHA Raigarh, Ambikapur, Jashpur and Korba districts of Chhattisgarh 1980	Poor people living in the catchment area of the 92 rural health centres and hostel students. (N = 92,000 individuals).	Type I	Have their own providers
SEWA 11 districts of Gujarat 1992	534,674 SEWA Union women members (urban and rural), plus their husbands living in 11 districts (N = 1,067,348 individuals).	Type III	Linkage with National Insurance Company
Student's Health Home Kolkata, West Bengal 1952	Full-time student in West Bengal state, from Class 5 to university level. (N=5.6 million students)	Type I	Have their own health facilities
Voluntary Health Services centre. Chennai, Tamil Nadu 1972	Total population of the catchment area of 14 mini-health centres in the suburbs of Chennai. (N= 104,247 individuals in two blocks)	Type I	Have their own hospital and health
Yeshasvini Trust Bangalore, Karnataka 2003	Members of the cooperative societies in Karnataka (N = 25 lakhs)	Type II	Operate their own programme

Figure: Types of Community Health Insurance schemes in India



Type I: ACCORD, MGIMS, RAHA, SHH, VHS

Type II: DHAN, Yeshasvini

Type III: BAIF, Buldhana, Karuna Trust, Navsarjan, SEWA

finally in Type III (or Intermediate design), the voluntary organisation plays the role of an agent, purchasing care from providers and insurance from insurance companies. This seems to be a popular design, especially among the recent CHIs, with five of the 12 adopting this. The insurance companies are mostly the GIC subsidiaries, e.g. National Insurance Company, the New India Assurance Company, the United India Insurance Company, etc. Of late private insurance companies like the Royal Sundaram, and ICICI Lombard have been involved with CHI programmes.

As most of these programmes serve the rural poor, the premiums also have been low; in the range of Rs 20 to Rs 60 per person per year. Only three programmes had premiums higher than Rs 100 per person. The premium is usually paid as a cash contribution once a year during a definite collection period. Two schemes (RAHA and MGIMS) allowed the community to pay equivalents in kind. The community and their representatives as well as the staff of the voluntary organisation helped with the collection of the premium, e.g. at Yeshasvini, the premium collection is organised through the existing cooperative infrastructure. Enrolment to the insurance programme ranged from a thousand to seventeen lakhs (Yeshasvini).

At most of the schemes, the unit of enrolment is the individual and membership is voluntary. While some of the schemes encourage family membership by providing a family package/rate (e.g. DHAN, Vimo SEWA and VHS), none requires enrolment of the whole household. However, several of the schemes do enrol groups rather than individuals – enrolment in these same schemes is to some extent ‘mandatory’, and they come to resemble social insurance schemes as a result. At Karuna Trust, for example, the cost of the premium is entirely subsidised for the poorest among the target population – the BPL-SC/ST – who are automatically enrolled in the scheme. Some of the self-help groups at DHAN purchase insurance for all SHG members (generally 15 to 20) out of profits earned by the SHG (i.e. certain SHGs have chosen to make the scheme mandatory). At SHH, once a school or institution registers, then it becomes mandatory for all the students to pay the premium.

As stated earlier, while some of the CHI schemes limited the benefit package to only ambulatory care, the twelve studied by the authors all provided inpatient care. Some also provided out patient care as well as outreach services. It is observed that the community prefers to have both outpatient and inpatient care. Most schemes had important exclusions like pre-existing illnesses, self-inflicted injuries, chronic ailments, TB, HIV, etc. One

scheme covered only surgeries, all other medical conditions being excluded. While most of the schemes reimbursed direct costs of treatment (consultation, medicines and diagnostics), one scheme (Karuna Trust) also reimbursed loss of wages for the patient. Some CHIs had also added other benefits, e.g. life insurance, insurance against personal accident and/or asset insurance into the package to make it more attractive to the community.

In the Type I CHIs, there is a cashless system of reimbursement. However, in the other two types, usually it is a fixed indemnity with patients having to settle bills and then getting it reimbursed 2-6 months later from the NGO. The exception was the Yeshasvini scheme, which, though a Type III scheme, had managed to negotiate a cashless system with the private sector by using the services of a Third Party Administrator (TPA). Most of the CHIs have a fixed upper limit, ranging from Rs 1,250 to Rs 1,00,000 per patient per year.

Most of the providers are from the private sector – either for profit or not-for-profit hospitals. Only one CHI (the Karuna Trust) had a public sector provider. In the Type I schemes, where the insurer is also the provider, there is an attempt to maintain quality and keep costs down. For example at ACCORD, the hospital largely uses only essential and generic drugs. However, in the Type II and Type III schemes, where the provider is mostly the private sector, we did not find any evidence of cost containment or quality checks. Yeshasvini was the exception, where they have managed to negotiate capitation fees for each surgery. At SEWA, there is an ongoing initiative to empanel select hospitals (primarily government and trust hospitals) judged to be providing a high standard of care.

As stated earlier, most of the schemes are administered by the community, their representatives or by the voluntary organisation staff. This helps keep costs down. Usually they handle the following activities:

Creating awareness among the community; collecting premium (at ACCORD, the sangam leaders collect the premium and hand it over to the NGO); monitoring for fraud (DHAN has an insurance committee comprising of SHG members who scrutinise every single claim); submitting claims; and channelling the reimbursements (at BAIF, the reimbursements are sent to the local SHG who while handing over the amount to the patient, reinforces the benefit of insurance). All these activities help in increasing the efficiency of the scheme. Also it helps build a sense of ownership among the community and increases accountability.

One of the weaknesses of the CHIs is the lack of techno-managerial expertise. This is reflected in the fact that most of them do not have inbuilt mechanisms to prevent adverse selection or moral hazard. Due to the asymmetry of information, it is possible that only the sick enrol in these schemes (adverse selection). Simple measures like a larger enrolment unit, a mandatory enrolment, a definite collection and waiting period are measures to prevent this. While all (except VHS) have a definite collection period, other measures are usually not used. SHH to a certain extent overcomes adverse selection by using the institution as an enrolment unit.

Similarly, because of the insurance programme, the behaviour of the patient or the provider may change (moral hazard). Capitation fee structures, standard treatment guidelines and copayments are some strategies to prevent this. The only measure consistently used by most CHIs to reduce the patient induced moral hazard is co-payments and deductibles.

The absolute number of enrollees varies tremendously, from only 909 at BAIF (scheme is only in its second year) to as many as seventeen lakhs at the Yeshasvini programme. The average subscription rate varies from 10 to 50 per cent of the target population. Except at Vimo SEWA, there has been no study as to why the rest of the target population are not subscribing, but during the interviews, some of the reasons for not paying were elicited. These included:

(1) No immediate benefit; (2) premium too high; (3) "we are well, why should we pay in advance? When we fall sick, we shall pay"; (4) large families – this is specially since most of the CBHI's unit of membership is the individual; (5) "(Insurance scheme) Hospitals are far away and so we have to pay a lot to access hospitalisation. Better use the premium money to go to a nearby doctor"; and (6) "we pay every year, but do not get any benefit out of it. So we have decided not to pay anymore".

There is tremendous variation in terms of claims submitted annually for inpatient care, ranging from only 1.4/1,000 insured per annum to more than 240/1,000 insured per annum. Among schemes with the highest rates of utilisation, adverse selection appears to be responsible for the high rates.

Among schemes with low rates of utilisation, it appeared that not enough had been done to address non-financial barriers to accessing health care. The indirect costs of health care are not addressed by the schemes (Karuna Trust being an exception), and in many of the schemes, the direct costs are only covered up to a 'cap' or 'ceiling' (as at DHAN, RAHA and SEWA). Even at those schemes that do not have a cap (e.g., SHH), non-financial barriers may prevent people from utilising the scheme (e.g., distance, lack of knowledge about the scheme, limited awareness of health/illness, etc.)

In terms of their ability to protect individuals and households against the catastrophic costs of health care, the schemes again seem to vary considerably. Those that provide the greatest degree of protection have the following characteristics: (1) Cover 100 per cent of the direct costs; (2) cover all (or at least some) of the indirect costs; (3) cover all kinds of illness (e.g., all non-elective causes of hospitalisation, including complications of delivery, chronic illnesses); and (4) provide benefit right at the source of health care, i.e., with no period during which the patient has to cope with the costs of care. Thus, it was generally the Type I schemes, which provide health care directly, and usually with no upper limit to the financial benefits, that provided the greatest degree of protection.

An important question is about the financial viability of these 'small' schemes. Of the 12 studied, four (BAIF, DHAN, Buldhanha

and Yeshasvini) are run purely on funds raised from the community. All the Type I schemes have supplemented the locally raised resources with external resources (either from the government or donors). These external resources range from 20-40 per cent of the total reimbursements. Only two have relied exclusively on external resources. Unfortunately, it was difficult to get accurate financial estimates of the administrative costs, especially since a lot of this is subsidised by the community.

Financing health care has always been a very difficult exercise. Even in rich countries like the US, there does not seem to be enough for all. It becomes all the more challenging in a low-income country like India. While the Constitution of India promises to provide adequate health care to the population, successive governments both at the state and the centre have failed in many ways to do so. This is probably one of the reasons why the majority of the public turns to the private sector for their health care needs.

Another equitable method of health financing is the social health insurance – seen in most European countries. Given the low percentage of workers in the formal sector, this appears to be a distant dream. However, these European (and Japanese) social health insurances have actually evolved from a conglomeration of small 'community health insurance schemes'. Historically, during the peak of the industrial revolution, worker's unions developed health insurance mechanisms to protect their members. This gradually developed into today's social health insurance [Ogawa et al 2003; Barnighausen T et al 2002]. Thus community health insurance can be seen as an important intermediate step in the evolution towards an equitable health financing mechanism.

The community health insurance programmes in India offer valuable lessons for the policy-makers and the practitioners of health care. While many state that the poor in India cannot understand the complexities of health insurance and will not accept any insurance product, we hereby document 12 schemes where health insurance has been operationalised. It is clear that what is required is a good product. Some of the conditions that have allowed these schemes to succeed are:

– An effective and credible community based organisation (or NGO). This is absolutely necessary as it is the foundation on which health insurance can be built. The CBO helps in disseminating information about health insurance and more importantly helps in implementing the programme with minimum costs.

– An affordable premium – this is very important. While most health insurance products (even for the poor) have premiums in the range of Rs 100 plus per member per year, we find that people are willing to pay only in the range of Rs 20 to 60 per person per year. This is significant, and needs to be taken into account by the insurers if they want their products to penetrate the rural market.

– A comprehensive benefit package is necessary to convince the community of the benefits of health insurance. Most of the CHIs documented, especially the Type I schemes have provided a comprehensive package and this is one of the main reasons why people have enrolled in their schemes. Unfortunately, most of the Type III schemes (except for Karuna Trust) have been forced to introduce exclusions by the insurance companies. While most insurance companies introduce exclusions, based on economic reasons, one has to look at health insurance within a public health context. Diseases like TB, HIV and mental illnesses have significant public health importance and should be covered. Similarly it is ironic that while the country has invested tremendously in safe deliveries, most health insurance products do not cover it. And finally as India enters an epidemiological transition and

will have to encounter chronic diseases like diabetes and hypertension, it becomes imperative that these diseases are included in the benefit package.

– A credible insurer is imperative for people to have faith in the product. This is where the NGOs and the CBOs score as they have a relationship with the community and so the people are willing to trust them with their money. Insurance companies need to learn from this important lesson and would need to approach the rural sector keeping this in mind.

– And last but not the least, the administration load of the scheme on the community should be minimal. Unnecessary documentation lead to frustration. In one of the schemes a community member mentioned that she had to pay more to get the certificates than she got in reimbursement. This is where the Type I and Type II schemes score over the others.

Many would dismiss community health insurance as a drop in an ocean. It may appear insignificant, given the scale of the problem in India. But, one needs to look at it in context. One of the main lessons from these case studies is the fact that a good community based organisation can help develop an effective community health insurance programme. And India is teeming with such organisations – be it the trade movement, or the cooperative movement. So upscaling should not present a problem if one uses these existing institutions. Already there are examples of community health insurance being introduced in the dairy cooperative sector (Mallur, Karnataka and Anand, Gujarat); the head loaders union (Mathadi trust in Mumbai), shop owner's union (Palakad, Kerala). The possibilities are endless, if approached properly.

However, one needs to mention a word of caution. The main pitfall in developing community health insurance is to find an appropriate provider. The Indian private health sector is unregulated and unaccountable [Bhat 1999]. In this context, introducing health insurance can lead to uncontrolled cost escalation without the promise of quality [Ranson and John 2001]. So it becomes imperative that while considering community health insurance, one should seriously consider mechanisms to introduce measures for cost containment, assuring quality and ensuring standard treatment practices. And this is where the CBO (or NGO) can play a crucial role, by countering the power of the providers. The CBO could negotiate with the providers and develop a package that is conducive for the patients and the CHI."

Yet another issue is the legality of these schemes, given the new Insurance act (IRDA Act 1999). Currently the act does not acknowledge the presence of these schemes and their role in the larger insurance market. This could also be the reason why many of the newer schemes have linked up with the formal insurance companies – to legitimise their activity. But in the process, they may have lost on the flexibility and innovations necessary for a successful CHI.

The other issue that needs to be addressed is that of financial sustainability. The very fact that many of them have been operational for more than a decade, itself is proof that it may be a sustainable form of health financing. While accurate financial data about the schemes were not available easily, rough estimates show that they are able to raise about 60 to 100 per cent of their resources. This has important policy implications, as it gives an indication towards the amount subsidy required to make these schemes viable. And given the fact that most of these schemes target the poor, it is important that the government comes forward to subsidise this equitable health financing mechanism.

In a country with one of the highest out of pocket health care expenditure in the world, it is imperative that some measures

be instituted to protect the poor. We suggest that community health insurance could be an interim strategy to finance the health care of the people; till a more formal social health insurance is in place. We also suggest that this is a feasible alternative given that community based organisations and movements exist in India. What is required is to regulate the providers and to legislate so that the community health insurance programmes find a space within the Indian insurance context. [47]

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