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Sudha, venu Menon

ICFAI Business School, Ahmedabad

15 December 2006

Online at <https://mpra.ub.uni-muenchen.de/1649/>

MPRA Paper No. 1649, posted 03 Feb 2007 UTC

**HEALTH SECURITY FOR RURAL POOR:
STUDY OF
COMMUNITY BASED HEALTH INSURANCE SYSTEM IN INDIA**

**Dr. SUDHA MENON
CONSULTING EDITOR
IBS, AHMEDABAD.
sudhavmenon@yahoo.co.in**

INTRODUCTION

Developing countries account for 84 percent of the world's population, and 93 percent of the worldwide burden of disease. These figures starkly contrast the fact that these same nations account for only 18 percent of global income, and a meager 11 percent of global health spending. Furthermore, of the 1.4 trillion disability-adjusted life years (DALYs) lost annually around the world, the developing world corresponds to an overwhelming 93 percent of this burden, while industrialized nations represent a mere 7 percent of lost years.[Schieber,G. and Maeda A: 1999]. Disability-adjusted life years (DALYs) are a measure by which international development agencies quantify the burden of disease. In layman terms, DALYs account for the years of life lost due to the effects of disease. DALYs are calculated using a two-thirds mortality and one-third morbidity ratio.

Among the developing world, South Asia, which is predominantly represented by India, ranks amongst the lowest in health spending: a central problem that hinders India's ability to advance its society. Figure 1 illustrates South Asia's global position in health spending:

Figure 1
Global distribution of health spending, and population among low-and middle-income countries

1994

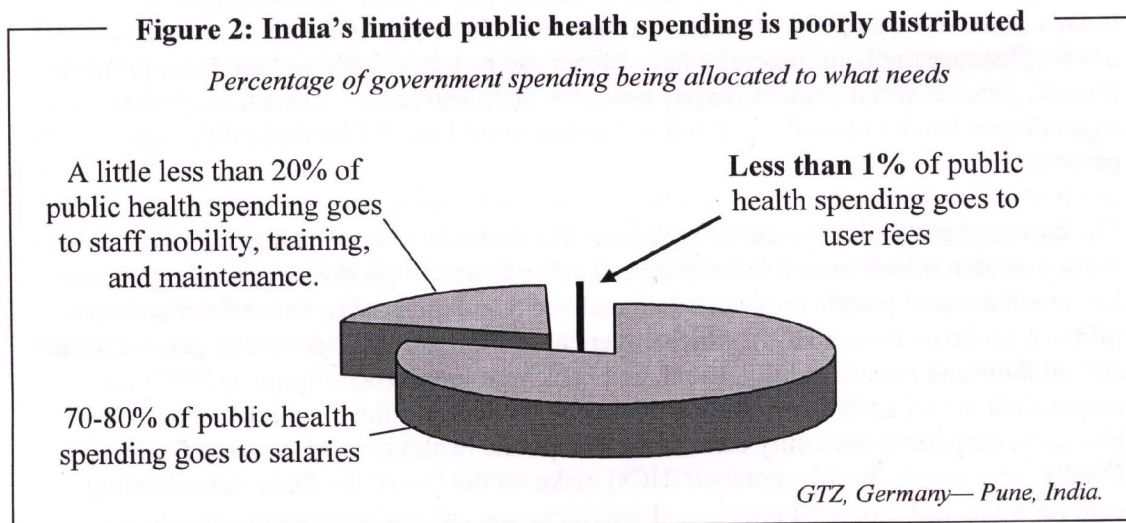
	Gross domestic product (%)	Health spending (%)	Population (%)
East Asia and Pacific	24	17	35
Europe and Central Asia	19	18	11
Latin America and Caribbean	35	42	9
Middle East and North Africa	8	9	7
South Asia	9	8	26
Sub-Saharan Africa	5	6	12

The World Bank Health, Nutrition, and Population, 1994. Database

India's public healthcare funding

The healthcare financing situation in India is dire at best. According to a 2001 report issued by the World Bank, public spending on health in India equates to less than 1 percent of India's GDP, poor in comparison to the average distribute of 2.8% in low- and middle-income countries[Ahuja:2004]. Public spending overall is inadequate to meet the needs of India's people and is even too deficient to provide the most basic of healthcare to the population. Furthermore, the government allocates the bulk of public spending to primary healthcare funds that are spread too thinly to provide effective care. [World Bank: 2001]

While the government's inadequate health spending alone contributes significantly to the insufficient healthcare provided to its population, substandard distribution of these funds worsens India's health spending problems. Of the money allocated for public health spending by the government, a disproportionately large amount is spent on salaries, and staff logistics, while only a fraction of a percent is spent on actual user fees. Figure 2 illustrates the asymmetrical distribution of public health spending.



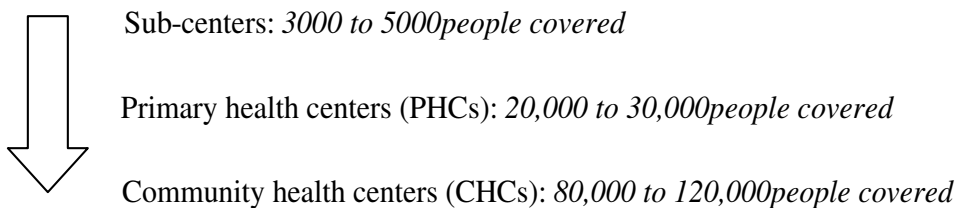
In addition to the deficient allocation, limited public spending issued by the government is not, as one may assume, distributed solely among the underprivileged, but is also utilized by well-off sections of society. In fact, when dealing with curative public services, the wealthier section of Indian society receives almost three rupees of care for every one rupee of care provided to the poorest fifth of the population. Paralleled to the difference in monetary allocation of care, there are also large disparities in the distribution of types of services between classes of society. Health spending for the poorer sections of the population focuses greatly on primary healthcare services such as immunizations and other outpatient procedures, whereas inpatient care is less likely to reach poorer populations. [World Bank: 2001]

SHORTCOMINGS OF PUBLIC HEALTH DELIVERY IN INDIA

It has been estimated that close to 87 percent of total health spending in India is private, and of that, 84.6 percent is out-of-pocket, point-of-service expenditure, lower only to Cambodia, the Democratic Republic of Congo, Georgia, Myanmar, and Sierra Leone. [Ahuja: 2004] Although state facilities exist, their lack of funding and blatant shortcomings forces India's population, even the rural poor, to rely on private providers for their healthcare needs. Because the poor generally have higher rates of morbidity and are more prone to disease, they are often required to pay more for their healthcare. Therefore, private expenditures leave vulnerable sections of society most affected by these forms of payment. [WorldBank: 2005]

The current rural health system is organized into three tiers: the first and most basic tier is the sub-center, which provides healthcare for five thousand people in general areas and for three thousand people in hilly, tribal, and backward areas. The second tier consists of primary health centers (PHCs), which cover care for 30 thousand people in general areas and 20 thousand people in hilly, tribal, and backward areas. (See Figure 3) PHCs are responsible for all ambulatory illness treatment services, routine preventive care practices, outpatient maternity care, as well as public health control measurements. Finally, community health centers (CHCs) make up the last of the three tiers covering care for 80 to 120 thousand people and providing specialized services in gynecology, pediatrics, surgery, and medicine.

Figure 3: Rural health three-tier system



In spite of the structure of the rural health system, various problems exist. Firstly, the public health system is understaffed and overtaxed resulting in an acute shortage of healthcare workers, leaving posts unfilled and care undelivered. In comparison to staffing norms established for subcenters, PHCs, and CHCs, current numbers exhibit a shortfall of approximately 28,000 auxiliary nurse midwives (ANMs), 65,000 male multipurpose workers, 21,000 nurse midwives, and 10,000 doctors. Additionally, money is misallocated for rural healthcare as it is primarily spent on salaries, with a minimum percentage used for drugs, supplies, transport of patients, or maintenance.

Studies show that people in rural areas are dissatisfied with the provided services. Reasons for this dissatisfaction are various: PHCs are generally far in distance, forcing people to walk or find some other mode of transportation in order to seek care. Even if people are able to reach the PHC, often the physician is either not present or unavailable to provide treatment. When people finally see a physician, prescriptions written often require people to travel another long distance to obtain medicines.

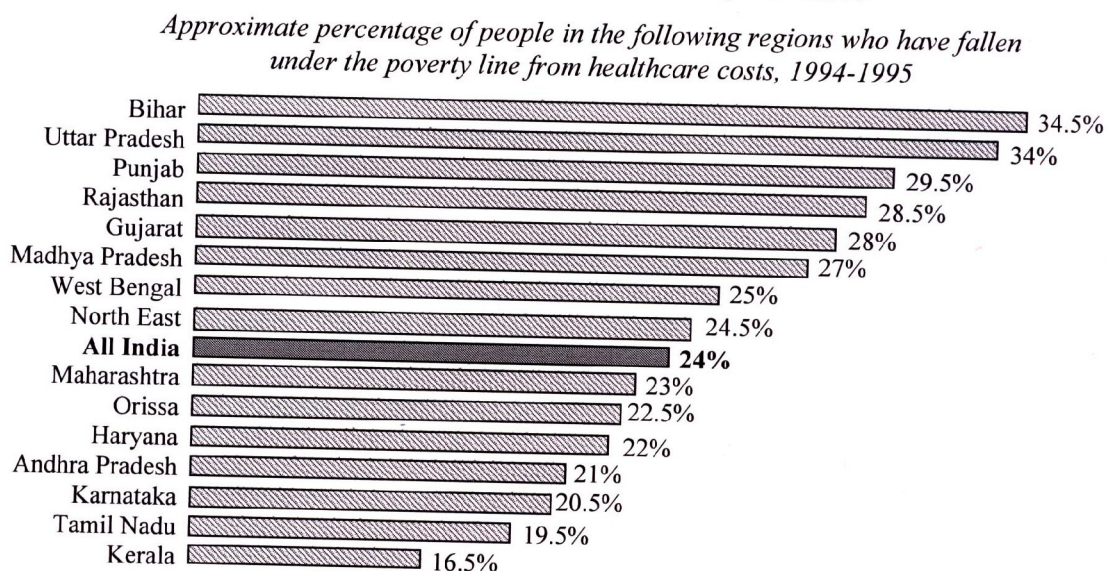
There is a significant shortage of medicine, as well as a lack of emergency equipment and life-saving drugs. Finally, long waiting hours and unsympathetic staff create additional reasons rural poor populations are dissatisfied with the public health system. Additionally, the rural public health sector lacks any structure for monitoring and quality assurance, resulting in the deliverance of the abovementioned inadequate care. [World Bank: 2001]

This widespread dissatisfaction with the public rural system causes rural poor populations to seek private care or go to traditional healers for their health needs. In fact, a health study conducted in 1997 at the Harvard School of Public Health showed that 82 percent of illness episodes in rural areas went to private practitioners for whom individuals were required to pay out-of-pocket, at the point of service.[Berman:1997]

PRIVATE SPENDING PERPETUATES THE POVERTY CYCLE

The trend of out-of-pocket health spending places the burden of health financing on the individual as opposed to the state, often causing poor families to fall below the poverty line. Although the rural poor are significantly less likely to be hospitalized for an ailment, the off occurrence of a hospitalization can imply catastrophic financial consequences for a poor family, especially without risk-pooling mechanisms to help families endure times of illness. [Garg: 1998]. Recent studies show that only 10 percent of India's population is covered under some form of risk-pooling. Hospitalized Indians who are predominantly the non-poor) spent more than 53 percent of their total annual expenditures on healthcare and close to 40 percent of those hospitalized borrowed money or sold assets to cover health costs.¹⁸ Families that are obliged to borrow money or sell assets to finance their care are frequently pushed under the poverty line as a result. Figure 4 demonstrates the percentage of hospitalized Indians who fall below the poverty line due to hospitalization costs.

Figure 4: One-quarter of the Indian population falls below the poverty line as a result of out-of-pocket health expenditures



"India, Raising the Sights: Better Health Systems for India's Poor." The World Bank. November 3, 2001.

NEED FOR HEALTH FINANCING IN INDIA

As the figures demonstrate, for many people living in developing nations, illness represents a permanent threat to their income earning capacity and, therefore, their livelihood. Health insurance (i.e. the practice of risk-pooling) has been progressively more recognized as a tool to finance healthcare provision in the developing world. The high demand for good quality healthcare and the extreme underutilization of existing health services have given rise to the need for community health insurance—an arrangement that may both increase access to healthcare as well as theoretically improve its quality. While alternative forms of healthcare financing have been scrutinized, the option of insurance seems to be promising as it offers the opportunity to pool risk by converting unpredictable healthcare costs into fixed annual premiums.

COMMUNITY-BASED HEALTH INSURANCE

The typical dialogue surrounding health financing cites three main types of insurance as viable options to provide care. First is social health insurance, a practice initiated in several European countries where the working population of society provides health funds for the entire population, working and non-working. Social health insurance utilizes basic socialist principles to hold all sections of society accountable for the good of the community. The next type of insurance model is private health insurance, a structure that generally prevails in capitalist societies. Private insurance favors those who can afford to pay regular premiums, i.e. the middle class and the wealthy. Private insurance, therefore, inherently excludes the poor and only provides benefits to paying members. Finally, and most notable in discussing health for the rural poor, is community-based health insurance (CBHI).

Studies conducted in various developing countries, including India, show that community-based health insurance (CBHI) schemes are highly effective in reaching poor populations. According to Friends of Women's World Banking, CBHI is defined 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 the members participate in its management.***" Such schemes frequently function in conjunction with healthcare providers or community organizations, such as local religious institutions, self-help groups (SHGs), or non-governmental organizations (NGOs).

CBHI requires that people make a small contribution (i.e. pay a premium), which is then pooled to provide benefits, such as medical costs, to those within the pool who may need assistance. Unlike social or private health insurance schemes, CBHI is distinct in that it is generally initiated and managed by the community it benefits. This characteristic of CBHI is particularly important as it entails that the features of any specific CBHI scheme tailor to the local needs of the people. (See Figure 5)

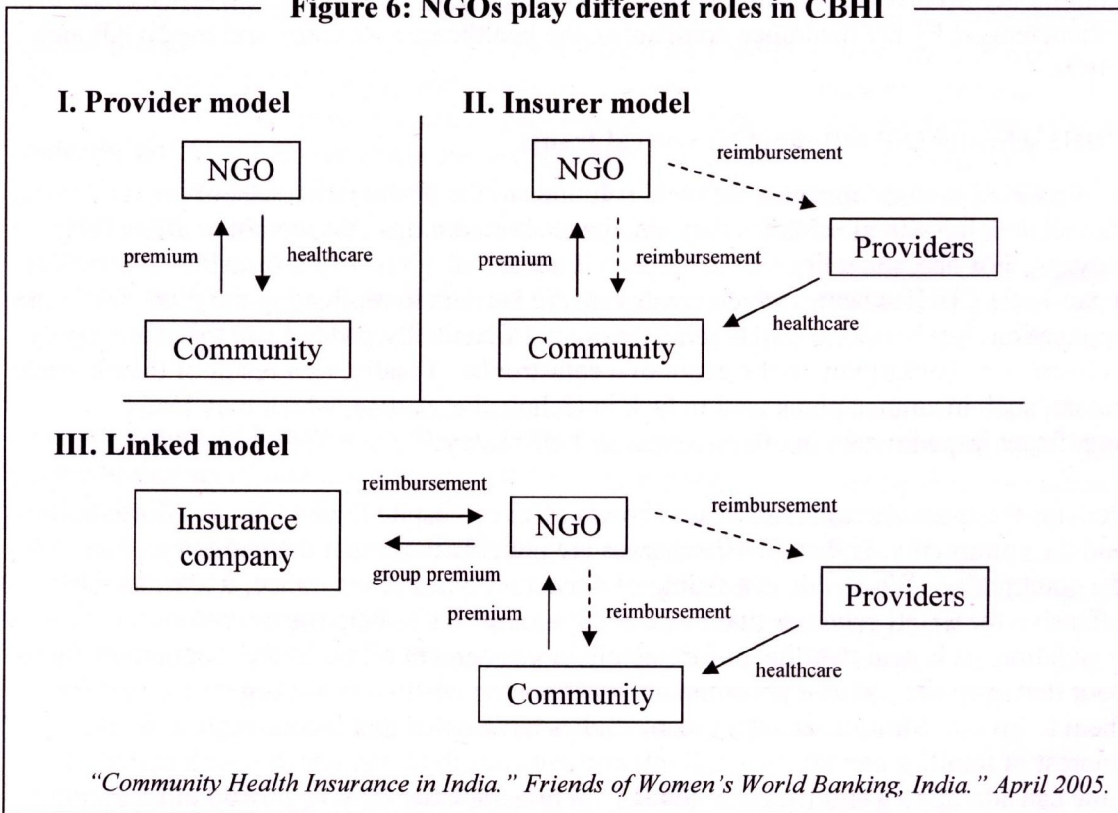
Figure 5: CBHI schemes tailor to the community
<i>Communal benefits of CBHI, in no specific order</i>
#1 Community-owned, therefore supported by a strong will to want it to succeed.
#2 Design agrees with the needs of the community, therefore likely to be more effective in caring for beneficiaries.
#3 Often managed or co-managed by the people, resulting in minimal overhead administrative costs if at all.
#4 Effective in reducing informational asymmetries
<i>"Community Health Insurance in India." Friends of Women's World Banking, India. "April 2005; Ahuja, R. "Health Insurance for the Poor in India." Indian Council for Research on International Economic Relations. March 2004.</i>

In fact, specifically in regards to low administrative costs, studies estimate that the average health insurance provider has to spend close to 20 percent of its premium amount on staff who are hired to popularize the idea of insurance, collect premiums, verify claims, and then ultimately reimburse them. In contrast, such costs can be minimized to a mere 5 to 6 percent of premium amounts for CBHI schemes, where the community manages or co-manages administrative tasks itself. Finally, CBHI have been known to make specific efforts to not only improve healthcare access to the rural poor, but to help fill gaps in levels of knowledge these target communities have regarding basic health information. Therefore, the health insurance schemes serve to improve access to healthcare systems while also improving healthcare education for these marginalized populations.

CBHI schemes take on various shapes

To date, there are approximately 30 CBHI schemes across India conservatively covering 3.5 million Indians.[World Bank:2005]. Each of these implemented schemes present unique characteristics as an inherent feature of their tailoring to the communities they serve. As a result, CBHI schemes have been established using multiple techniques of administration and efficiency practices.

CBHI schemes generally assume one of three main models: the provider model, the insurer model, and the linked model. In the provider model, the NGO acts as both the provider of healthcare as well as the agent collecting premiums and needed funds. Taking a slightly more distant approach, in the insurer model the NGO, in conjunction with other community-based organizations (CBOs), acts solely as the insurance agency, requiring them to either purchase healthcare services from a network of providers or reimburse CBHI members after having received and paid for care. Lastly, in the linked model, NGOs and CBOs act as intermediaries between the insurance agency, the providers, and the insured members. In this last model, the NGO and CBO act mainly in managing the scheme. Figure 6 depicts the variety of roles NGOs can assume.

Figure 6: NGOs play different roles in CBHI

Each of these three models carry with them specific idiosyncrasies that are often examined through the evaluation of the following meters: freedom to suit the local needs, premiums, benefit packages, financial risks, quality of care, and community involvement. For instance, the provider model allows for maximum flexibility in suiting local needs as the NGO sees fit, while the linked model scheme must function depending on the parameters of the insurance company employed. Similarly for premiums, the provider and insured models usually base their premiums on affordability and are set by NGOs and CBOs, whereas insurance companies dictate premiums set through the linked model. Benefit packages for linked CBHI schemes are restricted to the insurance provider and almost always have policy limitations and exclusions, while provider and insured schemes are open to including benefits relevant to the people. When it comes to financial risk, the provider and insurer models carry the most risk, while the linked model places a predominance of the financial burden on the insurance company itself. As for the quality of care, theoretically it should improve with the provider and insular models because they cater directly to the community, however with financial constraints, in application, the linked model may actually provide the highest quality of care. Community involvement is almost entirely dependent on each individual scheme and the parameters set by the insurance companies, the healthcare providers, and the NGOs and CBOs.

CBHI SCHEMES STILL FALL SHORT ON SEVERAL FRONTS

While CBHI models appear to be ideal solutions to the healthcare issues of the rural poor, like all developmental schemes they also have shortcomings that remain to affect their success. For one, the unique traits of each scheme make it nearly impossible to establish a pan-India CBHI scheme, which creates severe barriers to replicating the plans for future application. Furthermore, CBHI schemes are not financially padded and therefore highly vulnerable to bankruptcy in the event of a catastrophe. Finally, as a result of their organic nature, such insurance plans tend to lack in technical expertise, which may lead to significant impediments in effectiveness and efficiency.

Perhaps the most alarming drawback, however, even despite their focus on affordability and the community, is that CBHI schemes are not able to protect the poorest segments of the community. While this is a failing of almost all types of insurance, it appears most offensive for CBHI schemes that came about as a means to help the ultra-poor population. It is said that this unfortunately large segment of the Indian population are so poor that even the reduced premium amounts are too costly and not urgent enough for them to invest. Simultaneously, recent studies have noted that increasingly even the poorest of families can afford small intermittent contributions, which over a period of time can add up to a significant amount.²⁹ While the latter may be telltale of emerging trends, the former is a more accurate account of predominant issues facing healthcare financing in India today.

Recognizing this as a major glitch in CBHI schemes, current plans in India have invented their own ad hoc solutions to include the poorest sectors of the populations. For instance, the staff members of Medical Insurance Scheme (MIS)—RAHA, pay the premiums for the poorest communities in their field area out of their own pockets. Similarly, ACCORD-AMS-ASHWINI Health Insurance asks for greater premium contributions from those who can afford them to help subsidize the premium costs for those who cannot. Finally, in some states and through sparse policies, the government also provides certain subsidies to this section of society. All of these arrangements, however, are improvised, as mentioned, with no formal or sustainable structure in place.

Advancing the Public-Private Partnership

The term public-private partnership (PPP) carries with it a variety of connotations, many of which remain confusing and at times even conflict. Due to the diverse nature of development schemes in general, PPP programs have taken on multiple forms and focuses, often redefining its most current explanation. In a general sense, PPP, as it pertains to development, has been defined as "institutional relationships between the state and the private for-profit and/or the private not for-profit sector, where the different public and private actors jointly participate in defining the objectives, the methods, and the implementation of an agreement of cooperation.[Jutting:2000].

However, for the purposes of this study, the not-for-profit sector can be re-characterized as a public actor seeing as it assumes greater responsibilities in implementing and enforcing social developmental schemes otherwise overseen by the government. Therefore, PPPs can also be defined as institutional relationships between the for-profit private sector and various actors in both the not-for-profit sector and the state—parties that directly work on issues of public concern. It is the latter of these definitions that will be most applicable to the following discussion.

Since the notion of a partnership implies that the parties involved contribute mutually to some ongoing set of interactions aimed to meet a purpose, these same parties must agree to the roles they play within this union. The actors of a PPP can take on one of three common functions: provisionary, financial, and regulatory & monitoring. Those in the provisionary role literally provide a service to the target community, such as healthcare or education. On the other hand, actors assuming the financial role simply help to monetarily support the implementation of the set goal. Finally, PPP players who acquire the regulatory and monitoring role take responsibility for many administrative tasks required to ensure sustainability and efficiency of the objective. [Jutting:2000]

Leveraging the public-private partnership for healthcare financing

Although the discussion regarding PPP in the health sector typically addresses the private and public health delivery mechanisms and ways in which the two can cooperatively provide care, the value of a PPP arrangement can also be utilized to make healthcare financing viable for the rural poor. As the previous section enumerates, while CBHI schemes have been the most successful programs in extending the reach of healthcare financing to the poor of India, such plans are still unproductive in insuring the extreme poor populations of the nation. With limited ability to pay for their daily means, individuals and families that fall into this poorest section of society are both unwilling and unable to fund monthly or annual CBHI premiums integral to the mechanism of risk pooling. This inherent malfunction in CBHI schemes can be amended through the utilization of PPPs.

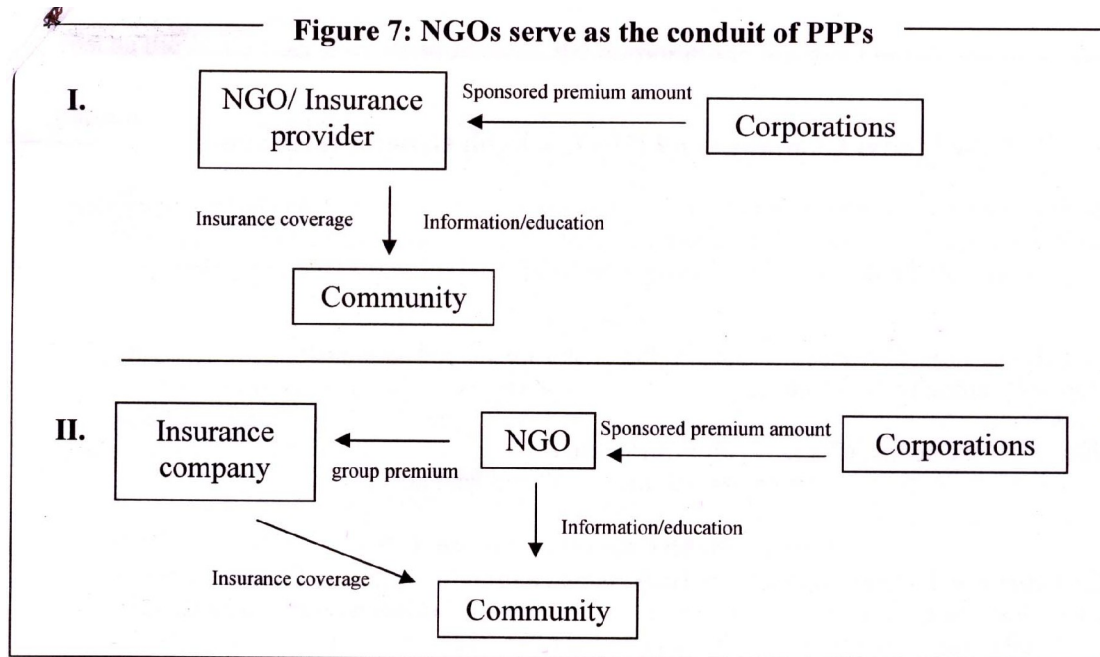
Riding the momentum of the increasing trend toward corporate-social responsibility, corporations all over India have begun to include issues of social concern on their agendas. More and more companies have initiated projects in which administrators allocate resources, both manual and financial, to help advance a social need, such as contributing to funds created for education or health. In some cases, corporations have even established full committees dedicated to seeking out opportunities for the company to remain actively and continually involved with certain development schemes. **EATON Corporation**, in Pune has established multi member committees of employee who survey assess and initiate participation in various developmental projects with NGOs in the area. . The same behavior can be leveraged to provide healthcare financing for the rural poor.

Because affordability is a salient issue preventing the rural poor from obtaining CBHI, receiving monetary support from the proximal corporate sector offers an efficient and effective solution. As well, for corporations looking to satisfy their corporate-social responsibility commitment, providing financial support for a project serves as a useful and straightforward mechanism to aid the community. Specifically dealing with healthcare financing, corporations could finance the insurance premiums for severely poor families in need of greater access to the health system.

IMPLEMENTATION: THE ROLE OF THE NGO AS AN INTERMEDIARY

While the abovementioned PPP appears sound in theory, there are many logistical complications that could make this type of corporate sponsorship program ineffective. NGOs must be appointed as central actors in such a sponsorship program as they are integral to the program's implementation. While the financial means falls within the hands of the corporations, accessibility to the community is a privilege almost exclusively held by the NGO. NGOs are closely linked to rural village communities within which they work. Generally speaking, members of an NGO have worked with the same community for multiple years and have built a rapport and trust that a newcomer would not experience. It is through this fundamental relationship that NGOs are able to help put into practice developmental schemes that rural poor communities would otherwise live without. Combining the strengths of these two major components, the for-profit private sector can come together with the not for-profit sector through a PPP that can help bring healthcare to the villages.

Working off of the various CBHI models, the corporate sponsorship program can take on one of two implementation models: one where the NGO acts as the intermediary between the insurance provider, the sponsoring corporation, and the community, and the other where the NGO actually acts as the insurance provider, and assumes the role as an intermediary between the corporations and the community. (See Figure 7).



Literally occupying the central role, NGOs are charged with the position of connecting for-profit funding to the community's health needs, while, in the case of model two, cooperating with an outside insurance agency. NGOs also may carry administrative burdens such as the collection of corporate contributions and the gathering of member information from the rural poor population. The case study on the following page outlines the basic features of one such PPP currently being piloted in the Indian state of Maharashtra.

CASE STUDY: CHAITANYA AND HDFC-CHUBB GENERAL INSURANCE

As an example of the above-examined PPP, Chaitanya and HDFC-Chubb General Insurance, located in the Pune district of Maharashtra, have recently joined in an endeavor attempting to provide CBHI coverage to SHG -women and their families in the Chaitanya field area. Founded in 1993, Chaitanya focuses on the establishment and strengthening of SHGs and development through micro-finance programs. Chaitanya's work has motivated the formation of the Grameen Mahila Swayamsiddha Sangha, the first independent federation of SHGs in Maharashtra. Currently, Chaitanya also carries out developmental activities including water & sanitation, agriculture, livelihood, and health.

HDFC-Chubb General Insurance (GIC)

HDFC Bank and Chubb Corporation, USA entered a venture together in 2002 to jointly offer general insurance services. Specifically, HDFC-Chubb GIC offers a rural initiatives program tailored to meet the needs of the rural poor and offer insurance services at reduced costs.

Rural initiatives group health insurance package

- Covers both personal accident and hospitalization expenses
- Special care and emphasis for women in both personal accident and hospitalization expenses
- Coverage of husband's accidental death
- Permanent disability for the woman member
- "Maternity benefit hospitalization coverage for both normal and cesarean births
- Compensation of lost wages due to hospitalization

Members insured

Premium

[Per family]

Insured member and spouse only	165	275	385	500
Insured member, spouse, and up to a maximum of two dependent children	220	330	440	600
Insured member, spouse, up to a maximum of two dependent children, and dependent parents	330	495	630	825
Coverage received	7000	14000	21000	28000

Corporate sponsorship program

As a means to help villagers help finance premium costs, Chaitanya and HDFC-Chubb GIC have petitioned corporations in the Pune area to become a third link to this PPP, filling a financial role in the partnership. Specifically, representatives have made presentations to corporations to encourage corporate employees to participate in a one-to-one sponsorship program where one corporate employee would sponsor the health insurance premium for one specific family in the villages Chaitanya oversees. Money contributed to the scheme first goes to Chaitanya who then deposits a lump sum into the HDFC-Chubb system. Chaitanya provides the link between HDFC-Chubb, contributing corporations, and the rural villages.

Corporations and NGOs assess degree of involvement

Just as the NGO may play various roles, the corporations involved in this scheme can also participate in more than one manner. For instance, if a corporation believes that this particular funding scheme is one through which it would like to make a long-term commitment, then NGOs can focus on linking up with a few select corporations who plan to maintain a multiple year partnership with the NGO and its relevant villages. The concern that lies with this plan, however, is that if these few committed corporations fold at some point or back out of the made agreement, the NGO, and the community, would lose a large portion of the premium money, leaving the scheme financially vulnerable. On the other hand, if corporations are not attracted to making long-term funding commitments, NGOs can focus on obtaining a broad base of corporations that regularly contribute, while the NGO simultaneously and constantly recruits more. This latter model allows for a continual flow of premium money without incurring significant set backs if a corporation were to change its plans, however, lacks a type of investment in its community that the former model would encourage. Furthermore, following the diversification option would require the NGO to consistently and actively create new partnerships while attempting to manage those already existing. Figure 8 outlines advantages and disadvantages to the type of involvement corporations can make.

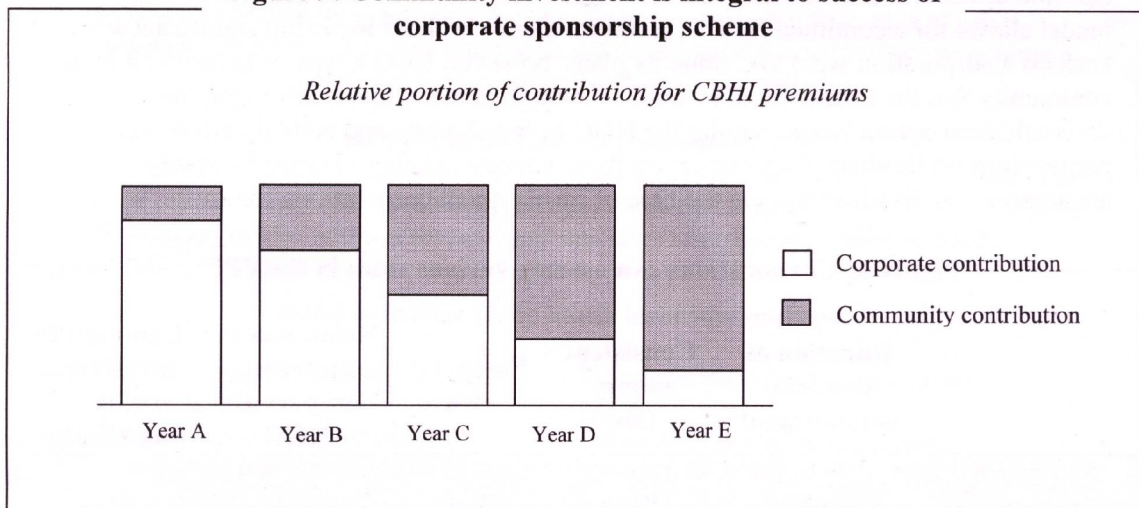
Figure 8

Nature of investment	Duration of financial commitment	Consistent money flow	Financial risk	Relationship maintenance on part of NGO	Community investment by contributor
Few select corporations invest	Long-term	Yes	High	High	High
Many various companies invest	Highly variable	No	Low	Low	Low

PPP must include features to help change mindsets, not merely behavior

While the funding of such a scheme is an effective means to initiate CBHI schemes, it is imperative that certain measurements are put in place to ensure that villagers' mindsets expand in regards to their understanding and knowledge of healthcare practices. The facilitating of healthcare financing for rural poor should help improve access to the healthcare system, but not without some investment on the part of those receiving its benefit. For this reason, any offering made from the corporate end of the PPP should be partial in its contribution, and with time, taper (See Figure 9). For instance, the first few years that such a PPP manages to successfully enroll and maintain a rural villager membership, the corporate contribution should equal 95 percent of the premium cost, leaving the remaining 5 percent onus on the villagers themselves. After the first few years, the corporate contribution should lessen, going from 95 percent, to 80 percent, then eventually to 50 percent, and so on incrementally until corporations are providing minimal to no funding for these premiums. Ideally speaking, after five to 10 years of utilizing a type of healthcare financing scheme, the villagers themselves will find value in the insurance and be willing to finance their own premiums. Of course, certain provisions must be made for those families unable to pay for their own premiums regardless of their understanding the value of investing in one's health.

Figure 9: Community investment is integral to success of corporate sponsorship scheme



In addition to ensuring that villagers provide some monetary investment in their health, rural poor populations enrolled in the corporate sponsorship PPP must receive regular information regarding the scheme, its purpose, and the importance of sound health habits overall—a task most likely to be delegated to the intermediate NGO. Healthcare financing must serve not only as a means for the poor to gain access to the health system, but also as a tool through which rural populations gain a greater understanding about preventative health practices and why habitual investments in one's health today will save more money in the future. Corporate financing of this scheme is a means through which healthcare financing can be made possible for the poor, but it should not be a permanent fixture in their lives.

Conclusion

Developmental schemes to curb the poverty cycle are numerous and each distinct in their approaches to mobilizing unprivileged communities. Development in the health sector is one of the most basic areas through which rural poor populations of developing nations, such as India, can gain ground in advancing their community. The lack of adequate healthcare for these groups originates from their lack of education as well as from poor healthcare infrastructure in the nation. The disproportionate amount of private health spending to that of public spending in India places the burden of healthcare in the hands of the everyday individual, expenditures that are often too expensive for average households to shoulder, let alone the poorer segments of society. As this report details, the most viable and present solution to improve people's healthcare access in India, while making financing affordable, is to invest in CBHI schemes tailored to provide basic healthcare to those without. As a means to ensure effective and efficient implementation of CBHI schemes, the private and public sectors should come together in a joint project through which the rural poor can receive health coverage through the reallocation of capital.

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