ACCORD Community Health Insurance

Increasing Access to Hospital Care

Described here is the ACCORD – AMS – ASHWINI community health insurance programme (AAA CHI), which aims to provide finances for the poor at the time of need using pre-payment and risk pooling mechanisms. From the data it appears that AAA CHI has been able to increase the access of the poor to health care. Some of the reasons for this achievement are: the existing solidarity in the community; the affordable premium; the comprehensive benefit package, and minimum administrative bureaucracy.

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In India, while 5 per cent of GDP is spent on health, the government contributes only 0.9 per cent towards it or less than Rs 100 per capita per year. Internationally, this is one of the lowest health expenditures by any government. More than 80 per cent of most government budgets are earmarked for salaries. This means that there are very little funds for drugs, programmes and other activities. And finally there is an inequitable allocation of health resources, about 30 per cent of the government health budget is used by the richest quintile while the poorest quintile gets only 10 per cent [Peters et al 2002]. These under-funded government health services thus provides poor quality of care. Common complaints include poor utilisation of the primary health care facilities, overcrowding at the secondary and tertiary health care facilities, lack of adequate manpower, drugs and equipment [Gupte 1993]. This causes most patients to shift over to the private sector for health care. About 85 per cent of patients use the private sector for ambulatory care, while 40-60 per cent use the private sector for inpatient care [Peters et al 2002].

Using the private sector in India implies out-of-pocket expenditure at the time of illness. This may have two outcomes – either the patient does not access care or the patient accesses care but is impoverished in the process [Kawabata et al 2002]. Utilisation studies in India have reported hospitalisation rates in the range of 15 to 20 hospitalisations per 1,000 population [Sundar and Sharma 2002, Ranson 2002, Raman 1996]. However, this is considerably lower than African and Asian figures [Criel et al 1998]. Those who do access care are pushed below the poverty line. Studies have shown that more than 40 per cent of hospitalisation patients borrow money or sell assets to meet medical costs. In the process, an average of 24 per cent of hospitalised patients become impoverished [Peters et al 2002]. Thus it appears that India's poor have problems with accessing hospital care. And those who do access health care have the risk of falling into iatrogenic poverty poverty [Meessen et al 2003].

One possible solution to this problem is to reduce the financial barrier through health insurance. Unfortunately, currently only about 10 per cent of the population is protected under any health insurance coverage. Of this, most are for employees in the formal sector [Ellis et al 2000]. The informal sector is totally unprotected and has to depend on the aforementioned poorly financed public sector or the expensive private sector to take care of its needs. The government is keen to increase the insurance coverage and has even introduced special health insurance packages for the poor ('Pay-off Time for NDA on Penson, Health Schemes', *The Times of India, July 14,* 2003). However, these initiatives have not been acceptable to the citizens of this country ('Concern over Low overall Health Insurance Focus', *The Economic Times,* December 9, 2003).

In this context, a few voluntary organisations have developed community health insurance[1] (CHI) schemes to meet the health financing needs of the poor [Ranson 2003]. Through a pre-payment and risk pooling mechanism, the poor are able to meet their health needs with minimum burden at the time of use. However, while currently there are more than 20 such schemes in our country [Ranson et al 2003], there is very little empirical evidence about their performance. We describe here one such scheme managed by Action for Community Organisation, Rehabilitation and Development (ACCORD), the Adivasi Munnetra Sangam (AMS) and the Association for Health Welfare in the Nilgiris (ASHWINI). We first describe the ACCORD-AMS-ASHWINI (AAA) CHI scheme in detail and look at its performance vis-à-vis access to hospitalisation. We finally look at some of the determinants of this performance and come up with recommendations for improved performance of CHI schemes.

We studied the AAA CHI programme and reviewed its performance over the past 11 years. Interviews with key informants provided the qualitative information; while secondary data from records, registers and reports provided the quantitative data.

Principal Findings

ACCORD – AMS – ASHWINI (AAA)

ACCORD is a local non-governmental organisation (NGO) staffed by a group of professionals and adivasi youth. Established in 1986, it works exclusively for indigenous groups, or 'the adivasis', of Gudalur taluk, Nilgiris district, Tamil Nadu. ACCORD's main objective is to empower the 15,000 plus adivasis of Gudalur to protect their rights. This ranges from land to forest rights. ACCORD also provides services like health, education, agricultural support and housing. The AMS is a federation of village level unions ('sanghas'). The main objective of the village sangham and the AMS is to defend the rights of adivasis. The AMS also takes responsibility for the development of all the adivasis in Gudalur. ASHWINI manages the health programme

today. The health programme consists of a two-tier structure – a network of seven health centres, manned by medical assistants and a 20-bed hospital with all basic facilities, including obstetrics and surgery. The health centres provide a mixture of curative and preventive care. Most of the villages also have trained village health workers who provide basic health care to their community. ACCORD initiated and developed the health programme and handed it over to a sister NGO – ASHWINI in 1998. ASHWINI is staffed and managed by adivasi youth.

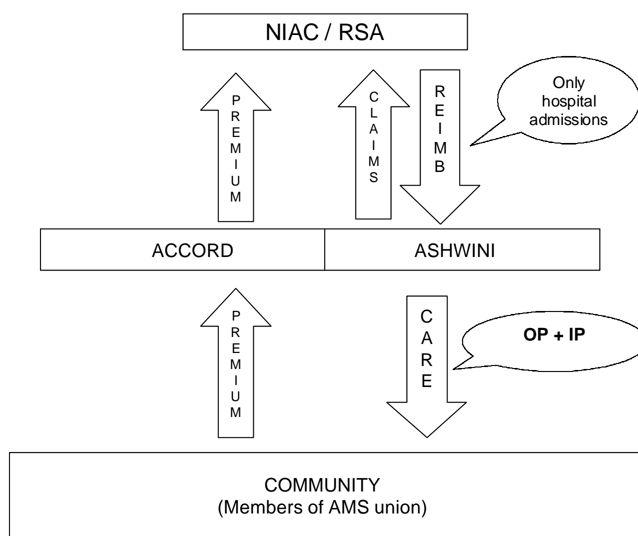
AAA CHI – History and Design: During the period 1987-1990, because of community health work, the demand for health care grew among the adivasis. While initially ACCORD tried to use the existing government and private health care facilities, they were found to be wanting in many aspects. A hospital for the adivasis became an increasing demand of the adivasi community. Prolonged discussions with the community always ended with the question: "How will this venture be funded?" The people agreed to contribute a certain amount towards the cost of running the hospital.

Keeping this promise in mind, the Adivasi Hospital was inaugurated in December 1990. ACCORD realised that user fees were inequitable and explored the possibility of insuring the adivasis. Many general insurance companies (GIC) companies were contacted, but only New India Assurance Corporation (NIAC) evinced some interest. Negotiations with them over a period of a year resulted in the development of a new package – the 'Composite Tribal Health Insurance Package', which was launched in March 1992. Its main objectives are given in Box. This programme (called AAA CHI here) has been operational for the past 12 years, the initial 10 years with NIAC and the last year with the Royal Sundaram Alliance Private Limited (RSA). The three main stakeholders – ACCORD, AMS and ASHWINI, manage the AAA CHI programme.

As the NIAC package did not meet all the needs of the adivasi community, AAA introduced some changes to make it more acceptable to the community. Thus the AAA CHI should be seen at two levels – one provided by the NIAC to AAA and the other by AAA to the adivasi community. The AAA CHI is depicted in Figure 1. The basic elements are as follows:

The community: Only adivasis residing in Gudalur taluk who are AMS members are eligible for the scheme. There are about 12,000 plus AMS members, of which only those between six months to sixty years are eligible to enrol as per the NIAC guidelines. These adivasis are traditionally hunter-gatherers and have been classified by the Government of India as 'primitive tribal groups' because of their pre-agricultural economy, low literacy rates and dwindling population. Today most of them are engaged as casual labourers in the tea estates and earn an average of about Rs 1000 (US$22) per family per month. This income has been threatened in the past three to four years, due to the fall in tea leaf prices.

Figure 1: Design of AAA Community Health Insurance Programme



The premium: The premium has to be seen at two distinct levels. In 1992, ACCORD negotiated with NIAC to insure all the AMS members for a period of five years. This enabled AAA to avail of the long-term discount as well as group discount. Additionally, the AAA limited the benefit package to a maximum of Rs 1,500 per person per year. All this reduced the annual premium from Rs 48 to Rs 13 per person per year. As the adivasis were not able to pay the lump sum of Rs 260 per household (equivalent to a quarter of their monthly income), AAA negotiated the following package with them. ACCORD agreed to pay the entire amount upfront to NIAC. The adivasi community agreed to repay this amount as annual instalments to ACCORD. The AMS took the responsibility of collecting the premium.

ACCORD thus paid the premium of Rs 65 per adivasi and covered 5,995 adivasis in the first round. The lump sum amount of Rs 3,86,318 was provided by CEBEMO, a Dutch funding agency. New members who joined subsequently were enrolled on a pro-rata basis. The scheme was renewed in 1997 for another five-year period; once again CEBEMO/BILANCE helped meet the lump sum payment of Rs 523,110 to insure 9786 tribals for five years. In 2002, NIAC hiked the premium by a substantial amount, so AAA approached Royal Sundaram Alliance Private Limited. They agreed to provide hospitalisation coverage upto a limit of Rs 1000 for a premium of Rs 20 per person per year. The AMS members have been insured for a year from 2003-2004.

In the initial years, as insurance was a new concept, the premium was heavily subsidised. In 1992, no premium was collected from the community. In 1993, AMS members were asked to repay at Rs 4 per person. In the next year, this was raised to Rs 6 per person, and in 1995 Rs 8 was collected. Thus by the year 1997, the entire annual premium amount was being paid by the adivasis. In the subsequent years, the premium amount was raised and in 2002 they paid Rs 22 per person. Thus while AAA insured the tribals en masse with a formal insurance company and paid their premiums for five years, the tribals repaid this premium on an annual basis.

Box: The Objectives of AAA Community Health Insurance Programme

1. To access health care with dignity by not depending on charity or handouts.
2. To encourage health seeking behaviour by offering comprehensive health care with minimal payment at the time of the use of services.
3. To enhance the feeling of solidarity among members of AMS.
4. To protect AMS members from catastrophic health expenditure.
5. To enhance the feeling of ownership of the health programme among members of AMS by contributing towards their own health care.
6. To provide a stable income for the Adivasi Hospital.

The premium is a community rated one and the unit of enrolment is the individual. It is usually collected once a year between December 5th (Adivasi day) and April 15th (Vishu). These dates are important on the tribal calendar and coincide with the coffee plucking season, when the demand for labour is high. While initially the AMS leaders and the ACCORD staff went from house to house to collect the premium, today a considerable part of it is collected at central collection points. An insurance card, with details of name, age, gender, village name and the unique AMS membership number, is given annually to those who repay. This card is valid for one year from April 15th to April 14th of the next year.

The money gathered at the collection centres as well as details of those insured is handed over to the hospital accountant once a month. At the end of the collection period, AAA shares the information about premium collection with the adivasi community, including villagewise details about numbers insured and the amount collected. The details of AMS members enrolled by AAA and those who have repaid annually are shown in Figure 2.

The insurers: AAA reinsures the tribals with a formal insurance company, who is the prime insurer of this scheme. From 1992 to 2002, it was the New India Assurance Company (NIAC) and in 2003, it was the Royal Sundaram Alliance Private Limited. This reinsurance mechanism increases the risk pool for the community.

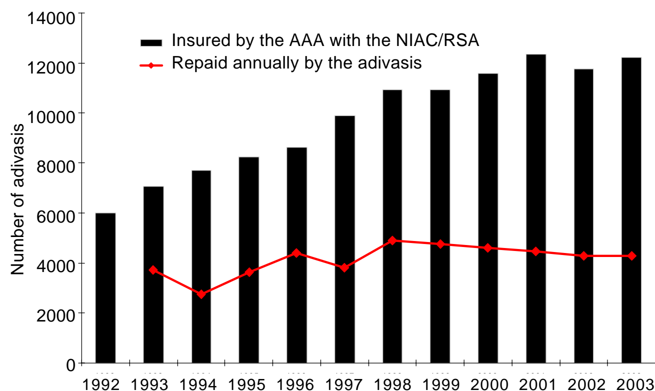
The providers: ASHWINI is the main provider of health care. As stated earlier, it has a network of health centres and a hospital. It refers patients to tertiary centres at Kozhikode or Coimbatore when necessary. ASHWINI's staff are predominantly adivasis themselves. It uses strategies like paying fixed salaries, and using essential drugs and standard treatment guidelines to keep the costs low. The average hospital bill is about Rs 750 per patient per episode of illness (2001). Less than 10 per cent of claims cross the Rs 1,500 limit. Also the adivasi management committee ensures that the care provided is acceptable to the community. While the health centres are open only for adivasi patients, the hospital admits non-tribals also. The non-tribals pay a fee for service, which is higher than the actual costs and helps cross-subsidise some of the services for the adivasis.

The benefit package: The benefit package has to be viewed at two levels. A package provided by the insurance company to AAA and another (more comprehensive) provided by AAA to the adivasis. NIAC assured only hospital care with an upper limit of Rs 1,500 per patient per year. This included most common ailments but excluded pre-existing and self-inflicted illnesses as well as diseases due to substance abuse. Deliveries and family planning operations were initially excluded. However, while renewing the policy in 1997, AAA managed to include the first two deliveries and family planning operations into the benefit package. All admissions were to be for more than 24 hours and in the ASHWINI hospital. In 2003, RSA maintained the same benefit package, but the maximum limit was reduced to Rs 1,000 per patient per year. Only psychiatric illnesses were excluded and reimbursement is through an indemnity mechanism.

In 1992, there was additional coverage for damage to hut and personal accident coverage for the head of the household. However, this was removed in 1997 as AMS felt it was not very beneficial. This further reduced the premium.

While this was the benefit package provided by the insurance companies, AAA offered a more comprehensive package to the adivasi community. For those who repaid the premium, outpatient (OP) services (including medicines and diagnostics) at the Adivasi Hospital were provided for a small co-payment of Rs 10 per visit.

Figure 2: Number of AMS Members Insured with Formal Insurance Company and Members Who Repay Annually



There were no exclusions for hospitalisation. And there were no upper limits. Also the insured patient did not have to pay anything at the time of discharge. The non-insured patient had to meet the cost of OP medicines and pay Rs 100 for every hospitalisation.

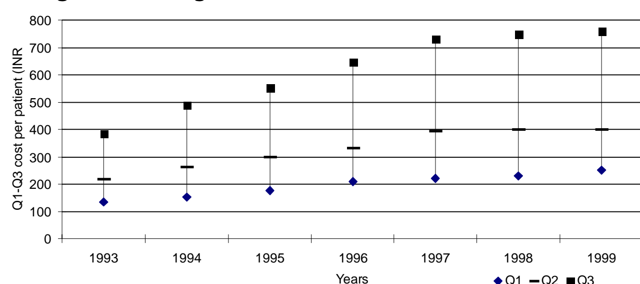
ASHWINI also provides promotive, preventive and basic curative care through its network of voluntary health workers (VHWs) and health centres. This benefit is provided to all AMS members, irrespective of their insurance status. As AAA provides comprehensive care it encourages people to live a healthy life and to seek care at the earliest when ill so that problems are addressed close to home, at the area centre or at the hospital. This cuts down morbidity and expenses. While theoretically the patient has to be referred by the health centre for admission, in reality this is not adhered to very strictly. Thus while the formal insurance company provides a hospitalisation package, AAA uses its resources to provide a more holistic cover. External resources, as well as the profits generated from non-tribal patients meet the difference in the benefit package.

Claims and reimbursements: Claims and reimbursements are simplified considerably. At the end of hospitalisation, three copies of the hospital bill are made. One copy is handed over to the patient (but the patient does not pay any amount). The second copy is kept for records and the third is forwarded by ASHWINI to the insurance company (on a monthly basis). Any hospitalisation for an excluded illness is not claimed by ASHWINI. Similarly claims are made only to a maximum of Rs 1,500. The insurance company in turn reimburses ASHWINI on a regular basis, usually after a lag time of three to six months. The reimbursement rates have been in the range of 95-100 per cent.

The administration: ACCORD, AMS and ASHWINI mainly administer the AAA CHI. ASHWINI and ACCORD field staff as well as the AMS leaders collect the premium. The field staff has other work and collecting premium is an additional responsibility that they have undertaken. The AMS leaders do the same on a voluntary basis. A system of receipts and strict accounting measures prevents fraud. The ASHWINI accountant processes the claims and submits it to the NIAC/RSA. The patient does not have to provide any documentation, except to bring along the insurance card at the time of admission. Feedback to the community is provided by ACCORD/ASHWINI every year.

Risk management: Adverse selection is kept to a minimum by encouraging the family to enrol as a unit and by having a definite collection period. Moral hazard is also minimised by a system of co-payments. Also the indirect costs of transport, food and loss of wages are a significant barrier to unnecessary hospitalisations.

Figure 3: Average Cost of Admission for Insured Patients



Paying the provider a fixed salary rather than a fee for service helps contain provider induced moral hazard. Figure 3 shows how the average cost per patient has remained steady over the years.

Cost recovery: This health insurance programme has been functioning over the past 12 years. It has mobilised revenue from both the community and donors. Table 1 shows the sources of income and expenditure in the year 1999-2000. Sixty per cent of hospitalisation costs are recovered through the insurance programme. However, this is a slight overestimate, as one also needs to factor in the outpatient and administration costs and unfortunately these figures were not available. The difference in the claims and reimbursements are mainly due to exclusions and also because 58 of the claims exceeded the Rs 1,500 limit. Donors and cross subsidy from non-tribal patients meet the deficit of Rs 2.36 lakhs.

Performance vis-à-vis Utilisation of Hospital Services

Hospitalisation was assessed from hospital records. The hospitalisation rate among those who have repaid the premium and those who have not paid the premium is shown in Figure 4. As can be seen, the insured use the hospital four times more than the non-insured. This was higher in the initial years, but has stabilised over the past years. Admission rates by distance show a gentle curve (Figure 5). There appears to be an increased utilisation of hospital services by those living in the middle distance. Table 2 shows the top five reasons for admission in both the insured and non-insured populations. The main reasons for admission in both groups are communicable diseases – respiratory and gastrointestinal infections. Deliveries and associated illnesses are another major reason for admission. And finally the admission rates by income quartiles are given in Table 3. From this table it appears that the utilisation is uniform in the three lower quartiles.

Discussion

Very few Indians are protected by any form of social security, especially health insurance, and most patients are forced to pay from their pocket to access quality care. This financial barrier lowers access to health care. Health insurance, by its pre-payment and risk pooling mechanisms, theoretically reduces the financial barriers, thereby improving access. One of the main functions of health insurance is to increase access to health care [Kutzin 1998].

Unfortunately in India, only about 10 per cent of the population (and that too, employees of the formal sector) are covered under any form of health insurance. However, voluntary organisations have been developing mechanisms to insure the poor in the informal sector against high cost health events. Currently there are more than 20 such schemes. These 'community health insurance schemes' are small ventures organised by voluntary organisations and encourage people to pre-pay for future health events. This results in risk pooling – between the healthy and the sick. While there have been various descriptive narrations about these CHIs [Ranson 2003], their performance has rarely been assessed. SEWA (in Ahmedabad) is one exception, where the effect of insurance on utilisation of health services [Ranson 2001], catastrophic health expenditure [Ranson 2002] and quality of care [Ranson et al 2003] have been studied. In these studies, the author concludes that there is not much increase in utilisation of health service due to insurance, that insurance has a protective effect against catastrophic health expenditure and that insurance does not ensure better quality of care.

In this article, we look at just one aspect of performance – utilisation of health services. There appears to be a higher utilisation of health care by those insured in the AAA CHI programme. From the data, it is clear that those who have subscribed to the insurance programme have used the hospital services much more than the non-insured. Considering the poverty of this population and the relatively high cost of hospital services, this AAA CHI seems to have overcome the financial barrier to accessing hospital care. It's effect is even seen over geographical distances. The data on admissions by distance shows that the gradient is relatively gentle, indicating that health insurance was able to overcome some of the normal effects of distance on utilisation. What is surprising is that those who access health care the most, appear to be those residing in the middle distance – within 5-35 kms. This is surprising but may be explained by the fact that people

Table 1: Cost Recovery of Community Health Insurance Programme, 1999-2000

Income	(Rs)	Expenditure	(Rs)
Premium collected from 4649 tribals @ Rs 15 per person per year.	69,735	Premium paid to the NIAC for 11585 tribals @ Rs 13 per tribal per year.	1,50,605
Reimbursement from the NIAC for 586 patients	2,76,467	Cost of treating 657 insured patients @ Rs 658 per patient.	4,32,306
Total	3,46,202	Total	5,82,911

Table 2: Admission Patterns among the Insured and Non-insured, 1999

Diagnosis	Number of Insured Admitted (Percentage of all Insured Admissions)	Number of Non-Insured Admitted (Percentage of all Non-Insured Admissions)
Acute lower respiratory infections	93 (14.6)	49 (22.9)
Deliveries	74 (11.6)	29 (13.5)
Diarrhoea + Dysentery	55 (8.6)	23 (10.8)
Injuries	37 (5.8)	14 (6.5)
Typhoid fever	33 (5.2)	3 (1.4)
TB	27 (4.3)	13 (6.5)

Table 3: Hospitalisation Rates per 1000 Adivasis by Economic Status

Economic status	Total Population*	Insured	Non-Insured
Q1	410	68.3	34.1
Q2	7460	51.3	19.6
Q3	3180	69.2	12.6
Q4	644	12.4	15.5

* *Source:* Census of India 1991.

Figure 4: Admission Rates at the ASHWINI Hospital

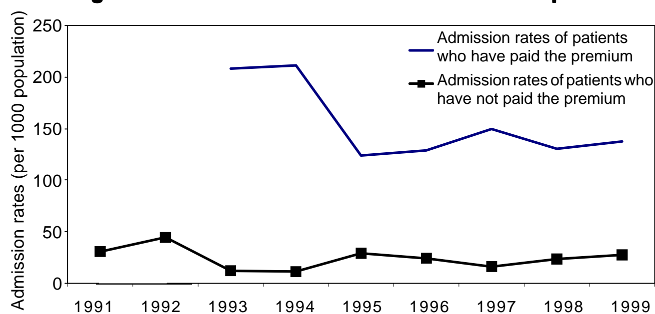
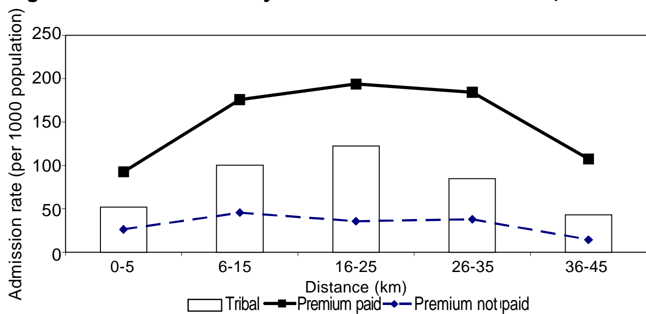


Figure 5: Admission Rates by Distance and Insurance Status, 2001-2002



who live nearby access the services early enough and so do not need hospitalisation.

The utilisation rates of health services are much higher, than those documented in India [NSSO 1998]. One explanation for this here could be adverse selection or patient induced moral hazard. Adverse selection would imply that people who have a higher probability of illness (e g, those suffering from chronic illness) insure at a higher rate as compared to others. A proxy indicator for this would be the average length of stay – which would be higher among patients with chronic illnesses than with others. However, Figure 6 clearly shows that this is not so. The insured have a lower length of stay (mean = 3.92 days) as compared to the non-insured (mean = 4.50 days). This is further reinforced by the top five reasons for admission, which indicate that both the insured and the non-insured appear to have similar illnesses. Thus adverse selection may be ruled out to a certain extent. This is understandable considering that steps have been introduced in the design to prevent adverse selection. Moral hazard by the patient may be a possibility, though the indirect costs (transport and food) are so high, that it should effectively pre-empt patients from unnecessarily seeking health care. The lower length of stay among the insured also indicates that they may be seeking health care earlier and so getting cured earlier. This would be one more argument to indicate that health insurance does improve access to health care.

While African studies have shown that CHIs have increased access to health care [Criel et al 1999, Baeza et al 2002, Atim 1998], a study from India showed that there was no such effect [Gumber and Kulkarni 2000]. This current study thus is the first to show a positive impact of CHI on utilisation of services in India. This is all the more important if one keeps in mind that the community is one of the poorest – adivasis in a remote corner of the country.

One of the other achievements of the AAA CHI has been the ability to mobilise community resources. The AAA has been able to tap into the enormous social capital that is available in the community. Volunteers have helped with time and staff have contributed by taking on extra responsibility. Sixty per cent of the hospitalisation costs of insured patients have been recovered through the insurance programme. This is a significant amount. Unfortunately, accurate figures on the outpatient and the preventive care programme were not available. This would have given a more precise idea about the exact cost and the subsidy required. This has policy implications as it can spell out the per capita subsidy required to make a CHI financially sustainable.

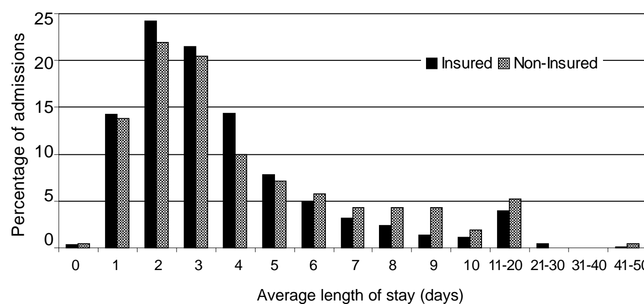
Health insurance is considered to be an equitable form of health financing. While private health insurance has the potential to increase inequities [Mahal 2002], CHI by its limited risk pooling does not enhance equity either. While there is risk pooling between the healthy and the sick, there is practically none between the rich and the poor. This is because the target population are the poor only. This can be rectified if other sections of society are enrolled into the CHI. This would of course mean catering to the needs of a more varied section of society, which has it's inherent problems. Another way to enhance equity is through reinsurance, wherein a formal insurance company amalgamates smaller and dedicated risk pools. This is what was done in the AAA CHI. The adivasi risk pool was enlarged by linking it with the NIAC's pool.

While the AAA CHI seems to have increased access to care, we describe here some of the determinants for this performance. One major determinant is that the CHI was introduced within the context of an overall development intervention. ACCORD was engaged in various development initiatives and the CHI was part of this. It was also built on the existing foundation of solidarity; the AMS had initiated a movement in which adivasis supported each other in times of need. The CHI was thus seen as an intervention where the healthy assisted the sick. And finally, the AMS was involved from the beginning in the design and implementation of the AAA CHI. So there was a sense of ownership, which helped sustain the programme over the years. In fact the CHI grew out of a felt need of the adivasi community to contribute towards hospital expenses. While other voluntary agencies or hospitals may not have this luxury, they could piggyback health insurance activities on existing group activities, e g, micro credit or the cooperatives.

The second issue was one of affordability. While the initial package was beyond the reach of this poor community, negotiations helped in making it more affordable and allowed the community to contribute regularly. This was further assisted by the initial subsidy until the community became aware of health insurance and its benefits. One worrying aspect about the adivasi subscription is that only about 40-50 per cent of the AMS members have enrolled at any point in time. And over the years, this has been reducing. Discussions with the staff and community reveal various reasons. One of the reasons stated is the steadily worsening local economy: it has resulted in a diminished cash flow. The other reason is the issue of distance. Those who reside further away from the hospital find that the indirect costs of transporting a patient to the ASHWINI hospital offsets any benefit obtained from insurance.

Yet another reason for the programme to 'succeed' was the creation of a benefit package that suited the needs of the people. While the NIAC benefit package was a typical "Mediclaim" package, AAA added further elements to it to make it more comprehensive: free outpatient care at the hospital, removal of exclusions, cashless hospitalisation and no upper limit. All of these helped make health insurance more acceptable. While

Figure 6: Average Length of Stay among Insured and Non-Insured Patients, Admissions 1999



economists may query the financial logic of having a small premium with a large benefit package, one needs to see health insurance not just from an economic point of view. Health insurance plays important health system functions also: increased access to health care and the protection of households from impoverishment at the time of illness [Kutzin 1998]. Thus for a CHI to be effective, it is imperative that the benefit package is tailored to meet the needs of the community. And ideally the providers should be acceptable to the community, in the case of the AAA CHI, the AMS managed the health programme. This plus the high quality of care provided by the programme made it very acceptable to the adivasi community.

One of the pillars of any CHI is the administration. Village volunteers, using existing community platforms, create awareness about insurance and collect the premium. The claims and reimbursements are managed with minimum documentation. However, this does not mean that the administration is lax – strict accounting and review processes ensure that fraud is practically absent. Regular feedback and transparency ensures that the individual is aware of the purpose that his/her contribution was used for.

One of the major limitations of this study is that we relied only on secondary data from the Gudalur Adivasi Hospital. This meant that we missed out on patients (especially non-insured) who sought care in other health institutions. Thus the gap in utilisation, between the insured and the non-insured, is actually smaller than portrayed here.

Conclusions

The poor in India need to be protected from high out-of-pocket expenditures on health. A well-managed pre-payment system with risk pooling is effective in removing financial barriers at the time of illness. This can increase access to care, an important step towards improving the health status of households. Community health insurance is an innovative method to extend social protection to excluded groups. However for this to happen, community health insurance needs to start on the foundation of solidarity, to have an affordable premium, an appropriate benefit package and a minimal administrative burden. Provision of health care is a major issue, and the agency needs to negotiate with the providers for measures to contain cost and maintain quality. EPW

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Note

1 Community Health Insurance 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 in which the members participate in its management" [Atim 1998].

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