Extending Social Protection in Health Through Community Based Health Organizations

Evidence and Challenges

Discussion Paper

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abbreviations :

CGAP	Consultative Group to Assist the Poor
IBRD	International Bank for Reconstruction and Development, World Bank
ILO	International Labor Organization
JHU	Johns Hopkins University
PHR	Partnerships for Health Reform
PAHO	Pan American Health Organization
STEP	Strategies and Tools against Social Exclusion and Poverty
UB	Bonn University
USAID	United States Agency for International Development
WHO	World Health Organization

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"Extending Social Protection In Health Through Community Based Health Organizations: Evidence And Challenges"

I. Introduction

Socioeconomic transformations around the world are challenging existing models of social protection in health. Although global in scope, this phenomenon is particularly pronounced in developing countries. While economic globalization has introduced new flows of capital and information sharing to many developing countries, at the same time the international economic and financial environment is more unstable than ever before. In this emerging interconnected environment, economic cycles have a broader impact than at any time in history.

Workplace stability also has been affected. Even in the industrialized regions of the world part-time work has been growing, and more people face new conditions in which the comprehensive social protection packages linked to fulltime jobs are less and less available. The effect of these trends is more dramatic in developing countries where the working age population in the formal sector has traditionally been small and traditional systems of social protection focus on formal sector workers covering a small fraction of the total population. In the past twenty years, ever-increasing proportions of the population of developing countries that work permanently in the informal sector have accelerated its growth rate. Moreover, for those who work in the formal sector new labor market trends face new unstable conditions, entering and leaving the formal sector in cycles that are more frequent than in previous decades.

One of ILO's strategic and operational objectives is to broaden the scope of effective instruments that achieve social protection by including individuals and households in the lowest income groups and in the informal sector (Social Protection Sector ILO, 2001). The recommendations of the 89th International Labor Conference provide ILO with an even more explicit mandate for mounting a global campaign to extend social protection in the world (International Labor Conference, 2001). Among all dimensions of extending social protection, health is key in protecting low income households.

Extending social protection in health requires identification of a feasible strategy and the definition of the right combination of organizational and institutional arrangements for each country. There are no cookie-cutter solutions and there cannot be universal blue prints for success in combating exclusion from social protection in health. The challenge is to focus on the need for effective strategies and organizational arrangements that prove in practice their ability to achieve the goals of social protection in health.

The ILO/STEP-Universitas framework for Extending Social Protection in Health (ILO/STEP-Universitas, 2002) emphasizes the importance of an explicit societal guarantee for access to health services (The Guaranteed Health Plan--GHP), which

particular content and characteristics should be in accordance to the country context, as a key instrument for extending social protection in health. It also calls for making a clear distinction between the objectives of inclusion in social protection in health and the possible instruments to achieve it. Under this conceptual approach, in order to develop an inclusive system of social protection in health, policy makers should consider and monitor the effectiveness of any arrangement to be implemented and/or in place, according to their capacity to achieve 3 key goals of Social Protection in Health: improving health status or at least the utilization of effective health services, in a context of financial protection and dignity for the members of the arrangement and for society at large.

The first dimension, the health status of a population, is considered not only an important component of a broader set of investments on human capital with impact at the micro and macro-economic levels (CMH, 2001), but also as a goal with uintrinsic value of its own. The second dimension, financial protection, highlights the importance of implementing financing mechanisms designed to protect individuals and households from excessive or catastrophic reductions of their consumption of goods and services other than health due to the excess contribution / expenditure in health services that could force them into poverty or maintain them in it and ultimately damage their long run capacity for creating human capital. The third dimension, referred to as dignity, is equally important and in the STEP-Universitas conceptual framework it is referred mainly to ensuring respect for human rights of families in the process of improving health, utilization of services and financial protection. Dignity is also related to respecting the legitimate expectations of a population, as reflected in their satisfaction with the system, regarding the way they are treated by the system that might or not be reflected on the other three objectives. All three dimensions should be considered when studying instruments and strategies for extending social protection in health. Problems in any one area can lead to systems that are not inclusive. A more in depth discussions of these three dimensions is presented under section "III" below.

The discussion and efforts regarding extension of social protection in health need to go beyond implementing specific arrangements and need to focus on making sure (through close monitoring and continuous evaluation) that those arrangements actually are achieving the objectives of social protection in health using any and all instruments proven effective under specific organizational and institutional contexts.

Different societies use various organizational arrangements for their systems of social protection in health. These, in turn, are usually linked to distinctive instruments for collecting the necessary financial resources, risk pooling, and purchasing health services as well as to distinctive predominant organizational and institutional incentives.

The most common organizational arrangements are:

i) Social security organizations, which can be a single national organization or several organizations (competing or non-competing). The private sector may or may not participate in

the management or ownership of these organizations. Social security organizations traditionally provide services for workers in the formal sector and either have their own networks of providers, may buy services from other providers, or both. Usually these organizations are funded via payroll taxes from workers, employers or both.

ii) Ministries of health and National Health Services, which frequently have large networks of public providers. Usually this organizational arrangement in developing countries provides services for workers in the informal sector and the poor and are funded by general taxes collected by the central and local governments.

iii) Voluntary for profit and non-for-profit insurance (usually private insurance schemes) with a formal or informal structure. Usually these organizations are financed by voluntary risk-based premiums.

iv) Community financing organizations and arrangements or informal insurance schemes organized by members of the community established by groups of individuals, by provider organizations, by NGOs, by trade unions or even by the local or central governments to organize users and/or collect additional resources. These organizations are usually predominant in settings where none of the above listed arrangements are effective or existing and are financed by different types of voluntary contributions and often by variable amounts of subsidization. Some forms of these organizations are also known as health micro-insurance or mutual health organizations.

Although the arrangements listed in "iii" above include those listed under "iv" above, Community Based arrangements have some distinctive characteristics (e.g. they are usually non commercial arrangements) that merit to keep them separately as a different instrument. Exploring these characteristics is exactly one of the objectives of this study.

Not surprisingly, countries are using the different organizational arrangements or combinations of them to attempt to extend and improve social protection in health to the excluded. Four key strategies based on the respective organizational arrangements exist for extending social protection in health. They often co-exist in developing countries:

i) Innovations in Extending Social Security arrangements in health to reach the excluded and the poor. This strategy includes reforms and initiatives to allow and or incentive the informal workers to join and

participate in an arrangement that has traditionally have been focused on the formal workers sector;

ii) Improving the effectiveness and efficiency of inclusion via Ministry of Health / National Health Service schemes (including public subsidy, regulation and provision policies);

iii) Facilitating and regulating Private health insurance entrance in the health insurance system, including channeling public subsidies through them; and

iv) Facilitating Community based health organizations (including micro-health-insurance).

Views differ in terms of which strategy should be prioritized in different country settings at different moments in time. The answer to this question depends on the historical, cultural, economic, and political tradition and reality in each country. The articulation of all these four strategies so they coexist and contribute with synergism to the main goal extending of social protection in health can also be consider as a fifth strategy which, as suggested in the conclusion of this paper, might potentially be more effective than choosing only one of them, particularly in the case of CBHOs and their potential as Entry-Points for other organizational arrangements.

This study searches for the evidence on the effectiveness of a particular organizational arrangement, Community Based Health Organizations (CBHOs), on achieving a positive impact on any of these dimensions for their members and society at large. In the next section, we describe the methodology of our analysis, the data collection, and the way in which we operationalized the conceptual framework for the analysis of community health organizations.

The study focus on CBHOs because of its increasing prevalence and emergence particularly in low-income developing countries. People are participating in these schemes and it is imperative for policymaking purposes to better understand them and explore their potential effectiveness as organizational arrangements for extending social protection in health. Recognizing this, the **89th International Labor Conference** (ILO, 2001) indicated the need for a rigorous evaluation of these schemes. This study aims to be one contribution to that effort.

CBHOs have also triggered an important policy debate in international health. During the last five years these schemes have increasingly been suggested among the set of possible mechanisms that are available to governments for expanding social protection in health (CMH, 2001; WHO 1998; ILO/STEP, 2001; ILO-PAHO Initiative, 1999).

In order to carry out ILO's strategic objective of supporting initiatives that "enhance the coverage and effectiveness of social protection for all" in the health sector, we need to objectively assess the actual potentialities and limits of community based health organizations for extending social protection in health to the informal sector and the poor. This document is a step in that direction and will be followed by a long-term field evaluation of CBHOs using primary data collection. We also need to do similar exercises

to better evaluate the effectiveness of the other 3 above listed organizational arrangements in achieving the goals of social protection in health. ILO research agenda in social protection in health also contemplates this effort.

The methodology section below describes the analytical approach to examine CBHOs, the data collection and the way in which this study operationalized the conceptual framework (ILO/STEP-Universitas, 2002) for the analysis of community health organizations.

II. Background and Research Questions

During the past ten years, interest in CBHOs as instruments for extending social protection in health in developing countries has grown significantly. Although these types of organizations have existed long before the 1990s, it was during that decade that documented experiences became more widely discussed and the literature started to accumulate.

Despite the interest displayed by different organizations (International bilateral and multilateral, donors, foundations, NGOs, trade unions and communities), it is not clear specifically how CBHOs actually contribute to achieving the goals of extension of social protection in health, particularly for people in the informal sector, the poor and society at large. As shown in the result section, a large body of descriptive articles and papers focus on functioning and sustainability characteristics of community based health organizations. Although it is clear that people are joining and using CBHOs and much anecdotal evidence exists on that, very few data-oriented studies have been conducted on the benefits for health organization members and society at large.

One of the first and most difficult problems in conducting a systematic study and review of CBHOs is the categorization of these types of arrangements and programs. Many labels have been used to describe a broad range of schemes and arrangements that resist easy classification. This has led to a situation in which authors create ad hoc categorizations for the schemes they study. Although in the current debate it would appear as if a general understanding exists about the types of programs included under different labels, a consensus has not yet emerged on how to categorize this extremely diverse range of schemes. Some labels used in the past (and sometimes considered equivalents) are micro-insurance, community health finance organizations, mutual health insurance schemes, pre-payment insurance organizations, self-generated financing, voluntary health insurance, mutual health associations, community based health insurance, and community self-financing. Considering the large range of actions and objectives we found analyzing the evidence on these schemes, the paper refers to them generically as Community Based Health organizations. As shown later in the results section, CBHOs are not only about financing and are not exclusively owned or managed by communities.

Since the second half of the 1990s, literature reviews and analytical studies with international comparisons have become more frequent, and articles providing general comparisons of larger number cases have been published (ILO-PAHO, 1999; ILO/STEP-PHR 1998; ILO-STEP 2000; WHO, 1998; CHM, 2001). The published papers and reports that include analysis of some aspects of social protection in health do not include all dimensions of the ILO/STEP-Universitas framework for social protection in health (ILO/STEP-Universitas, 2001). They tend to be focused on description and financial sustainability of the schemes and, in a few cases, on impact on service utilization by members of the scheme.

Furthermore, we lack reviews with hard data due to the scarcity of information on the actual impact on the extension of social protection in health. After obtaining such data and proving the effectiveness of these schemes, it will be necessary to evaluate their cost-effectiveness as an effective strategy at a national level.

The key issue in evaluating CBHOs as an instrument for extending social protection in health, is to evaluate the impact of these schemes on achieving the goals of social protection in health, this is, how effective are they in improving the health status or at least the utilization of effective and needed services in a context that also ensures (an ideally improves) financial protection and dignity particularly for the poor. In this context, the challenges are multiple: a) operationally defining the dependent variables (health status, utilization of services, financial protection and dignity of the members of the household and society at large in their contact with the health system); b) operationally defining the possible independent variables, those that can influence the success or failure of CBHOs; c) measuring these variables in all relevant sub-population groups so we can estimate the impact of CBHOs not only on members but also in society at large, particularly the poor; d) collecting all the data for dependant and independent variables as well as variables to control for such as health risk (at least a proxy of it such sex and age), income, others. The challenge of measuring the variables not only for members and non-members but to distinguish among different sub-populations is key.

The challenge in evaluating the impact of CBHOs is not only about the impact of such schemes on its members but also evaluating it on the impact on society at large. There is a need to examine not only how any strategy (in this case CBHOs) benefit their members but also that in doing so it does so harming non-members, particularly the poor. For example, if a specific strategy is capable to allow its members to better leverage public resources to be targeted to them, it could mean that those resources might be targeted away from other groups. It would be certainly useful that this means better targeting of resources to the poor but, it would be worrisome if those other groups from which the resources are diverted are indeed the poor. So, the evaluation of CBHOs is not an evaluation only of the impact on its members but on society at large and particularly on the poor. Unfortunately, as shown in the result section, not only data based evaluation is scarce but the existing evaluations tend to focus on the effects of the schemes on their members rather than on society at large.

This document aims to contribute to the process of evaluating the effectiveness of CBHOs as a useful strategy for extending social protection in health. The study attempts to systematically review the published literature of the past ten years within the framework of the goals of social protection in health, with a focus on descriptive and empirical analysis of specific cases from developing countries. The study attempts to begin to address the following three research questions:

1. What is the existing evidence regarding the effectiveness of community based health organizations in achieving the goals of extension of social protection in health for its members and for society at large?
2. What evidence is available regarding the determinants (technical, organizational or institutional) of good performance of CBHOs for their members, the poor and society at large? What are community based health organization?. In order to identify if a sub-group of CBHOs is more effective than other (identifying the relevant independent variables), it is important to clarify whether community based health organizations are homogeneous types of schemes, or whether they comprise a group of different technical, organizational and institutional arrangements.
3. What is the evidence on who benefits from CBHOs? Are CBHOs effective instruments for extending social protection in health to the poor?

III. Conceptual framework and methodology

A. Conceptual Framework

As mentioned in the previous section, in order to design the methodological approach, this study uses the ILO/STEP-Universitas conceptual framework for the analysis of instruments for the extension of social protection in health (ILO/STEP-Universitas, 2002). We will summarize some of the most important features of this framework used for the analysis of the cases studied and will refer to the reader to the original document "Extension of Social Protection in Health: Conceptual Framework and Overview of Alternative Arrangements" (ILO/STEP-Universitas, 2002).

The framework proposes that effectiveness of a strategy and organizational arrangement in extending social protection in health occurs when workers and their families:

- Maintain or improve their health status or at least improve the utilization, in a timely manner, of needed and effective health care services and public health interventions in quantities and quality defined as adequate through social dialog;

- Do not contribute an excessive proportion of their income to finance their participation in the health system providing the interventions in the above defined conditions, this is, they are financially protected; and

- Have their dignity, as also defined through a process of social dialogue at national level, respected at all time within this process.

1. Dependent variables: Health Status, Utilization, Financial Protection and Dignity

The study addresses research question No1. (Evidence on Impact) through examining the existing evidence of impact of CBHOs on health status, utilization, financial protection, and dignity. The study then searches for evidence that CBHOs improve any of these dimensions. Consequently, these 3 objectives of social protection in health determine the 4 dependent variables the study looks at: health status, utilization of services, financial protection of household and dignity of household members.

Although, a final goal of social protection in health is to improve the health status of its participants, the study (as the framework) recognizes the difficulties in measuring and evaluating that dimension and therefore it also includes analysis on achieving utilization of appropriate and timely services rather than on achieving improved health status. Utilization of health services is the dimension most familiar to those working in public health or health care. Adequate utilization can be thought of as the use of an appropriate quantity of needed quality services provided in a timely manner to an individual or family during a certain period of time. Theoretically, in order to evaluate the utilization of health services as a goal of social protection in health, information on the quantity, timing and quality of all services would be required.

The concept of utilization, as used in this study and its conceptual framework, ultimately refers to guaranteeing effective and needed health services for the promotion of health, prevention and treatment of illnesses, and rehabilitation of good health. The study, therefore, include searching for evidence on the impact of CBHOs in improving health services utilization by their members, the poor and society at large.

The analysis for utilization as well as for the other dimensions of inclusion in social protection in health needs not only to be focus on demonstrating benefits for its members but also that such benefits are not derived from harm to non members particularly the poor. This necessarily brings the question of who benefits from a particular strategy as key in the evaluation of CBHOs or any organizational arrangement for public policy for extending social protection in health. Even if positive impact on members is demonstrated, the evaluation for public policy purposes needs to be focused on society at large an particularly the poor. If the very poor do not participate in the schemes, it is important to take into consideration changes in other alternative services available to the poor as a consequence of CBHOs. If CBHOs concentrate financial resources from public or private funds to non poor population and reduces manpower, services or financial resources available to the poorest groups, then we cannot deem these arrangements or any that causes such effect as effective mechanisms to extend social protection to the poor. The evaluation of CBHOs therefore should not be focused on accomplishing benefits for members only but also on the effects on society at large and particularly on the poor.

Financial protection means that the household (or individual if the analysis is done at that level) does not contributes or expends directly or indirectly (e.g. cost of transportation) more than an acceptable proportion of its total income in order to gain access to adequate health service and/or to finance the system of social protection in health (ILO/STEP, 2001). Such a proportion of household income should not lead to a family's impoverishment or keeping a poor household in poverty. Aside from ethical considerations at the basis of a system of financial solidarity, there is empirical evidence that high costs can be a barrier to access and may have significant opportunity cost for other inputs to the welfare function of the household resulting in damage of its capacity for human capital formation. In the ILO/STEP-Universitas framework, also in a agreement with the WHO proposals on health system performance, household contribution is defined as the total amount of direct and indirect expenditures spent in order to finance the system and utilize health services and goods. This includes general taxes allocated to the health system; contributions to social security, voluntary health insurances, or community health insurance; and direct expenditures such as co-payments and other out-of-pocket expenditures. Finally, household total income is defined as the sum of the incomes of all household members.

Ideally, the contribution or expenditure level should not force a household to reduce consumption of other goods so as to damage the household's capacity for human capital accumulation. An excessive level of household health expenditures can result from the cost of treating acute or chronic health conditions but, it can also result from the financial burden of contributing to a risk pooling scheme. In this regard, it is not only excess out-of-pocket expenditures we should be concerned about, although certainly it has the most significant negative consequences on both utilization of services and disposable income for other inputs to human capital creation in the household.

This definition of excessive contributions requires us to understand the actual impact of health expenditures on household consumption in general. It also requires understanding its impact on the reduction of other goods and services that affect human capital accumulation. Some evidence exists of the impact of health shocks on household consumption (Gertler and Gruber, 2001). However, no evidence exists on the short- and long-term impacts of health shocks on the reduction of consumption of other goods and services and their negative impact on human capital creation and accumulation at the household level. Further research is needed in order to develop a rational approach to operationalize the definition of financial protection and public subsidy policies in health linking it to evidence of health shock effects on consumption and human capital of the family.

In the meantime, some preliminary approaches to defining financial protection are being used. One very preliminary method is the use of specific and arbitrary limits on health expenditures for the lowest income quintiles. This method sets excessive expenditure / contribution at the level of a certain proportion of total household income equivalent to the cost of a standardized package of services (ILO/STEP-LAC, 2001), ideally, the Guaranteed Health Package for that country or population. Although this approach is compatible with the frequently scarce information available on household income and

expenditures, it is insufficient in capturing the impact on human capital creation and accumulation. Another approach is defining a limit on health expenditures as a proportion of disposable income available to the household after subtracting household expenditures for the consumption of other goods and services. This method follows from a recent WHO methodological exercise regarding financial protection, which defines disposable income as total income minus expenditures for eligible food consumption (Knaul et al., 2001). Lastly, the one proposed theoretical approach the study will use when searching for evidence of contribution of CBHOs to financial protection is to define excessive health expenditures as the level of expenditures that would reduce other household consumption to a level of consumption corresponding to households below the poverty line (ILO/STEP-LAC and IADB, 2001).

The third dimension inherent in the goals of social protection in health is related to respecting the "Dignity" of workers and their families in the process of seeking and obtaining health services and ensuring financial protection. It is crucial to ensure that the way in which health services are obtained and in which financial protection is ensured do not violate the dignity of workers and their families. Of the three goals of inclusion in social protection in health care, "Dignity" remains the least developed conceptually. This is reflected not only in the ILO/STEP-Universitas framework, but also, in the debate on the evaluation of the performance of a health system in general. Research is currently underway within the ILO research agenda to develop a conceptual and practical definition of what constitutes dignity within country-based systems of social protection in health. In this study, as our analytical framework does, the specific operational definition of "Dignity" in the context of social protection in health, subject to the relevant human rights international conventions, should be done strictly at country level, including assessment of satisfaction of the legitimate expectations of workers and their family with the system. Therefore, this study looks under Dignity first to any evidence as stated in the studies that human rights are protected or improved by CBHOs. Additionally, and only with the objective of getting the most comprehensive understanding possible of the benefits for users and population at large, the study searched also for any benefit, not captured by health status or utilization or financial protection, reported by the studies.

As the study shows latter, in practice, the lack of evidence on the Dignity dimension found in the sample of documents and publications examined, confines the findings only to "other benefits", this is, the study was not able to find evidence on human rights.

2. Independent Variables: Technical Content, Organizational and Institutional incentives

There are many possible causes of failure of organizational arrangements in social protection in health to achieve inclusion (achieving the 3 goals of social protection in health) as defined in the conceptual framework and this study. The study examine them here briefly as they are the possible determinants of success for CBHOs and the study looked for information and evidence on them in hope that it would be able to correlate

them with the impact of CBHOs on health status, utilization, financial protection and dignity.

Table 1 and 2, summarize the characteristics of possible determinants of CBHOs performance.

Table 1: Some Characteristics and potential determinants of performance of CBHOs

Characteristics of the scheme benefit package (SBP)	If benefits are explicit and well defined and/or if there is enforcement of it (under-coverage) How much congruity there is between the type of intervention included in the benefit package and the financing and/or health care delivering mechanisms defined for its implementation
Characteristics of Supply	Characteristics of the main provider available to CBHO
Characteristics of Financial and Purchasing Arrangements	Pre-payment level Characteristics of pooling, determining cross-subsidization from low-risk individuals to high-risk individuals (risk pooling) Characteristics of pooling with cross-subsidization from high-income groups to lower income-groups (equity subsidy) relationship between the purchaser and the provider (strategic purchasing)
Characteristics of Organizational and Institutional Context	The organizational and Institutional incentives and their compatibility with the collecting, Pooling and purchasing arrangements in place

The study divides all these possible causes in two possible key characteristics of CBHOs that could determine its performance as instruments to extend social protection in health: a) Technical design characteristics; and b) Organizational and Institutional incentives. This approach is also complementary to that of other authors in the field of health systems (Preker & Harding, IBRD 1999; WHO, WHR 2000; ILO/STEP 2001).

Technical content characteristics in this study include the characteristics of the benefit package and the financing and purchasing arrangements discussed more extensively latter in the study. Organizational and Institutional characteristics include all characteristics of the organization in its own and of the context in which it operates such as: degree of autonomy, accountability of the organization, market exposure, unfounded mandates; governance, ownership, state stewardship context, type of main source of provision, rules for public funding utilization and other.

As indicated before, the study looked at these characteristics for two reasons: a) The expectation that having sufficient evidence on dependant variables would allow for studying CBHOs characteristics (independent variable) as potential determinants of good

performance; and b) to examine how homogeneous or diverse are CBHOs, and distinguish among different CBHOs arrangements.

a) Technical Content

Characteristics of the Scheme Benefits Package (SBP)

As discussed in the ILO/STEP-Universitas framework, the absence of an explicit benefits package or its poor definition can contribute to lack of social protection in health. There are various problems related to a lack of clarity when a SBP has been poorly defined. One potential problem caused by a lack of an explicit SBP is that it is impossible for the members to actually know what they are entitled and to demand the compliance with it by their respective organizational arrangement. Unfortunately, although access to healthcare is often granted as a citizen right even at constitutional level, this is frequently the case in many developing countries and among all types of health systems whether the system is a National Health Service, private insurance system, or community-based health organizations.

The lack of clarity of a SBP may also exclude basic services of proven effectiveness that families need or include such services only under very restrictive conditions (henceforth, called "under-coverage"). A SBP may also encourage perverse incentives for users and providers due to a lack of congruence between the characteristics of specific health services included in the SBP and the organizational arrangements available for its provision and financing (ILO-STEP, 2001). This problem will from now be called "incongruity between services and organization" or simply, "incongruity."

The lack of coverage of appropriate health services can result as a consequence of any of the previously mentioned problems of a SBP. Understanding the incongruity between health services and organizational arrangements for its provision and financing is key to understanding the incentives for the actors to under-cover services.

Characteristics of supply

There are various reasons underlying a poor supply of health services. They include: 1) a total absence of providers for the services included in the SBP; 2) lack of supply due to the "non-eligibility" of providers available to users; 3) lack of supply due to providers who are "eligible" but inefficient or of low quality; and 4) lack of supply due to existence of providers that are "eligible" and efficient and good quality but that discriminate against certain groups of the population.

Characteristics of the Financing and purchasing arrangements

Financing and purchasing arrangements affect utilization and financial protection by members of any social protection in health system. The key characteristics in the financing and purchasing arrangements potentially affecting performance of CBHOs are:

- Financing definitions in the SBP: Definition of the financing aspects of the SBP such as co-payment, cap on total coverage and deductible levels, if any;

- Pooling Characteristics: Risk pooling mechanisms available or chosen. This includes the absence of pooling or the absence or insufficiency of cross-subsidies between low- and high-risk groups, problems all present when no pre-payment exist or the pool size is very small and/or is restricted to high risk or low-income participants. It also includes the existence or not of cross-subsidies from high to low income (equity-subsidy);

- Purchasing Characteristics: Does strategic purchasing exist?. Barriers to access or discrimination by providers due to perverse incentives resulting from a flawed purchaser-provider relationship, but also from an imperfect incentive framework for providers (including payment mechanisms, regulation and management).

b) Organizational and Institutional Context

So far the above-analyzed CBHOs characteristics are restricted to the technical content that might determine performance. A good technical content, however, does not ensure good performance. Policymakers soon learn that non-technical design determinants often become a major obstacle in the implementation of inclusion strategies.

In the absence of a proper organizational and institutional environment, the ideal technical content recommendations might not only be ineffective but may also have a negative impact on combating exclusion from social protection in health in developing countries. Policies that promote an inclusive system of social protection need not only consider the best possible technical content, they must also evaluate it according to the organizational and institutional characteristics of the settings in which such designs will be implemented and simultaneously introduce the required organizational and institutional changes.

A key element for achieving the maximum potential of adequate technical content is an adequate incentives framework for the social protection organization. External (institutional) and internal (organizational) incentives must be in line with the technical content chosen so that all actors involved will have clear incentives to effectively promote the ultimate goal of inclusion for their members and the system overall will also ensure inclusion of all members of society. Main internal and external incentives of potential key importance in this respect are:

- *Degree of autonomy* given to the organization, this is, how much is the organization entitle to make decisions on key financial and administrative decisions without previous consultations with owner or others;

- To whom the organization is *Accountable* (to the Government?, to the owners?, to the community?);

- The level of *Market exposure* of the organization, this is, what proportion of its total revenues come from users choosing the organization and how much comes from fix subsidies*;*

- The *Financial responsibility* of its top management, this is, is top management of the organization held responsible for its financial performance;

- The proportion of *Unfunded mandate*s given to the organization by society (which has explicit or implicit rules or expectations including regulation, customs or other), this is, goals that society expects from the organization but does not finance them or does not allow the organization to charge for them;

- *Ownership* and the rules and practices related to the *governance and management* of the organizations*;*

- Rules and practices related to use of *public financing* for public policy objectives;

- Rules and practices related to the role of *stewardship*, this is, rules that shape the relationship between the state (usually through the government) and the organization; and

- The characteristics of the *main source of provision of health services*, in this case, public or private and ambulatory or inpatient.

From the above-described internal and external incentives, it is clear that optimal technical designs (prepayment, risk pooling, equity subsidy and strategic purchasing) might work differently in organizations subject to radically different organizational and institutional incentives. For example, the incentives influencing strategic purchasing are significantly different for Ministries of Health than for voluntary private insurance schemes when public hospitals are their main providers of services.

Table 2 lists all CBHO characteristics (independent variables) searched for by the study:

Table 2

Characteristics and Possible Determinants of Effectiveness

- **Technical Content**
  - Level of Pre-payment
  - Pooling Characteristics
  - Strategic Purchasing
  - Benefit Package characteristics
- **Internal (Organizational) and External (Institutional) Incentives**
  - Autonomy
  - Accountability
  - Market Exposure
  - Financial Responsibility
  - Unfunded Mandates
  - Ownership and Governance
  - Public Funding implementation rules
  - Stewardship
  - Characteristics of main source of provision

B. Methodology

In the first stage of the research the study included in the sample frame all schemes that were not nation-wide arrangements and that were designed to expand social protection in health in a developing country at a regional or local level. The organizations studied included mandatory and non-mandatory schemes with and without community participation. However as a result of the preliminary analysis we concluded that focusing on voluntary schemes that required contributions from members or their communities (either as pre-payment or co-payments, in cash or in kind) allowed us to carry out more meaningful inter-scheme and international comparisons focused on what is traditionally known as community financing – community schemes.

The final sample frame of the study was composed by documents containing descriptions or analysis of schemes identified by the respective author as "community schemes", and/or that included non-mandatory (voluntary) contributions from their members or their community as key features of their technical design. Descriptive and, if available, analytical data relevant to our research questions on these schemes were collected from reports, articles, papers, presentations and books published in the past fifteen years that contained any descriptive or analytical information on these types of schemes. State mandated contributions were not included.

The study drew on several physical and electronic databases of academic, development and multilateral agencies. Additionally we also requested that several organizations and individuals active in this field identify documents relevant for the study (see Annex D for

a list of individuals contacted). For the research of documents in electronic catalogues, archives and databases, we used several categories and combinations of keywords for our search. Documents collected were restricted to no earlier than 1986.

Where the documents contained information that was repeated in other, already published documents, we kept the reference and used any document that contributed new descriptive or analytical information useful for the analysis. Finally, we must point out that the data search was limited by deadlines necessary for the timely publication of this document; therefore it includes documents available only until October 2001. Table 3 summarizes the regional composition of the sample case analyzed. Annex B contains a detailed list of all cases (258) for which information was collected and analyzed in the study out of 127 documents reviewed by the study team.

Table 3: CBHO Cases

Total Cases: 258	Total Studies: 127

	Number of Cases	% from total
Africa	133	52%
Asia	91	35%
LAC	32	12%
South Pacific	2	1%

The information of each case collected from the reviewed documents was discussed by the study writing team for each case and abstracted onto a coding matrix. Data from this matrix was summarized in a set of tables that will be presented in the next section organized around the three research questions listed above. In this matrix each part of the data was entered into a series of columns (variables) and each row represents the information available for the CBHO case analyzed. The set of the variables used in the analysis is described in this section.

The variables were organized according to two main categories: technical content and organizational and institutional incentives.

In order to identify and collect the data for the relevant independent variables for our analysis and categorize the different types of schemes and programs we used proxies to

the various components of the technical content, organizational and institutional incentives of each case on which we had any information. In this section we include a list of all the variables that were considered for the analysis.

1. Dependent Variables

Regarding research question No. 1 of the study (evidence on impact of CBHOs), all cases were analyzed based on the available documentation of the effects of CBHOs on health status, utilization of health services, financial protection of the household and any other reported benefits for the members and the population at large. Specifically the following four questions were applied to the cases:

1. Is there any reported evaluation on any of the three goals or on any "other benefit"?
2. If yes, does the author(s)/evaluation reports any improvement in any of the goals or does it report any other benefits?
3. If yes, does the evaluation present a reasonable methodological approach and has it reasonable internal validity for each of the reported benefits, according to the author's own conceptual framework and definitions?
4. Is the evaluation valid in the context of the ILO/STEP-Universitas framework definitions used for this study?

Health status: The study searched for any information on evidence of improvement on the health status of the members and/or population at large as reported by the authors/evaluation. No restriction on health status was imposed, this is, any indicator of mortality or morbidity reported is included in the analysis. This dimension of the benefits of any organizational arrangement of social protection in health is often difficult to assess since the health status of a population changes over long periods of time and frequently there are other variables outside the health system that affect its outcome and require complex research designs and analysis to control for them.

Utilization: The study searched for any evidence reported by the authors / evaluation that any kind of utilization of services was improved for members or population at large as a result of CBHO (s) evaluated.

Impact on financial protection of individuals and households of the target population and population at large: The study searched for any information that could yield evidence of effect of CBHO(s) on financial protection. When validating financial protection in relationship to the ILO/STEP-Universitas framework, the study did not consider the level of out-of-pocket expenditures as a comprehensive enough measure of financial protection because the study conceptual approach focuses on total health expenditures as a true measure of financial protection.

Impact on the "dignity" dimension of social protection: The study initially searched for two aspects included under dignity: a) Any evidence that human rights conditions of

members and/or society at large was improved by CBHOs; and b) Any benefit, other than improving health status, utilization of services or financial protection, as defined by the authors or the CBHOs it self was rendered to the members and/or the population at large. As shown later in the study, at the end, the study focused in general on "any additional benefits" as there was no specific enough information on the contribution of CBHOs to human rights. Having in mind the need to better develop the Dignity dimension and that the ILO/STEP-Universitas framework determines that the definition of dignity is strictly a prerogative of the national level, except for human rights, exploring "any other benefits" is a useful first approach for understanding possible national and sub national contributions to the Dignity dimension for future analysis.

For inclusion in the study data matrix, in each of the four main impact dimensions (health status, utilization, financial protection other benefits), for data collection and conclusions, we asked in each CBHO case:

- Did the author/document reviewed/studied this variable? This binary categorical variable (yes/no) addresses whether the author sets out to investigate this variable as part of the analysis.
- What were the conclusions regarding the impact of the CBHO on each of the four dimensions of social protection in health (being the fourth one the "all other benefits" variable).
- Do the analysis and conclusions have internal validity? This categorical binary variable (yes/no) answers the question of whether the analysis used a scientifically consistent methodology to measure, as defined by the respective author(s), what it intended to measure regarding each of the dimensions of social protection in health or additional benefits.
- Do the analysis and conclusions meet the criteria of the ILO/STEP-Universitas conceptual framework? This categorical binary variable responds to the question of whether the definitions used by the author/s (particularly financial protection) meet the criteria described in the previously mentioned conceptual framework, this is, that is focused on overall payments / contributions of the household.

2. Independent Variables

Regarding research question No. 2 of the study (characteristics of CBHOs as potential determinants for performance), all cases were analyzed based on the available documentation of the characteristics of CBHOs. The characteristics searched for were:

Technical Design

Characteristics of the Scheme Benefit Package (SBP)

- Outpatient services: This variable collects information on whether the scheme offers or not any type of outpatient services. All types of outpatient services were considered from basic primary health care to specialized outpatient services.

However, it does not include preventive services if it is the only type of services offered by the scheme as outpatient services. SBP containing only preventive public health services are reported as a separate kind of package in the results section.

- Inpatient services: This variable collects information on whether the scheme offers any type of inpatient services. It includes inpatient obstetric services and deliveries.

- Medications: This variable collects information on whether the scheme covers any type of prescription drugs including generic and brand drugs.

- Other services: This variable refers to laboratory and other diagnostic tests. It does not include vaccination (which would be included under outpatient services).

- Summary Benefit Package Characteristics: For purposes of our analysis we constructed a variable which summarizes the characteristics of the benefit package: Type of package which is a binary categorical variable:

  - ✓ Comprehensive: It includes all of the following services: outpatient and inpatient services and Pharmaceutical and may be other services.
  - ✓ Non-Comprehensive: Is a benefit package that includes any out-patient services, prescription drugs or other benefits but does not include inpatient services.
  - ✓ If it included preventive services exclusively without any other of the mentioned services, it is then reported as a separate kind of package.

- Co-payments: Binary categorical variable (yes/no) refers to whether the scheme (the definition of the SBP) uses (includes) co-payment mechanisms to collect funds. It does not exclude the possibility of concurrent pre-payment.

Financial and Purchasing Arrangements:

- Pre-payment: Binary categorical variable (yes/no) that classifies the cases reviewed according to whether the scheme collected contributions using a pre-payment mechanism or not.

- Does the CBHO bear the financial risk?: This binary categorical variable (yes/no) looks at whether the scheme bears more than 50% of the financial risk or not.

- Who bears the financial risk?: This categorical variable looks at what organization bears more than 50% of the financial risk of the scheme. Possible organizations were: CBHO, Government at national or sub-national level, private sector for profit, non-community NGO, other.

- Equity Subsidy: This binary categorical variable (yes/no) refers to explicit information on whether the scheme has or not any mechanisms built into the technical design of its contribution collection systems for cross-subsidization from higher to lower income groups.

- Strategic purchasing: This binary categorical variable (yes/no) refers to whether there is any evidence that scheme is able to decide by itself what services to purchase, from whom and how to contract for the purchasing and payment of these services.

- Number of Members: Categorical variable that classifies the schemes according the number of their members.

- Number of Households: Categorical variable that classifies the schemes according the number of the households less frequently reported but also used as a proxy for the size of the scheme.

- Type of population covered: The percentage of the population covered by the CBHO that is not covered by any formal system of social protection in health and/or is under the poverty line. This variable lumps together these two categories of the population given the limitations of the data available.

Organizational and Institutional Incentives

Market exposure and sources of financing.

When information was available on total recurrent costs of the scheme and data on the breakdown by sources of financing, the data was coded according the following categories:

- Market Exposure: This binary categorical variable (yes/no) refers to the question of whether more than 50% of its total revenues and total estimated cost of the SBP are collected directly from its members and/or their communities. When such information was absent but the whole benefits package offered (explicit and/or implicit) was clear enough, an expert's judgment by the authors was done on what proportion the revenues from participants would be out of total cost of the whole package offered. When perceived as close to the 50% it was categorized as "yes".
- Community Financing: There are contributions by the members of the scheme.
- Public Funding: There are public sources of funding including social security organizations, central and/or local governments.
- Private Funding: There are NGOs, national and/or international donors funding.

Accountability:

- Accountability: This categorical variable classifies the cases reviewed according to whom or to what organization are the schemes ultimately accountable. If such information was directly available in the documents reviewed it was entered as the name of the organization to which the scheme was ultimately accountable. In other cases when the information was not explicit in the document the study searched for indirect evidence through existence of any information on who reviews the auditing and balances, who evaluate CBHO or management performance and other similar information. Existence of accountability was defined as existence of any mechanisms of this sort.

Financial Responsibility:

- Financial responsibility: This binary categorical variable classifies the cases reviewed according to whether the management of the arrangement is held responsible for the financial performance of the organization or not.

Unfunded Mandates:

- Unfunded Mandates: Information on whether the CBHO was held responsible for the provision of some publicly mandated services for which no extra fund allocation was made (subsidy) or for which the CBHO is not allowed or not expected to charge.

Ownership

- Legal Ownership: Explicit information on who is the legal owner.

- "De Facto" Ownership: The study defines de facto ownership as convincing evidence that someone other than the management of the scheme (otherwise it would be captured by analyzing autonomy as described below) is entitled, although not necessarily exercising it, to exercise any of 3 key decision rights: a) Defining the content of the benefit package; b) defining the contribution level and collecting mechanisms; and c) allocation of financial resources besides the provider payment mechanism. The study considers de facto ownership when there is evidence that the community exercises at least one of these three decision rights even if there is no evidence of legal ownership by community. The study examined:

- Setting the Benefit Package (or Scope of Benefits): Whether the community is entitled to define, at least once at any point in time in the existence of the scheme, what benefits should be covered or not;

- Setting the Level of premiums: Whether the community is entitled to define, at least once at any point in time in the existence of the scheme, the maximum and minimum level of premiums to be charged for the scheme; and

- Whether the community participated, at least once at any point in time in the existence of the scheme, on the decisions regarding the allocation of financial resources within the scheme, other than the defined provider payment mechanism, at any point in time.

Governance

- Governance: This binary categorical variable (yes/no) responds to the question of whether there is analysis in the reviewed study/CBHOs of explicit or implicit rules and costumes that regulate the relationship between the owners and the management of the scheme. In case explicit rules where analyzed, the data matrix summarized those rules.

Rules on Public Funding

- Public Funding regulation: This binary categorical variable (yes/no) responds to the question of whether there is analysis in the reviewed study/CBHOs on explicit or implicit rules and costumes that regulate the use of public funds by the scheme.

- Stewardship: This binary categorical variable (yes/no) responds to the question of whether there is analysis in the reviewed study/CBHOs explicit or implicit rules and costumes that regulate the relationship between the government and the scheme. It must be differentiated from an explicit or implicit contractual relationship with public providers, which is, captured under strategic purchasing and from autonomy which is collected in decision rights and community participation. In case explicit rules where analyzed, the data matrix summarized those rules.

IV. Results

A. Availability of Information

The search resulted in 127 documents reviewed that contained information on a total of 258 schemes.

A main finding is the lack of hard data and analytical work on CBHOs. Out of the 127 documents, only 38% were published in Journals or Scientific publications with editorial or review committees. Of the 127 for the 258 schemes, none attempted to evaluate the impact on the health status of its members, only 24 (9%) attempted to analyze the impact on utilization of services, only 9 (3%) attempted to analyze the impact on any aspect of financial protection of the household and only 11 analyze and report any additional benefits.

Regarding characteristics of the schemes and potential determinants of performance, most information in most of the existing literature and analysis is focused on the technical design characteristics of the schemes, mainly on level of pre-payment, contained in 92% of the analysis of cases, and on characteristics of the benefit package (81% of all cases analyzed). Table 4 summarizes the findings regarding available data on characteristics of CBHOs.

Table 4

Characteristics of CBHOs: Information Available for 258 cases

	Information Available	% of total cases
Technical Design	Number of cases	
Pre-payment	238	92%
Benefit Package	208	81%
Pooling	136	53%
Strategic Purchasing	62	24%
Internal (Org.) Incentives		
Autonomy	0	0%
Accountability	37	14%
Market Exposure	27	10%
Financial Accountability	52	20%
Unfunded Mandates	0	0%
External (Inst.) Incentives		
Ownership (Legal)	128	50%
Ownership (Legal and "de facto")	184	71%
Governance	104	40%
Public Funding	0	0%
Stewardship	0	0%
Characteristic of Main provider	132	51%

B. Dependent Variables: Evidence of the impact of CBHOs on the goals of Social Protection in Health for members and/or society at large

Tables 5, 6 and 7 summarize the findings regarding the evidence on the effect of CBHOs on health status, utilization of services, financial protection and "other benefits".

Table 5

What is the Evidence on Impact of CBHOs?

Information Available on 127 documents for 258 cases

Impact	Cases for which any analysis is available out of 258	Cases for which Positive Impact Reported out of 258	Case analysis with sufficient Internal validity out of 258	Cases with validity According to Universitas framework out of 258
Health status	0	0	0	0
Utilization	24 (9%)	14 (5%)	1 (0.4%)	1 (0.4%)
Financial Protection	9 (3%)	8 (3%)	1 (0.4%)	0
Other Benefits	11 (4%)	11 (4%)	0	

None of the documents reviewed provided information on the impact of CBHOs on the health status of the population. Such an analysis is extremely difficult to conduct not only for these types of schemes but for other organizational arrangements for combating exclusion in health as well even under good quasi-experimental conditions.

Several documents, however, included analysis of the impact of CBHOs on utilization of health care services and on financial protection, as defined in each study. This information is summarized in tables 6 and 7.

Table 6
Impact of CBHOs on Utilization of Health Services

A positive impact found?	Number of Cases out of 258	% from total n
No	10	42%
Yes	14	58%
Total (n)	24	100%

As shown in Table 5, although 14 out of the 24 cases for which the utilization variable was examined report positive impact, only 1 shows sufficient internal validity of the results. When data is available, the most common problems determining lack of internal validity are related to sample selection and the existence of control groups, source of information for comparing utilization and the lack of controlling for possible confounding variables, particularly by health status / risk of the members and non-members (key to account for the possible distortion resulting from adverse selection in a voluntary scheme). Additionally, most of the studies focus only on changes in utilization of members and not on the impact on different population groups and society at large.

Table 7
Impact on Financial Protection

Any positive impact reported ?	Number of Cases out of 258	% from total n
No	1 / 0*	11% / 0*
Yes	8 / 0*	89% / 0*
Total (n)	9	100%

* Considering total contributions of the household for the definition

In the case of financial protection, only 9 out of the 258 cases were examined on their impact on financial protection. 1 out of the 9 analyses had sufficient internal validity. However, none of them was in accordance with the study framework definition of

financial protection. Most of the 9 reporting positive results (including the one with sufficient internal validity) focus their analysis on out-of-pocket financing to analyze the level of financial protection provided by the scheme.

Most studies indicated some potential additional benefits of CBHOs not captured either by Health Status, Utilization or Financial Protection. Only 11 cases however, present them as specific findings. The study included them all in the study under the "other benefits" category. Some of these benefits will serve to better define the operationalization of the Dignity dimension. Unfortunately, although these studies reported such benefits for the members, none systematically evaluated the benefits and therefore lack of internal validity is evident in all of them. Table 8 lists all benefits other than health, utilization and financial protection as reported by the studies.

Table. 8
Reported Benefits other than Health, Utilization or Financial Protection reported.

- "Community empowerment"
- "Closer relationship to providers"
- "Communities more involved in health campaigns"
- "Women empowerment"
- "More interest of community on health care related issues"
- "A sense of ownership over the program"
- "Access to health care information"
- "Partnership between local health authorities and communities"
- "Providing a voice for the community in health care related issues"
- "New ties among the community members"
- "Awareness on the need for more solidarity within the community"
- "A new sense of community participation over the provision of health care services"

C. Independent Variables: Characteristics and possible determinants of good performance of CBHOs

This section describes the findings regarding the characteristics of the CBHOs analyzed in two main areas: Technical Design and Organizational and Institutional Incentives.

1. Technical Design Characteristics

Prepayment. Tables 9 and 10 show the information gathered on revenue collection for the cases where it was available in the reviewed studies. The information specifically details the existence of pre-payment and of co-payments.

Table 9
Pre-payment

Any Pre-payment Mechanism?

	Number of Cases out of 258	% from total
No	15	6%
Yes	223	94%
Total (n)	238	100%

From all cases for which information and some kind of analysis was available (258), the study found information on pre-payment for 238. The majority (223 / 94%) of the schemes reviewed collected revenues using pre-payment mechanisms. This is not surprising given the collection definition of the study used for the search of studies and cases. The few schemes from which we obtained data that did not use pre-paid contributions were either plans where the members' contributions were entirely subsidized but the co-payments were not waived (very few plans), or arrangements that collected the contributions only as user fees (the majority).

Information on co-payments was scarce, the study found information only for 61 out of 258. Table 10 summarizes the findings and suggests that co-payments are used in many schemes as a source of revenue or for other purposes.

Table 10
Co-Payment

Any Co-payment?

	Number of Cases out of 258	% from total n
No	17	28%
Yes	44	72%
Total (n)	61	100%

Benefit Package. Tables 11, 12 and 13 summarize the information found on benefit packages. The package is defined as the aggregate of all services that the scheme offers to their members, either by direct provision and financing or as facilitators or entry-points

(as discussed later in this section) to larger pooling/provider networks (e.g. public health district).

Table 11
Benefit Package: Outpatient Services

Outpatient services included in the benefit package?

Outpatient Services	Number of Cases out of 258	% from total n
No	41	20%
Yes	165	79%
Only Preventive	2	1%
Total (n)	208	100%

As shown in table 11, the study found information for the benefit package characteristics on out-patient services for 208 of the 258 CBHO cases. All of them included information on the coverage of Outpatient services. Two out of the 208 cases for which information was available on the characteristics of the benefit package, had only preventive services. As shown in table 12, out of the 195 cases for which information was available on the presence of inpatient services in the CBHO benefit package, 146 (74%) included inpatient services either directly financed and/or provided or as "facilitator" to a larger pooling/provider network.

Table 12
Benefit Package: Inpatient Services

Inpatient services included in the benefit package?

Inpatient Services	Number of Cases out of 258	% from total n
No	46	24%
Yes	146	74%
Basic or only maternity	3	2%
Total (n)	195	100%

As shown in table 13, the study found information about the inclusion of pharmaceuticals in the benefit package for 179 out of the 258 cases. Among them, 73% of the cases included pharmaceuticals as part of their benefit packages.

Table 13
Benefit Package: Pharmaceuticals

Pharmaceuticals included in the benefit package?

Prescription Drugs	Number of Cases out of 258	% from total n
No	48	27%
Yes	131	73%
Total (n)	179	100%

As a result of the analysis on the contents of benefit packages of CBHOs, the study distinguishes benefit packages in two categories: comprehensive and non comprehensive packages. A comprehensive package includes at least three types of services (outpatient, inpatient and prescription drugs). A non-comprehensive package does not include inpatient services and include any of the other two services. The definition of the package offered was done based not on what the CBHO promised to provide or finance directly but on what the CBHO promised to give access to. This is an important distinction as many CBHOs present a relatively small package to be financed and some times delivered directly by the scheme but, at the same time, many case study authors report that they facilitate access to other services and or, that the services purchased are done so at substantially subsidized prices, the latter indicating that an important part of the pooling is being done at a level different than the respective CBHOs scheme. This means that a CBHO might have a very restricted explicit package being provided by own providers or paid directly from their funds but in practice, it is serving as an entry or facilitator for access to a much larger package of benefits. We discuss this in the next section. The fact that they promise or implicitly aim for facilitating access however does not mean that they actually do so, as this is what is being examined under the dependent variables (Health Status, Utilization, financial protection and other benefits). Table 14 summarizes the findings on these two kind of packages offered. The study found information about all three kind of benefit for 161 out of 258 cases. Out of the 161 schemes for which the information is available, 121 offer a comprehensive package and 40 offer a non-comprehensive one.

Table 14
Benefit Package: Comprehensive or Non Comprehensive

Does the scheme offer or facilitates access to a comprehensive or to a non comprehensive set of services?

Categories	Number of Cases out of 258	% from total n
Comprehensive	121	75%
Non-Comprehensive	40	25%
Total (n)	161	100%

Table 15 shows the results of distinguishing CBHOs that finance (and sometimes also provide) the whole package they offer from those that finance only part of it but "facilitate" or act as entry point to a larger package of benefits. We call the first case "Self-contained CBHOs" and the second type "Entry-point CBHOs".

Table 15
Characteristics of the Package

Types of CBHOs:
Entry-point vs. "Self-Contained"

Categories	No. Cases out of 258	% from total n
Entry-point	66	64%
Self-Contained	37	36%
Total (n)	103	100%

Financing and Purchasing Characteristics.

Tables 16 summarize the findings regarding the number of members and households of the CBHOs studied. We include the result in this section as the number of members is directly related to the size of the risk pool in the absence of substantial subsidies. For

members, the study found information available for 85 out of the 258 cases. Table 16 shows the results.

Table 16

Size of Risk Pool

Distribution of CBHOs according to number of members
(figures of the latest year available for each case)

Number of members (individuals)	No. Cases out of 258	% of total cases n
<100	19	22%
100-500	28	33%
500-1,000	5	6%
1,000-2,000	7	8%
2,000 – 5,000	8	9%
5,000 – 10,000	4	5%
10,000 – 100,000	12	14%
100,000 – 1,000,000	2	2%
Total (n)	85	100%

Tables 17 and 18 summarize the results of the information on the characteristics of the schemes regarding risk pooling. Table 18 shows the percentages of schemes that bear the bulk of the financial risk versus those that do not. Bearing the financial risk in practice reflects the existence (or not) of subsidies required for providing the package the CBHO is offering (either comprehensive or non comprehensive) and therefore members contributions are a small fraction of the cost of providing the benefit package. Given the absence of good financial data, the "small proportion" judgment is based on expert judgment by the authors when it was evident that the package of services offered was very large compared to the package of services the scheme could finance out of its resources and that the provision of services is being rendered substantially subsidized by the sub-system to which the CBHO is acting as entry point or, the CBHO is being subsidized externally. We need to remember here again, that the package offered does not mean the package directly provided or financed by the CBHO but the package it explicitly or implicitly is offering even if the scheme is only the facilitator or entry point to the larger benefit package.

Table 17

Pooling Characteristics of CBHOs

Does the scheme bear the financial risk?

	Number of Cases out of 258	% from total n
No	90	66%
Yes	46	34%
Total (n)	136	100%

Table 19 shows who bears the financial risk for those schemes where member contributions account for only a minority of the financial risk for the entire package. Information on who bears the risk was available for 85 of the 90 cases that do not bear the risk.

Table 18

Pooling Characteristics of CBHOs

Who bears the financial risk if the CBHO does not?

	Number of Cases out of 258	% from total n
Central and local governments	69	81%
Central gov. and others	7	8%
Non Governmental Org.	7	8%
Hospital and others	2	2%
Total (n)	85	100%

The study also attempted to produce cross tabulations examining the pooling characteristics of CBHOs and some possible determinants of the effectiveness of pooling. Tables 19, and 20 summarize the findings. Unfortunately the scarcity of information determines too small number of cases for each of the cross tabulations. Information for both, size of the risk pool and who bears the risk was available simultaneously for only 36 cases.

Table 19

Size of the Scheme and Scheme Risk Pooling

Size	Risk Pooling at scheme level?				
No. Members	Yes	%	No	%	Total %
< 1,000	1	9%	10	91%	100%
1,000 – 10,000	6	40%	9	60%	100%
> 10,000	6	60%	4	40%	100%
Total No. Cases	13		23		

Table 20

Type of the Package and bearing the risk

Scheme bears risk?	Type of Benefit Package			
	Non-Comprehen.	%	Comprehensive	%
Yes	3	14%	26	38%
No	18	86%	43	62%
Total:	21	100%	69	100%

Table 21 presents the information available on strategic purchasing. A scheme is considered to do strategic purchasing if convincing evidence exists that the scheme discusses / negotiates with providers on the type, price, and/or quality of services to be provided to their participants, and/or establishes contracts that include these issues and defines payment mechanisms. Also, that the CBHO has the right to choose any provider it wants, when available, even if it does not exercise that right.

Table 21
Strategic Purchasing Characteristics in CBHOs

Does the scheme conducts strategic purchasing?

	No. Cases out of 258	% of total cases n
No	52	84%
Yes	10	16%
Total (n)	62	100%

2. Organizational and Institutional Incentives

Table 22 summarizes the variables analyzed under Organizational and Institutional Incentives and the number of cases for which that information is available. Detailed definitions of the variables are contained in the methodology section.

Table 22
Ownership and Organizational and Institutional Incentives for CBHOs

Available Information

	Information Available	**% of total cases**
Internal (Org.) Incentives	Number of cases out 258	
Autonomy	0	0%
Accountability	37	14%
Market Exposure	27	10%
Financial Accountability	52	20%
Unfunded Mandates	0	0%
External (Inst.) Incentives		
Ownership (Legal)	128	50%
Ownership (Legal and "de facto")	184	71%
Governance	104	40%
Public Funding	0	0%
Stewardship	0	0%
Characteristics of main provider	132	51%

Legal Ownership of a scheme is frequently difficult to establish for a variety of reasons (WHO, 1998). Most documents reviewed contained little information in this regard. 128 (50% of all cases) had some information on legal ownership. Table 23 summarizes information on legal ownership.

Table 23

Who appears to be the legal Owner of CBHO?

Organization	No. of cases	% of total cases n
Central Government	24	19%
Local Government	23	18%
Central + Local Government	9	7%
Central +Local Gov. + NGO	1	1%
Central Gov. + Community	1	1%
Central Gov. + NGO	1	1%
Local Government + others	2	2%
Health Center	2	2%
Health District	1	1%
Hospital	14	11%
Social Security	2	2%
Community	12	9%
Community + private company (for profit)	1	1%
Non-community NGO (international or donor)	32	25%
Private company (for profit)	3	2%
Total (n)	128	100%

Legal ownership is difficult to evaluate and, in poor and far away areas may be impossible or very difficult to establish by communities. So, as discussed in the methodology, the study looked for evidence of "de-facto ownership" as defined in the methodology section. More information was available regarding the participation of the community in certain decisions and on management of the schemes. Consequently, although information on legal ownership was available for only about half of the schemes studied , we were often able to establish "de facto" ownership as defined in the methodology section. Table 24 summarizes the findings combining legal and "de facto" ownership.

Table 24

Legal and "de-facto" Ownership of CBHOs

Organization	No. of cases out of 258	% of total cases n
Central Government	24	13%
Local Government	23	12%
Central + Local Government	9	4%
Central +Local Gov. + NGO	1	1%
Central Gov. + Community	1	1%
Central Gov. + NGO	1	1%
Local Government + others	2	1%
Health Center	2	1%
Health District	1	1%
Hospital	14	8%
Social Security	2	1%
Community	68	36%
Community + private company (for profit)	1	1%
Non-community NGO (international or donor)	32	17%
Private company (for profit)	3	2%
Total (n)	184	100%

Detailed information regarding the delegation of all 3 key decision rights to the community by the owners is scarce. The following tables present information on community participation in the three decision rights. Table 25 summarizes these findings.

Table 25

Any Community Participation at any time on…?

Definition of Benefit Package	No. of cases out of 258	% of total cases n
No	43	43%
Yes	57	57%
Total (n)	100	100%
Level of Premiums		
No	53	51%
Yes	51	49%
Total (n)	104	100%
Allocations of Proceeds or Assets		
No	58	75%
Yes	19	25%
Total (n)	77	100%

As shown in table 22, no information on **Autonomy** was found for the case studies.

Market exposure. Information on scheme financing is scarce and the breakdown of the sources of financing is even less available. We found accurate enough information for only 27 out of the 258 cases. The information on the percentage of the contributions of the community that was available is summarized in table 26. The proportions were calculated according to the financing of the whole package offered, as defined in the Benefit Package discussion above. Valued of 85% or more are classified as 100%.

Table 26

Market Exposure

Revenues from community as percentage of total revenues required for the benefit package offered	Number of Cases out of 258	% from total n
<50%	19	70%
>50%	6	22%
100%	2	8%
Total (n)	27	100%

Table 27 shows the information available on other sources of revenue available to the CBHOs when market exposure is less than 100%.

Table 27

Other Sources of Revenues/Subsidies

Public Funds (Central and local government and social security)					
Contributes to financing?	No. Cases	%	If yes what percentage?	No. Cases	%
No	18	14%	< 50%	9	31%
Yes	110	86%	>50%	20	69%
Total	128	100%	Total	29	100%
Private sources (including local and international donors)					
Contributes to financing?	No. Cases	%	If yes what percentage?	No. Cases	%
No	29	25%	< 50%	14	64%
Yes	86	75%	>50%	8	36%
Total	115	100%	Total	22	100%

The above tables on CBHOs financing suggest that in the majority of arrangements, community financing represents only a portion of the total financing of the schemes. Public sources of financing contribute funds to a large number of schemes either directly or indirectly through subsidized prices for health services.

Accountability. To whom the CBHO is accountable is defined by the existence of information of any accountability mechanism (e.g. review of auditing reports, other). The study found information for 37 out of the 258 cases. Table 28 summarizes the findings.

Table 28

To whom are CBHOs accountable?

	Number of Cases out of 258	% from total n
Central and or local governments	22	59%
Members and or community	7	19%
Government, community and non-community NGO	6	16%
Central government and n-c-NGO	1	3%
Non- community NGO	1	3%
Total (n)	37	100%

Information regarding **financial responsibility** is also scarce. The study found information for 58 out of the 258 cases. Table 29 summarizes the information that was available for this variable.

Table 29

Financial Responsibility

Is the management held responsible for the financial performance of the scheme?	No. Cases out of 258	% of n
No	6	12%
Yes	46	88%
Total (n)	52	100%

Information on **unfunded mandates** was available for almost none of the schemes reviewed.

Governance in this study is defined as the set of rules and customs shape the relation between the health care organizations and its owners. Given the fact that most documents emphasize community participation as a goal, it is only indirectly and from a few documents that we can learn about the actual rules or practices that regulate the relationship between the legal or "de facto" owners and the scheme. No information was available directly related to this set of incentives.

Financing for **public policy objectives** refers to the rules and customs that shape the use of public funds for the achievement of public policy goals by the organization. The analysis of this incentive is relevant as long as public funds are part of the scheme's financing arrangement, which seems to be suggested by the market exposure information. A large proportion of CBHOs, are subjected directly or indirectly to such financing. It seems, however, that most of the subsidization is done via price subsidization rather than direct financial transfers. Unfortunately, no information was available in the case analysis.

Stewardship mechanisms comprise an incentive that is discussed within the conceptual framework from ILO/STEP-Universitas for the extension on social protection in health. This incentive is related to the rules and customs that shape the relationship between the government and health care organizations and include, among others, the regulatory framework. There was no information available for analysis in any of the cases.

Characteristics of main provider. Basically the study examined here the ownership characteristics of the main providers. Table 30 summarizes the results of the findings on types of providers. It categorizes providers into three types: Own (CBHOs has its own providers), private providers, public providers. The study considers this variable under external incentives as the relationship (from the rules and customs and the degrees of freedom for one or the other) between the CBHO and the different type of providers may be substantially different determining different external incentives for the CBHO.

Table 30

What are the predominat type of providers for the services included in the benefit package?

Types of Providers	Number of Cases out of 258	% from total n
Own	23	17%
Private	5	4%
Public	81	61%
Own + Public	5	4%
Private + Public	13	10%
Own+Public+Private	5	4%
Total (n)	132	100%

V. Discussion and conclusion

A. Discussion

The study found useful information for 258 cases derived from 127 documents collected from existing literature either published in peer-reviewed journals, by bilateral or multilateral organizations or by any research organization or individual. The literature review was done in English, German, French and Spanish. We believe that the relatively small number of documents and case reviews found can be explained mainly by the lack of research in this field and by the difficulties of the small scheme in publishing and publicizing their experience.

The findings show that there is few data on impact, in any definition (that of any of the authors or that of the proposed framework), with acceptable levels of internal validity (Table 5). There is also very few data on characteristics of CBHO (table 4) making it only possible to do some single variable (characteristic) tabulations. The existing data focuses mainly on technical content characteristics of the scheme. It is not surprising given the still predominant neoclassical approach to evaluating determinant of performance of health systems, that most available data is focused on technical design

characteristics and little analysis exist on Organizational and Institutional incentives potentially affecting CBHOs performance (Table 22).

Cross-tabulation are very difficult to interpret, as the number of cases presenting information simultaneously on two or more characteristics is too small. In any case, the study explores some cross tabulation particularly for pooling characteristics v/s the other technical design characteristics (Table 19 and 20).

In almost all the existing literature there is limited data analysis of independent or dependent variables for the cases described by the respective authors. For those containing data, all of the descriptions of the CBHOs characteristics and those including data analysis are cross-sectional studies of scheme characteristics at one point in time only. It is essential to analyze CBHOs behavior and impact along time for those schemes that continue functioning as the schemes evolve and might change their capacity to achieve the goals of social protection in health. The existing case literature is mostly focused on existing (surviving schemes) and none on schemes that were not able to continue working. It is important to get information in the future on schemes that do not exist any more and the causes of them disappearing. A longitudinal research approach would allow accounting for this if the sample of schemes is sufficiently large.

Additionally, almost all studies are focused on the scheme and the scheme members with only marginal or no analysis of the impact of the scheme in the population at large and the possible effects of the schemes beyond their members.

Several factors explain the difficulty in studying the actual impact of CBHOs. Many schemes involve relatively small groups of people (more than 50% of the schemes have 500 members or less), and the collection of reliable data would require use of scarce financial resources that managers prefer to devote to operative goals. Most practitioners in this field perceive that the benefits are so evident that they focus the research efforts on issues related to the financial sustainability and enrolment rather than on impact on members and society at large. Often sponsors of these schemes are interested in information on the use of specific services and on making the schemes sustainable rather than a broader analysis. A household survey to collect empirical evidence requires large numbers of both beneficiaries and non-beneficiaries to achieve adequate levels of statistical power and is thus very expensive. Analyzing CBHOs impact has a large public good component (national and international), this is, the lessons learned benefit mostly policy makers at national but mainly international level, therefore, it is unlikely that one CBHO or isolated government would do all the analysis by them self. Additionally, governmental organizations often view community-based health organizations either as outside the scope of public policy or as representing a relatively small proportion of the total resources devoted to health care nationwide.

1. **What is the existing evidence on the impact of CBHOs in their members and society at large?**

The study found very limited evidence of positive impact of CBHOs, in the published literature, as a strategy for the extension of social protection in health to their members and/or society at large, for any of the three main dimensions analyzed or for other possible benefits.

Evidence of positive impact on health status is very difficult to obtain even under the best quasi-experimental conditions, so it is not surprising not to find any. However, even for utilization of services the information and analysis is scarce and non-conclusive mostly due to the few studies that address the question (allowing for information only on 24 out of the 258 cases) and due to the lack of internal validity for most of those studies that address the question (Table 5). The main internal validity problems are related to, inter allia, lack of base lines, absence of control groups, problems in sampling techniques, control for confounding variables (most notoriously health status and risk) and sources of data for utilization analysis. Often documents use data on changes in the three dimensions utilizing providers' databases without acknowledging the limitations of the conclusions of an analysis based solely on such data.

Some evidence for the financial protection dimension exists, as defined in the studies by each author (Table 7) but not as defined in the proposed ILO/STEP-Universitas framework, which we argue is more meaningful than using out-of-pocket financing only. All the studies (for 9 out of 258 CBHO cases) that actually used hard data and statistical approaches focused only on out-of-pocket expenditures and did not look at total health expenditures. As discussed in the ILO/STEP-Universitas framework, defining financial protection only on the basis of absence or reduction of out of pocket financing, although an improvement compared to no analysis at all, is totally insufficient for protecting the household from excess financial contribution in the context of health shocks. If the household continues spending the same or even more via premiums, pay-role-tax and/or taxes after the intervention reduces out-of-pocket, the out-of-pocket only analysis will not capture it and the conclusions regarding financial protection are not valid.

Although the references to other benefits is frequent in many of the studies and for many of the cases, the evidence on other possible benefits is also missing as most analysis is limited to statements and descriptions of possible benefits with limited data analysis and internal validity (Table 8)

Many documents discuss the issue of scheme success and effectiveness or state that the schemes do so but, often the focus is mostly on scheme financial sustainability and membership. Table 31 shows a summary of the elements that the study found are usually considered in the evaluation of performance of the schemes and variables used as indicators of success in the available literature.

Table 31

Typical variables that the study found are usually considered as indicators of success of a CBHO in the available literature

- Large or growing number of enrolled members
- Increased utilization of the services provided by the CBHO
- Reduced level of out-of-pocket expenditures
- Financial sustainability of the scheme
- Improved quality of care

The concern of many authors regarding the number of enrolled individuals, as an important element of the assessment of CBHOs, is based on the assumption that if people are enrolling in the scheme there must be gains that the individuals are obtaining from joining them. Although there is merit in this argument, in terms of public policy, not all gains of individuals become automatically an objective of public policy. If enrollment of the population does not have proven impact on health status or at least on utilization of needed and effective health services and/or on the financial protection and/or other benefits (including dignity) as explicitly intended objectives of the health system defined by society, they can not be included as "other benefits".

Under the "financial sustainability" research approach for assessing impact, the goal is not focused on measuring the impact on health, use of services or financial protection of the members of society at large but on the ability of the schemes to be capable to attract enough financial resources and survive. The focus again here is not the benefit on the members or society at large but the capacity of the scheme to keep functioning overtime by maintaining stable sources of financing. Although financial sustainability is a necessary condition for effective schemes, it dos not ensure its effectiveness in protecting their members and society at large.

2. What are the characteristics of CBHOs and what are the determinants of good performance?

The initial objective of this study was to examine the existing evidence on impact of CBHOs on their members and society at large and examine the evidence on determinants of positive impact. Unfortunately, the lack of evidence on impact makes it impossible to evaluate determinants of success or best practices.

However, the information collected on the characteristics of the CBHOs is useful to get a better idea of how diverse these schemes are and that in practice there are different arrangements under CBHOs which would require separate evaluation in the future.

The data and information available suggests that most CBHOs are usually **small organizations** with a few showing large membership. As shown in tables 16 and 17 above, almost 70% of all cases for which information was available have less than 2,000 members, 22% less than 100 members and 83% have less than 10,000 members. Only 16% have more than 10,000 members. However, the sample of cases containing information about the size of the pool represents only 33% of all cases. We believe that, if at all, the sample of studies and cases is skewed toward the larger schemes rather than the smaller schemes, those that can afford a better statistical system and the publication and dissemination or their experience and data as well as the most attractive for researchers to study. As it is well known in the risk pooling literature, a small number of members makes it very difficult for these schemes to be able to function as a self-sufficient risk pooling mechanism.

The available data (Tables 23 and 24) also suggest that **a minority of the schemes are either legally or "de facto" owned by the community**. Out of the 128 cases for which information on legal ownership was available, less than 11% was legally owned by the community or by the community together with a partner organization. As legal ownership might be difficult to establish for communities, particularly in developing country settings, the study also explores "de-facto" ownership defined as the community exercising at least one of 3 decision rights (see methodology section). In that case, the study found information for 184 out of the 258 cases with the community "de facto" owning the scheme in less than 39% of the cases. This relatively low ownership by community could be compensated by strong accountability mechanisms to the community. The data also shows that **a minority of the CBHOs are accountable to the community**. As shown by table 28, out of the 37 cases for which information on accountability of the CBHO was available (a small number unfortunately from the 258 cases studied), only 19% were accountable to the community. When considering accountability to community together with any other organization, the proportion increases to 35%. However, the sample numbers are too small to be conclusive.

Data (table 9) also shows that most of the CBHOs use pre-payment in their collection (94%), except for those related to the "user fees" strategy, and that the majority of the prepayment schemes uses co-payment (Table 10). This is not surprising as the definition and document search was based on voluntary community contributions (pre-payment or user fees).

In terms of pooling, as shown in table 19, **the majority of the schemes do not bear the risk**. Out of 136 for which the information was available, 66% did not bear the financial risk (did not do the pooling inside the scheme as significant level of direct or indirect subsidies were present) and 34% did. The size is an important issue in term of pooling as the literature in health insurance suggests. Although the cross tabulation between size and pooling contained in table 19 has too small a number of cases, it does seems to confirm this, suggesting an important difference between the CBHOs of less than 1,000 members and those with more than 1,000 members. The numbers are inconclusive though. When

the scheme does not bear the risk, it is usually (more than 90% of the cases) beard by the public health care system (Central, regional and local) (Table 18).

The fact that the majority of CBHOs do not do pooling inside the scheme is not only related to their typically small size but also related to the findings regarding Market Exposure. Although available information is scarce, as shown in table 27, the majority of the schemes (70%) have less than 50% market exposure, meaning, that most of the scheme have explicit or implicit subsidies to provide or facilitate access to the Benefit package they offer.

In terms of the benefit package, **most CBHOs offer a comprehensive benefit package** instead of a non-comprehensive one, this is, in the study definition, they offer benefit packages containing outpatient and inpatient care as well as medications (Tables 11 to 15) but, the large majority of CBHOs seem to be able to do so as a result of direct or indirect subsidies as they do not do pooling inside the scheme (Table 20). However, the actual access to the package offered should be reflected by the dependent variables (at least under utilization) for which the study has not enough evidence. Although the benefit packages can be grouped in these two types (comprehensive and non-comprehensive), the actual specific detail content for each CBHO varies significantly from one to the other (e.g. actual type of inpatient services offered).

The number of cases for which information is available for multiple variables at the same time is often too small to do meaningful cross-tabulations for analyzing the above findings on benefit package, pooling characteristics and sources of financing simultaneously in the preliminary analysis. However, from the few cases for which cross-tabulation was possible, it seems there are in actuality two distinct kinds of CBHOs: "Self contained" CBHOs and "Entry Point" CBHOs (Table 32).

Table 32

Two Main Types of CBHOs:
Entry-point vs. "Self-Contained"

Categories	No. Cases from 258	% from total n
Entry-point	66	64%
Self-Contained	37	36%
Total (n)	103	100%

Self-contained schemes do pooling mostly at the scheme level and have a higher level of Market exposure. Typically, there is an explicitly and concisely defined set of benefits in these cases. These are the minority of the schemes and include the largest schemes examined in this study.

Entry-point schemes are essentially a facilitator of entrance to larger and more complex health care organization or sub-system at the local, regional or national levels either from the public sector or from NGOs other than the community. In these schemes the set of benefits tends to be more implicitly defined by the availability of services and providers within the larger arrangements. These benefits may or not be complemented by other services such as drugs or primary health care services typically provided either by trained community members, ancillary personnel, nurses or physicians or a combination of these professionals at the local level. In these schemes, frequently, the larger arrangement is a public system with its own method of organizing the collection of revenues, pooling and provision of services. This is the case, for example, with arrangements in which member contributions essentially provide a waiver for the user-fees for the utilization of health care services in the public system. In almost all documents reviewed very little or no information was available on the organization of risk pooling or equity cross-subsidies between the entry-point CBHOs and the larger health care organization or sub-system to which they facilitate access to.

Most CBHOs are actually "Entry-Points" to larger pooling arrangements. Given the findings of this study, this is a key aspect to be analyzed in further research. From the available data, the majority (almost two thirds) of the schemes were classified as entry-point schemes, and only a little more than one third as self-contained. This is also compatible with the type of providers predominant for the services of the package. Out of 132 cases for which the information was available, for more than 61% of them the services were provided only by public sector providers at subsidized prices (Table 30).

The finding that the majority of CBHOs explicitly or implicitly offer a comprehensive benefit package, most of them with public subsidies, might potentially facilitate in the future their role in the delivery of a society guaranteed health plan (GHP), as proposed by the ILO/STEP-Universitas framework as a key element of a national policy against exclusion from social protection in health. However, the actual capacity of states to take advantage of CBHOs for delivering the GHP depends on their effectiveness as "Entry – points" or pooling capacity and on being able to overcome significant diversity in the specific contents of the benefit package of each scheme. This key issue is further discussed in the conclusion below.

3. Who benefits from CBHOs?: Do the poor benefit from CBHOs?

Although the overall goal of extending social protection in health is to reach out to those individuals and families who are excluded, a key priority for public policy among them is to focus on the poorest segments of the excluded population. One initial objective of the

study was to explore whether the poor benefit from CBHOs. Unfortunately, the evidence is very scarce. Although most documents indicate that these schemes serve mainly the poor, the very few studies containing data and analysis with acceptable internal validity suggest that income plays an important role in the probability of joining the scheme. Higher income increases the probability of joining the scheme and there is a statistically significant difference between members and non members in term of income with members having higher income than non members (the one study showing internal validity for financial protection). Table 33 summarizes the information available on income and participation in CBHOs.

Table 33

Evidence of CBHOs protecting the poor:
Studies that analyze enrollment by poverty groups

Studies that discuss enrolment by income	Cases for which the liklyhood of the poorest groups to be enrolled in CBHOs was statistically analyzed	Number of cases were likelihood was lower amongst the poorest groups
9	5	2

The question of who benefits from the strategy is key in the evaluation of CBHos or any organizational arrangement for public policy for extending social protection in health. Even if positive impact on members is demonstrated, the evaluation for public policy purposes needs to be focused on society at large an particularly the poor. If the very poor do not participate in the schemes, it is important to take into consideration changes in other alternative services available to the poor as a consequence of CBHOs. If CBHOs concentrate financial resources from public or private funds to higher income population and reduce manpower, services or financial resources available to the poorest groups, then we cannot deem these arrangements as effective mechanisms to extend social protection to the poor. The evaluation of CBHOs therefore should not be focused on accomplishing benefits for members only but on the effects on society at large and particularly on the poor.

B. Conclusions

Extending social protection to those excluded is a priority in the health sector. Countries and communities are using different organizational arrangements or combinations of them to attempt to extend social protection in health to the excluded including innovations in existing social security arrangements, Public Health Sector Reform to improve efficiency of public subsidies and health services to reach the poor, facilitation and regulation of private sector initiatives for extending coverage and facilitating CBHOs. Although CBHOs can rightfully be considered under the private sector initiatives or under public sector strategies, particularly after the above findings on Ownership and accountability, these initiatives have some particular characteristics that differentiate them from commercial initiatives and we still thing they should be analyzed separately. These four strategies often co-exist in developing countries.

The focus of this study on the effectiveness of the different strategies on extending social protection in health is on community based health organizations (CBHOs). The focus is on CBHOs because of its increasing numbers and members participation particularly in low income countries and because they have been relatively ignored as part of public policy in health system. Recognizing the need to better understand this phenomenon, the 89th International Labor Conference indicated a special interest on carrying on a rigorous evaluation of these schemes. The study also focus on CBHOs because in the last five years these schemes have increasingly been included among the set of possible mechanisms that are available to governments for expanding social protection in health (CMH, 2001; WHO 1998; ILO/STEP, 2001) and because In order to carry out ILO's strategic objective to support initiatives that "enhance the coverage and effectiveness of social protection for all" in the health sector, we need to objectively assess the actual potentialities and limits of community based health organizations for extending social protection in health to the excluded and the poor. This document is a step in that direction and will be followed by a long-term field evaluation of CBHOs using primary data collection.

The study found a limited amount of quality data and analysis on this topic. This lack of data did not allow the study to conduct an acceptable quality meta-analysis.

Very few evidence on impact, in any definition (that of any of the authors or that of the proposed framework), is available in the published literature with acceptable levels of internal validity. There is also very few data on characteristics of CBHOs. Another finding, although not surprising given the still predominant neoclassical approach to evaluating determinant of performance of health systems, is that most available data is focused on technical design characteristics and little analysis exist on Organizational and Institutional Incentives affecting CBHOs performance.

It is also interesting that often scheme evaluations are focused on "financial sustainability" of the scheme. This study did not explore this dimension, as, in terms of public policy, the financial sustainability of the scheme is an instrument for it's functioning when it actually impacts positively on members and society at large. Public

policy in social protection in health should not be focused on ensuring the financial health of schemes but on or improving (or at least not damaging) the financial health of households in the context of the health system.

The findings and preliminary conclusions need to be taken with caution as it is possible that the information available reflects only a very small fraction of existing CBHOs and that the findings for those to be found and analyzed schemes could change the preliminary conclusions. It is likely, due to the limitations of resources and time, that there are documents that were not included that might change the preliminary findings and conclusions. Also, the lack of quantitative information forced the authors to make "expert judgments" and derive indirect evidence for some of the cases (as discussed in the methodology section), which in turn, makes also for being cautious in considering the internal validity of this study.

Despite the scarce data and information available, some conclusion can be derived form the revised data.

First, that we have no evidence from the documents reviewed that CBHOs positively impact health status or at least the utilization of services and financial protection for their members and/or for society at large, particularly the poor. The fact that the study found almost no evidence on impact in the published literature does not necessarily mean that CBHOs have no positive impact on members and/or society at large. It means that those interested in this field have not been able to asses the impact or, more likely, the focus has been on describing the schemes and not on their effectiveness as a tool for extending social protection in health, as defined by achieving key outcomes such as improving health status, utilization of services, financial protection and/or other benefits to members and society at large.

Second, that we do not have evidence from published literature on other additional benefits either. Despite being often mentioned in most documents on this matter, the analyses of additional benefits are also lacking internal validity.

Third, that, according to the scarce data available, CBHOs tend to be small organizations (70% covering less than 2,000 members) with community participation in key decisions at one point or another in their history but with limited legal or "de facto" ownership by the community and with significant dependence from other health subsystems or subsidies as reflected by their low market exposure. The majority of the schemes are "entry-point" schemes with low market exposure and significant dependence from larger provider schemes, particularly the public sector. There is a relative low level of ownership by the community or accountability to it that CBHOs show. A minority of the schemes is legally or "de facto" owned by the community and this low ownership characteristic does not appear to be counterbalanced by strong accountability mechanisms as only 19% show any existing accountability mechanism of the CBHOs to the community. Unfortunately, the number of cases is too small to be conclusive.

The very significant prevalence of CBHOs as "entry points", with significant pooling outside the scheme and important presence of direct and indirect subsidies as well as the importance of public providers for CBHOs, suggest that more than searching for impact of CBHOs as isolated self standing organizational arrangement, its impact and importance should be evaluated as a potential strategy to link the community with the other 3 alternative organizational arrangement for extending social protection in health discussed in the introduction of this paper, particularly public health sector. The findings in this study seem to suggest that its potential rests on the relationship of CBHOs and public sector pooling and provision arrangements. In this regard, CBHOs might potentially be an instrument for organizing their members to get better access and protection from the public health sector, or other social security and/or private health insurance. A good evaluation of CBHO should be able to capture this benefit in increased utilization, financial protection and/or dignity for their members. If so, the question of who benefits form CBHOs and the impact on society at large becomes key. Even if there are demonstrated benefits from CBHOs to their members, if they occur at the expense of the poorest of the poor, CBHOs or any social protection strategy cannot be qualified as a success for extending social protection in health.

The "key test" of any strategy should be its capacity to actually achieve the goals of inclusion in social protection in health in a feasible, effective and efficient way in a particular country context. We also believe, as proposed by the ILO/STEP-Universitas framework, a key component of such capacity is to be able to contribute to a national objective of inclusion in the health sector as demonstrated in their capacity to deliver the Guaranteed Health Plan, even if the conditions of the country allow for a modest one.

The evidence gathered in this review does not allow us yet to assert that CBHOs are an effective organizational arrangement for extending social protection in health. However, it is important to analyze the CBHOs phenomena dynamically in time as the prevalence of this schemes is increasing and research and future field experimentation might be able to identify particular types of CBHOs that can have a clear positive impact on their members and society at large. In this regard, we believe that supporting local demands for experimentation in CBHOs, accompanied with sound monitoring and evaluation, can contribute to identify good performing models of CBHOs.

It is also difficult to evaluate its potential in implementing a GHP. The finding that most of them serve as "Entry-points" instead of "self-contained" schemes is promising in terms of the potential for states to "steer" them towards a national objective as reflected by the country GHP. The finding that most of them offer or facilitate access to a comprehensive benefit package already using subsidies (mostly via prices from the public sector) also works in the same direction. However, the small size and relatively low proportion of the population that they cover today and the pending question of the potential for aggregation of pools in the future, do now allow for a conclusion yet in this regard.

It is urgent to implement quality medium and long-term research on impact and determinants of performance of CBHOs to further evaluate its potential for extending social protection in health particularly for the poor. The research needs to focus the

analysis not only on describing what CBHOs are but also on evaluating their impact on participants, the poor and society at large. It is also key to support demands form the local and national level for experimentation with CBHOs, accompanied with strong monitoring and evaluation process to generate much needed evidence. In the absence of such evidence, policy makers need to exercise caution and prudence in including yet the CBHO organizational arrangement as a proven effective tool for Extending Social Protection in Health on large-scale operations.

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Annex A

Community Based Health Organization, cases analyzed for the study

AFRICA

Benin

1. Sirarou
2. Sanson
3. Alafia de Gbaffo
4. Ilera at Porto-Novo
5. Borgou
6. Various Health Centers including Pahou Project
7. User fees implementation under Bamako Initiative

Burkina Fasso

8. Dakwena
9. Tounouma

Burundi

10. Carte d'assurance Maladi (CAM)

Cameroon

11. Babouantou de Yaounde
12. AFFERAZI
13. Association des Amis clan d'age no. 13
14. Association des resssortissants SAWA de Yaounde
15. BACUDA Batibo Cultural and Development Association
16. Mpouakone
17. Mupehoproma
18. NSO-NGON
19. POOMA of Younde
20. Biyem Assi
21. User fees

D.R. of Congo

22. Bwamanda Hospital Insurance
23. Masisi
24. Bokoro
25. St. Alphonse
26. CASOP
27. REMEF
28. Mutuelle Union et Prevoyance
29. SNRH
30. Mutuelle Nsalasani

Congo

31. User fees

Cote d'Ivoire

32. Prepayment Health Centre Scheme
33. Abidjan Grand-Campement

Egypt

34. School Health Insurance

Ghana

35. Nkoranza
36. Dagaaba Association in Duayaw Nkwanta
37. West Gonja Hospital
38. User fees, 1985

Guinea

39. User fees implementation under Bamako Initiative

Guinea Bissau

40. Abota

Kenya

41. User fees
42. Chogoria Hospital
43. Harambee Movement
44. Tumutumu Hospital
45. Kwale Health District Center

Madagascar

46. PHACOM
47. Community Health Care Financing System Manompona

Mali

48. Commune V
49. Bla
50. Djenne
51. Kolondieba
52. Molodo
53. Cscom, Madiama
54. Centre Sante MUTEC
55. Mutuelle de sante du quartier de l'hippodrome a Bamako
56. MEUMA
57. MUTAM
58. MUTAS
59. User fees

Mauritania

60. User fees, 1993

Mozambique

61. Health reform (No comm.)

Niger

62. Boboye District
63. User fees, Say

64. Tax earn+fee, Boboye
65. User fees, 1993

Nigeria

66. Ala/Idowa
67. User fees implementation under Bamako Initiative

Rwanda

68. Murunda (Kanage Cooperative Scheme)
69. Byumba
70. Kabgayi
71. Kabutare

Senegal

72. Arifa
73. Mont Rolland
74. Ngeye Ngeye
75. Sanghe
76. Mutuelle de Yoffe
77. Dimeli Yoff
78. Faggaru
79. Diappo
80. FAGGU
81. Fandene
82. Fissel
83. Gandiol Sante
84. Goxu Mbaaj
85. Koudiadiene
86. Lalane Diassap
87. Mboro
88. Multi Assistance de l'Education
89. Mutuelle des Voluntaire de l'Education
90. Mutuelle Sococim Entreprises
91. Pandhienou Lehar
92. Saint Jean Baptiste
93. soppante
94. Thially
95. Wer Werle (Profemu) Thies
96. User fees

South Africa

97. HOSPERSA
98. NASASA
99. SIZWE

Tanzania

100. Umasida - Dasico
101. Umasida - Mwandamayala
102. Umasida - Mandela
103. Umasida - Suma
104. Umasida - Nasitunajaribo
105. Bumbuli Hospital
106. Bunda Designated District Hospital
107. Mbhurahati Health Trust Fund
108. Selian Hospital
109. Tusaidiane Bima Ya Afya Ya Atiman
110. New Programme for Contributions

Togo

111. USYNCOSTO
112. Assoc. Sages Femmes du Togo
113. Djagbagba
114. MU-CO-TA-S-GA
115. MUSA - CSTT
116. MUSAD ADIDOADE
117. Mutuelle OTP

Uganda

118. AIG/NHHP Partnering
119. Kisiizi Hospital
120. Mutolere
121. Nyakibale
122. PACODEC
123. Ishaka Hospital
124. Kisoro Hospital
125. Kampala Hospital
126. Kiwoko Hospital
127. Nsambya Hospital
128. Health sect reform (u. fee)

Zambia

129. UTH
130. User fees
131. Health sect reform (u.fee)

ASIA

Bangladesh

132. chan
133. Grameen
134. BRAC
135. Dhaka Hospital Family Health Card Program
136. Dhaka Hospital School Children Card Program
137. Dhaka Hospital Worker Health Card
138. Dhaka Hospital Sport Card
139. Dhaka Hospital Destitute Card
140. IIRD
141. User fees
142. User fees

China

143. Rural Health Prepaid schemes RCMS Qidong county
144. rural Health Prepaid schemes RCMS Haining county
145. rural Health Prepaid schemes RCMS Xiaoshan county
146. rural Health Prepaid schemes RCMS Xinmi county
147. rural Health Prepaid schemes RCMS Wushi county
148. rural Health Prepaid schemes RCMS Wuxue county
149. rural Health Prepaid schemes RCMS Xinghua county
150. rural Health Prepaid schemes RCMS Changyang county
151. rural Health Prepaid schemes RCMS Yongning county
152. rural Health Prepaid schemes RCMS Lingwu county
153. rural Health Prepaid schemes RCMS Yongxiu county
154. Cooperative Health care Scheme Yuandi and Xunyi
155. Sichuan Rural Health Exp.
156. Devolution to townships

India

157. Kasturba Hosp Ins of Sewagram
158. Bombay BMCWS Chawla
159. Raigarh Amb. Health Assoc. RAHA
160. Christian Hosp. Bissamaucuttak, Orissa
161. Tribhovandas Foundation
162. SSSS
163. SEWA
164. SWRC Social Work and Research Centre
165. Urmal
166. Bengali Health Scheme
167. Barpali
168. VHS Hospital
169. KSSS
170. Goalpara
171. ACCORD
172. ASSEFA
173. Cooperative Development Fund CDF
174. SPARC

Indonesia

175. Dana Sehat
176. Socio Econ. Dev. Project Irian Jaya
177. Tabulin Financing Scheme
178. NHI Class II+IV

Nepal

179. Tikathali VDC - Lalitpur
180. Lamatar VDC - Lalitpur
181. United Mission Medical Insurance Scheme
182. Setidevi VDC - Kathmandu
183. Siddhipur VDC - Lalitpur
184. Harisiddhi VDC - Lalitpur
185. Layaku, Kirtipur - Kathmandu
186. Wasbang, Lothar - Chitwan
187. Bhandar - Ramechhap
188. Emergency funds of local solidarity self-help groups
189. Maternity Benefit Vijaya Yourth Club Credit Union
190. Maternity Benefit of local mother's groups

Philippines

191. ORT Health Plus Scheme OHPS
192. ACDECO ANGONO
193. NOVADECI Novaliches Development Cooperative Inc.
194. Tarlac HMP
195. Medicare Programe II Project, Unisan, Quezon
196. Medicare Programme II Project, Sampaloc, Quezon
197. Smokey Mounatain Cooperative
198. Fed PHC Mother's club
199. HEWSPECS Pilot HMO
200. Bukidnon BHIP
201. CHEAP Cooperative Health Mergency Assistance Programme
202. Peso for Health Guihulngan Hospital Community Health Care Project
203. Barangay Federation of Health Workers BHW Surigao
204. Guiamras Health Insurance Programme GHIP
205. Linabo Parrish Medical Health Care Insurance for Students
206. Lunas Damayan Bagong Silang Cooperative
207. Lunas Damayan Pagkakaisa ng Kababaihan
208. Lunas Damayan Pandayan Multipurpose Cooperative
209. Maibo Bulig-Bulong Programme (MBBP) South Cotabato
210. MMGHHS Medical Mission Group Hospitals & Health Services
211. San Isidro Medicare II Project
212. Silago Multi-purpose Cooperative's Coop Medical Aid Plan
213. Tribal Women's Health Project in South Cotabato
214. User fees

Taiwan

215. Farmer's Health Insurance
216. Labor's Insurance for the Self-Employed

Thailand

217. Health Card Scheme
218. SWHI
219. Klong Pia Credit Union in Songkla
220. Sri Haruethai Klung Credit Union

Viet Nam

221. School Health Insurance
222. Bao Hiem Y Te

LATIN AMERICA AND THE CARIBBEAN

Argentina

223. OSMU Trenque Lauquen
224. Servicio de Salud Asociación Mutual S.M. Laspiur

Bolivia

225. Tupiza
226. IPTK
227. Tiwanaku Caja de SS campesina
228. Jesus Nazareno
229. Mutual del Seguro Social CIMES

Colombia

230. Coffee Growers Association

Dominican Republic

231. Los Bateyes, Asoc. Mutual AMUTRABA

Ecuador

232. Seguro Social Campesino
233. Seguro Comunitario Solano
234. Seguro Familiar FEPP
235. SICSI Seguro Social Popular - Sistema Comunitario de Salud Integral
236. Muisne
237. Sistema Solidario de Asistencia Medica Salud Mutual
238. FICI
239. Asociación Barrial Quito Norte

El Salvador

240. User fees (revolving fund)

Guatemala

241. Servicio Solidario Salud CGTG
242. ASSABA
243. ACSMI

Honduras

244. Fund. Desarrollo Nacional
245. Community Drug Funds
246. User fees for drugs

Jamaica

247. User fees (public hospitals)

Mexico

248. CIMIGEN

Nicaragua

249. Asoc. Mutua del Campo
250. Seguro de Salud Universal ATC

Peru

251. Seguro del Agricultor
252. Prepagas Lima
253. Seguro del Agricultor - Municipalidad Las Yaras
254. Seguro del Agricultor - CLAS de la Municipalidad de Ite

Uruguay

255. Policlinica J.P. Varela

Venezuela

256. Sistema Autogestionario de Servicios de Salud Cooperativa Los Naranjos

South Pacific

Papua New Guinea

257. Palmalmal Health Centre Scheme
258. Gaubin

Annex B

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