Appendix to:

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Provider payment in community-based health insurance schemes in developing countries: a systematic review

in Health Policy and Planning

Notes:

Monetary amounts are expressed in local currency at the time of the study and/or in year-2000 US$. The year-2000-US$ amounts are indicated as $. 
## Supplementary table: Characteristics of 34 community-based insurance schemes included in the final review

| Scheme                                                                 | Enrollment sizes or rates                                                                 | Annual premium contribution | Benefit package                                                                 | Type of provider payment method                  | Source                                      |
|------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------|
| Community Financing Scheme, Nkoranza, Ghana (est. 1990)                | As of 1995: 22,891 enrollees. In 2001, ownership of the scheme was transferred from the hospital to the community. By 2004, the Nkoranza scheme covered approximately 44,000 people, or one-third of the district population. | New enrollee: $10.07 Renewal: $8.69 | Probationary period of 3 months; 100% coverage of hospital costs for patients referred to Nkoranza district hospital. | Capitation paid to hospital per enrollee, no co-payment. Initially, hospital billed scheme directly on a fee-for-service basis. | Atim 1999, Smith and Sulzbach 2008            |
| Mutuelle Famille Babouantou de Yaoundé, Cameroon (est. 1991)           | As of 1995: 455 (family and individual) enrollees.                                       | Couples: $60.14 Individuals: $32.81 Dependents: $16.42 | Probationary period of 3 months; $109.37 paid to enrollee upon hospitalization exceeding seven days, or surgery that leads to over fifteen days incapacitation. Maximum of one disbursement per year. | Enrollee pays fee-for-services for any facility (public or private). | Atim 1999                                    |
| Scheme                              | Enrollment sizes or rates                                                                 | Annual premium contribution | Benefit package                                                                 | Type of provider payment method                                                                 | Source                      |
|------------------------------------|------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------|
| Assurance Maladie à Base Communautaire, Nouna health district, Burkina Faso (est. 2004) | Households within Demographic Surveillance System (DSS) (approx. 60,000 in 2004). As of 2010: 8315 enrollees. | Mandatory enrollment of entire household but annual premium set on individual basis: Adults: $3.5 Children: $1.4 One-time household membership fee: $1.30 | Probationary period of 3 months; 100% coverage of selected services at public first-line facilities, up to 15 days inpatient care at district hospital if referred from first-line facilities. Only generic drugs on national essential medicine list were covered. | Capitation paid to first- (75%) and second-line (25%) facilities per enrollee, no copayment. Capitation covered costs of drug prescriptions. No reimbursement to providers for service costs. | De Allegri et al. 2006a, De Allegri et al. 2006b, Gnawali et al. 2008 |
| Action for Community Organization, Rehabilitation and Development (ACCORD), Tamil Nadu, India (est. 1992) | Members of local tribal union (target population = 11,875 individuals). | Individual enrollment: INR 20 ($2.37) per person. | Primary and secondary care at private facilities, with limit of $173.68. | No co-payment, third-party reimbursement. | Devadasan et al. 2006 |
| Bharat Agro Industries Foundation (BAIF), Maharashtra, India (est. 2001) | Poor women members of a local community banking scheme (target population = 1,500 women). | Individual enrollment: INR 225 ($26.41) per person. | Primary and secondary care at private facilities, with limit of $578.95. | Indemnity if upper limit is exceeded. Insurance company reimbursed patient through NGO. | Devadasan et al. 2006 |
| DHAN Foundation (KKVS), Tamil Nadu, India (est. 2000) | Poor women members of a local community banking scheme (target population = 19,049 individuals). | Individual enrollment: INR 100 ($11.74) per person or INR 150 ($17.63) per family. | Primary and secondary care at private facilities, with limit of $1157.89. | Deductible + indemnity if upper limit is exceeded; KKVS reimbursed patients. | Devadasan et al. 2006 |
| Scheme                                                                 | Enrollment sizes or rates                                                                 | Annual premium contribution                                                                 | Benefit package                                                                 | Type of provider payment method                                                                 | Source                      |
|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------|
| Jowar Rural Health Insurance Scheme (JRHS), Maharashtra, India (est. 1981) | Small farmers and landless laborers living around Kasturba hospital (target population = 30,000). | Family enrollment: Minimum INR 48 ($5.63) per family in kind. | Primary and secondary care at private facilities, with no limit. | Co-payment, third-party payment. | Devadasan et al. 2006 |
| Karuna Trust, Karnataka, India (est. 2002)                             | Local population with a focus on scheduled tribes and caste populations (target population = 278,156 individuals). | Individual enrollment: INR 30 ($3.68) per person. Subsidized for the poor. | Primary and secondary care at public facilities, with limit of $289.47. | The insurance company reimbursed the NGO, which in turn refunded the patients or the provider. No co-payment, third-party provider payment. | Devadasan et al. 2006 |
| Navsarjan Trust, Gujarat, India (est. 1999)                            | Select Scheduled Caste individuals in local population (size of target population unknown). | Individual enrollment: INR 159 ($18.68) per person. | Only secondary care at private facilities, with limit of $1736.84. Enrollee paid fee-for-service, plus indemnity if upper limit was exceeded. Insurance company reimbursed patient through NGO. | | Devadasan et al. 2006 |
| Raigarh Ambikapur Health Association (RAHA), Chattisgarh, India (est. 1980) | Poor people living in the catchment area of 92 rural health centers and hostel students (target population = 92,000 individuals). | Individual enrollment: INR 20 ($2.37) per person. | Primary and secondary care at private facilities, with limit of $147.37. Indemnity if upper limit was exceeded; third-party payment. | | Devadasan et al. 2006 |
| Self-Employed Women’s Association (SEWA), Gujarat state, India (est. 1992) | SEWA Union women members (urban and rural), plus their husbands living in 11 Districts of Gujarat (target population = 1,067,348 individuals). | Individual enrollment: INR 22.50 ($2.63) per person or INR 45 ($5.26) for family. | Primary and secondary care at private facilities, with limit of $231.58. Indemnity if upper limit was exceeded; fee-for-service. Insurance company reimbursed patient through NGO. | | Devadasan et al. 2006 |
| Scheme | Enrollment sizes or rates | Annual premium contribution | Benefit package | Type of provider payment method | Source |
|--------|--------------------------|-----------------------------|----------------|-------------------------------|--------|
| Student’s Health Home (SHH), West Bengal (est. 1952) | Full-time students in West Bengal State, from class 5 to university level (target population = 5.6 million students). | School or college enrollment: INR 4 ($0.47) per student. | Primary and secondary care at private facilities, with no limit. | Co-insurance; third-party payment. | Devadasan et al. 2006 |
| Voluntary Health Services (VHS), Tamil Nadu (est. 1972) | Total population of the catchment area of 14 mini-health centers (target population = 104,247 individuals). | Family enrollment: INR 250 ($29.37) per family of five | Primary and secondary care at private facilities, with no limit. | Co-insurance; third-party payment. | Devadasan et al. 2006 |
| Self Employed Women’s Association (SEWA) CBI scheme prospective reimbursement pilot, Gujarat state, India (est. 1992) | In 2003: 101, 809 members. | Individual enrollment: Annual premium of INR 85 ($9.95). Members could also make a one-time fixed deposit of INR 1000 ($117.53) rupees in SEWA Bank, and interest from deposit was used to pay the annual premium for individual enrollment. | Inpatient care up to a maximum of INR 2000 ($235.05) per year. | Prospective reimbursement: members were reimbursed before discharge from hospital. 80% of the predicted cost of hospital admission [up to a maximum of 1600 INR ($188)] could be reimbursed within 48 hours of admission. | Ranson et al. 2007 |
| SEWA Medical Insurance Fund (part of the Integrated Social Security Scheme) (est. 1992), Gujarat, India (previously described above) | Target population: Women aged 18-58. In 1999-2000, statewide coverage was 16% of SEWA members. | See previous entry on SEWA. | Choice of provider left entirely up to the enrollee. The member had to submit certain documents within three months of discharge from hospital. Enrollee paid fee for service at time of use, SEWA reimbursed enrollee within three months. In 1999-2000, the mean rate of reimbursement for all 171 reimbursed claims was 76.5% (median 92.6%). | Devadasan et al. 2006, Ranson 2002, Ranson and John 2001, Ranson et al. 2006 |
| Scheme                                                                 | Enrollment sizes or rates                                      | Annual premium contribution                                      | Benefit package                                                                                                                                                                                                                                                                                                                                 | Type of provider payment method                                                                 | Source     |
|------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|------------|
| The Asociación por Salud de Barillas (ASSABA) community health financing scheme, Guatemala (est. 1996) | In 1993: target population of 65,000.                        | Individual enrollment: Q20 ($5.80)/year. Family enrollment: Q80 ($23.17) for less than 4, Q100 ($28.98) for 4-6, and Q10 ($34.77) for over 6.                                                                 | Primary healthcare provided in public facilities, secondary care at Bethesda Hospital (private, non-profit). Coverage did not include non-emergency illnesses, inpatient care limited to 3-4 days, depending on type of illness. | Provider services purchased through a capitation contract for secondary care at Bethesda Hospital. | Ron, 1999  |
| Organizing for Educational Resources and Training (ORT) Health Plus Scheme (OHPS), Philippines (est. 1991) | In 1994: target population: communities in which the ORT daycare centers were located (15,000). | Individual enrollment: $8 per person. Family enrollment: Family less than six: $16; Family larger than six: $20. | Ambulatory and inpatient care, prescribed drugs and basic ancillary services. Primary care provided by salaried doctors and nurses providing services in the existing preschool day-care centers. Inpatient care provided at hospital in provincial capital, where enrollees receive “preferential" treatment: shorter waiting lines, fewer rooms in beds, etc. | No co-payment or deductible. Primary care health workers were paid on salary basis from project; secondary inpatient care contracted to public hospital (initially private but changed to government tertiary care hospital due to claim dispute) in the provincial capital. Services were purchased on a capitation basis. | Ron, 1999  |
| Scheme | Enrollment sizes or rates | Annual premium contribution | Benefit package | Type of provider payment method | Source |
|--------|--------------------------|-----------------------------|-----------------|-------------------------------|--------|
| 54 micro-health insurance schemes (MHI) in three health districts, Rwanda (est. 1999) | In 1999: 3 districts (Kabgayi, Byumba, Kabutare) with 54 public or church-owned facilities. Enrollment reached 19% by 2003. | Household enrollment: Households enroll via annual premium of RWF 2500 ($32.5) in 2000. | All schemes covered drugs and services provided in all “affiliated” primary level facilities, and ambulance transport to the district hospital, where a limited package of services was covered. Health centers played a gate-keeper function for insured patients, whose hospital treatment was only covered by MHI with health center referral. | MHI paid health centers a monthly capitation payment. The insured patients paid a RWF 100 ($1.25) co-payment per episode of illness in health centers, as well as user fees for services not covered by MHI (e.g. drugs excluded from the Ministry of Health essential drug list). All facilities received subsidies from donors and government in form of salaries for public employees, salary mark-ups, and drug donations. | Musango et al. 2004, Schneider and Hanson 2007, Schneider and Hanson 2006 |
| Maliando Mutual Health Organization, Kissoudougou District, Guinea (est. 1998) | Catchment area of Yende health center (target population – 17,000). Enrollment reached 8% in 1998. | Household enrollment: The annual subscription fee per individual was $10.53 in 1998, rising to $13.16 in 1999. | Coverage at all first-line services at Yende government health center, as well as emergency obstetric and surgical care for all adults along with healthcare for children under fifteen, at the government district hospital. | Co-payment per episode of illness, no specific information on how premiums were used for payment. | Criel et al. 2005, Waeltkens and Criel 2004 |
| Scheme                                                                 | Enrollment sizes or rates                                                                 | Annual premium contribution                                                                 | Benefit package                                                                 | Type of provider payment method                                                                                     | Source                                      |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Jyorei community health insurance, Japan (est. 1835)                   | Target population: rural, self-employed farmers.                                           | Premium levels (in-kind contributions of rice set to household income level (34 levels established).) | Curative and preventative services provided by contracted doctors.                | Doctors hired under contract with rice and lodging being the form of payment. Initially no co-payments. Consultation fees were introduced in 1891 in response to escalating costs due to the introduction of Western medicine. | Ogawa et al. 2003                           |
| Bangladesh Rehabilitation Assistance Committee (BRAC) Micro Health Insurance Program, Bangladesh (est. 2001) | Target population: all residents in NGO catchment area (12,258 enrolled in 2004).        | Cash premiums collected annually, individual enrollment but family size determines premium amount, and “ultra-poor” enroll free. | 50% off pathology tests; ultra-poor 80% off. 10% off medication fee; ultra-poor 80% off. $35.50 provision for referrals. Free annual check-up for head of household. For ultra-poor: At least 2 post-consultation follow-up home visits. Free transportation to referral hospitals and clinics. | Co-payment, salaried health worker staff. For referral, patients were required to pay the total cost of treatment at the referred center. To claim reimbursement, the BRAC cardholder was required to submit the prescription, medicine bills and the treatment bill to BRAC field workers, which were then reimbursed in cash after one week. | Desmet et al. 1999, Ahmed M 2005             |
| Scheme                                                                 | Enrollment sizes or rates                                                                                                                                                                                                 | Annual premium contribution                                                                                                                                                                                                 | Benefit package                                                                                                                                                                                                                      | Type of provider payment method                                                                                                                                                                                                 | Source                                                                                     |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| Grameen Bank Kalyan (GK), Bangladesh (est. 1997)                      | Target population: all residents in NGO catchment area (58,000 enrolled in 2004). Eligible villages were those that were located within an 8 km radius of a GK health center.                                                   | Non-Grameen Bank (GB) villagers paid slightly higher premiums and copayments than Grameen Bank members. Enrollment covered up to six members of an enrollee’s family, with $1.42 for each additional member. $8.50/10.67 (GB/non-GB) per year. | 25% off retail price of 15 essential basic medicines; 10% off retail price of other medicines; 30-50% off normal pathology tests; 50% off referred consultation fees; $35.50-71 provision for other hospitalization costs; up to $142 for pregnancy related costs; free annual check-up for head of household; free immunization against six diseases; free house visits by female health assistant. | Medical consultation fee: $0.38/0.71/3.54 (GB/non-GB/non-cardholder). Each GK clinic was staffed by a qualified doctor, a manager, a paramedic, a lab technician and 4 to 5 Health Assistants. The more remote the area, the higher was the salary. For referral, enrollees received a 50% discount on referred consultation charges and paid directly to the referral treatment center. | Desmet et al. 1999, Ahmed M 2005                                                                 |
| Society for Social Services (SSS) Health Program, Bangladesh (est. 1993) | Target population: all residents in NGO catchment area (45,424 enrolled in 2004). Enrolment was compulsory for all SSS borrowers living in the 6 sub-districts of Tangail in which the hospital and 16 clinics were located. | Members were required to pay $1.42 each year for a health card.                                                                                                                    | Health service benefits were available to a cardholder’s entire family, no matter how large. Coverage included curative healthcare at SSS clinics, referral to SSS hospital if required, 30% discount on SSS hospital charges. | Members were required to pay a registration fee of $2.13, equivalent to a co-payment, on each visit to the hospital or clinic. For referral, cardholders paid charges directly to the clinic or hospital at the time of receiving treatment. | Desmet et al. 1999, Ahmed M 2005                                                                 |
| Scheme                                           | Enrollment sizes or rates                                                                                                                                                                                                                                                                                                                                                           | Annual premium contribution                                                                                                                                                                                                                       | Benefit package                                                                                                                                                                                                                     | Type of provider payment method                                                                                     | Source                      |
|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Save for Health, Uganda (SHU) (est. 1999)         | Multiple independent sub-schemes in 3 districts. By 2005, 2840 enrollees. Requirement for village-based enrolment comprising a minimum of 100 people. Kiwoko hospital was the main provider for SHU and was owned by the Anglican Diocese of Luwero.                                                                 | The contribution per individual member of a family in the SHU scheme amounted to an average Ushs 3800 ($8.05) as an initial payment, and about Ushs 800 ($1.71) per annum.                                                                                     | Waiting period of three months. The hospital provided 12% discount of the hospital bill to scheme members.                                                                 | Co-payment plus salary for hospital providers.                                                                    | Basaza et al. 2008, Basaza et al. 2007 |
| Ishaka Scheme, Uganda (est. 1999)                | Owned and controlled by Ishaka Adventist Hospital. By September 2006, 6% enrollment in catchment area.                                                                                                                                                                                                                                                                      | Group-based enrolment requirement; 60% of the group were required to enroll before the scheme became operational. The premium was Ushs 15,000 ($31.81) every three months for a family of 4 and Ushs 3,700 ($7.86) for an additional person. | Waiting period of two weeks. All services provided in both outpatient and inpatient departments at Ishaka hospital including drugs and diagnostic tests. Dental and optical cares were excluded. | Co-payment of $2.38 for outpatient consultations and $11.90 for inpatient admissions. Salary for hospital providers.                                                                 | Basaza et al. 2008, Basaza et al. 2007 |
| Scheme                             | Enrollment sizes or rates                                                                 | Annual premium contribution                                                                 | Benefit package                                                                                       | Type of provider payment method                                                                 | Source          |
|-----------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------|
| Uplift Health, Pune City, India (est. 2003) | Adults of Pune city, India who borrowed money using Uplift’s microfinance method. Membership in 2005 was 16,356; UpLift’s social workers collected premiums. | Premiums were age-related, then (in 2004) standardized at INR 100 ($11.94) per person per year, discounted to 50% if entire households joined. | Reimbursement of up to 80% of hospitalization costs, capped at INR 5,000 ($111.55) per person and year. Different maximum limits applied for specific illnesses. 14 pre-existing conditions and bills from out-of-network hospitals were excluded. Scheme also paid income-loss compensation of $1 per day (for days 3-18 of hospitalization). | Enrollees paid fee-for-service and were reimbursed by the scheme. | Dror et al. 2009 |
| Nidan (associated with SEWA), Gujarat, India (est. 2001) | Target population: Market vendors in Patna, Bihar. As of 2005, the scheme had 10,189 members | Nidan’s Plan A (chosen by 66% of members) INR 170 ($20.32) per insured person plus spouse; Plan B INR 350 ($41.84) per insured person plus spouse. | Preexisting conditions and maternity-related costs were excluded. People aged 18-55 eligible to join; renewal was possible until age sixty. Plan A provided coverage up to INR 6000 ($715.79); Plan B covered up to INR 6000 ($715.79). | Enrollees paid fee-for-service and were reimbursed by the scheme. | Dror et al. 2009 |
| Scheme | Enrollment sizes or rates | Annual premium contribution | Benefit package | Type of provider payment method | Source |
|--------|---------------------------|-----------------------------|-----------------|---------------------------------|--------|
| Bharatiya Agro Industries Foundation (BAIF), Pune, India (est. 2003) | Target population: women aged 18-70 participating in so-called self-help groups in rural Pune. As of 2005: 600 households enrolled. | Family enrollment: The annual premium was INR 150 ($15.79) (plus an administrative fee of INR 25 ($2.63). | Coverage of hospitalization up to INR 5,000 ($598.16). Claims not fully settled were eligible for reimbursement in future months when balances were positive. | Enrollees paid fee-for-service and received reimbursed from the scheme. A committee of scheme members settled claims. | Dror et al. 2009 |
| Four CBI schemes were developed by the Ministry of Health of Mali and the USAID-funded Partners for Health Reform project (BlaVille, Kemeni, Wayerma, Bougoula), Mali (est. 2003) | In 2004, coverage ranged from 3.3%-11.4% | Member households paid a once-off enrollment fee ($7.04) and a monthly ($1.81) or annual premium (based on the number of beneficiaries). | When members or their beneficiaries needed curative or maternal care and were up to date on their premium payments, they paid a portion of charges (usually 20-25%) at the time of service, and the CBI covered the remaining portion. Only one of the schemes covered hospitalization. | CBI schemes signed agreements with local primary health-care centers and, where available, referral health centers. Members paid a portion of services charges at time of care, while the CBI reimbursed the health centers the remaining sum afterwards. | Franco et al. 2008 |
| Scheme | Enrollment sizes or rates | Annual premium contribution | Benefit package | Type of provider payment method | Source |
|--------|--------------------------|-------------------------------|-----------------|--------------------------------|--------|
| 10 CBI schemes in Anambra state, southeast Nigeria | The CBI scheme has been established in 10 local government areas (with a minimum population of 100,000 people). | Household enrollment: Premiums were 100 Naira ($1.46) per adult per month and 50 Naira ($0.74) per child per month. | No specific information available on benefit package. | The scheme directly paid the selected public health facilities that the beneficiaries use. The state government refurbished and equipped the health facilities involved in the scheme, and made matching contributions to the premiums paid by the householders to the scheme. In addition, the state government paid the salaries of the healthcare providers. | Onwujekwe et al. 2009 |
| Scheme | Enrollment sizes or rates | Annual premium contribution | Benefit package | Type of provider payment method | Source |
|--------|---------------------------|-------------------------------|-----------------|--------------------------------|--------|
| Community-Health Funds (CHF) in four provinces (Parwan, Saripul, Nimroz, Helmand), Afghanistan (est. 2005) | The CHF pilot was administered by health facility staff and targeted households living in the catchment areas (90 minutes walking distance from the facility) of the pilot health facilities. The household was the unit of enrollment. | Household enrollment: Premium levels were set by facility staff in consultation with community members and varied with economic status and household size. The annual reference premium was set at 300 AFA ($6) for less poor households with 1-5 members. Economically vulnerable households (identified by health center staff) could enroll free of charge. Premium paying enrollment rates ranged from 1%-38% | Benefit package covered all services and drugs offered at the designated health facility in addition to inpatient care at the nearest district hospital. No ceiling on use of services. | Co-payment of 1 AFA ($0.06) when using health services. Health center staff paid salary by Ministry of Health or Provincial-level NGOs. Revenues earned through cost sharing could be used only for certain prescribed activities, such as the administration of the CHF scheme, quality improvement including the purchase of drugs and supplies, bonuses for health facility staff, community outreach and other community activities. There was a 10% cap on the use of funds for staff bonuses. | Rao et al. 2009 |
| Scheme | Enrollment sizes or rates | Annual premium contribution | Benefit package | Type of provider payment method | Source |
|--------|---------------------------|-----------------------------|-----------------|--------------------------------|--------|
| New Cooperative Medical Scheme (NCMS), Linyi County, Shandong Province, China (est. 2003) | Government-launched CBI scheme for rural zones. Enrollment rate of 94.6% in Linyi in 2004. | Premium contribution plus per capita funding of the NCMS was 23 Yuan ($11.58), composed of 10 Yuan ($5.04) from the individual and a total of 13 Yuan ($6.54) from various levels of government. | NCMS benefits covered drugs, outpatient services in village health stations, outpatients and inpatients in township hospitals and in county or higher level hospitals. Patients at village health stations received a 20% discount for medical expenses during each visit, and village doctors kept a record of discounts given, which were then inspected by NCMS officials. Hospital outpatients also directly paid for medical services at prices discounted at 20%. Inpatients received 20-75% reimbursement for medical expenses, higher reimbursement rates for higher expenses. Coverage ceiling of 20,000 Yuan ($10,066) per person per year. | Of the total available NCMS funds, 70% were allocated to inpatient reimbursements and 30% to outpatient services delivered by township hospitals or village doctors. NCMS has contractual agreements with various health facilities (e.g. village health stations) relating to the payment system and the delivery of health services, which were then inspected by NCMS officials. The NCMS paid village health stations an annual capitation of 3 Yuan ($1.5) per insured villager. Capitation payments accounted for about half the NCMS funds allocated for outpatient services with the rest going to township hospitals. | Sun et al. 2009 |
| Scheme                                           | Enrollment sizes or rates                                                                 | Annual premium contribution | Benefit package                                                                 | Type of provider payment method | Source                                      |
|-------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------|---------------------------------|--------------------------------------------|
| Rural Mutual Health Care (RMHC), Shaanxi province, China (est. Dec. 2003) | Voluntary enrollment in Tiechang township in Shaanxi province from 2004 to 2006. Enrollment rates were RMHC was 64.32, 59.80 and 79.58%, respectively, in 2004, 2005 and 2006. | No information.               | Reimbursement of outpatient and inpatient services provided by selected village clinics. | No co-payment. The Fund Office of RMHC acted as a single purchaser and selected the village doctors on a competitive basis. Contracted doctors were compensated with a salary plus a bonus based on selected health outcomes and performance measurements. Village doctors were not allowed to purchase drugs themselves. Instead, drugs were purchased through a competitive bidding process and then distributed by township health centers to the village clinics. | Zhou et al. 2009, Wang et al. 2009 |
| Community Health Fund in Hanang District (est. in 1998), Tanzania (est. in 23 districts in 1995) | Government owned, operated by district health teams. Voluntary, except for civil servants (who were required to enroll prior to the establishment of the National Health Insurance). Enrollment rate peaked at 23% in 1999, and then substantially declined to 3% in 2001. | Household enrollment, annual premium of 10,000 TZS ($13.22), with exemptions for the extremely poor. | Unlimited access to outpatient services at participating primary-level facilities, and referrals to district-level hospital. Services from both government and private (both non-profit and for-profit) facilities. | Salary for public providers, plus, direct budgetary subvention to providers. No specific information on private providers. | Chee 2002 |

AFA = Afghanistan Afghani  
CBI = community-based health insurance  
INR = Indian Rupee  
NGO = Non-governmental organization  
Naira = Nigerian Naira  
Q = Guatemalan Quetzal  
RWF = Rwandan Franc  
TZS = Tanzanian Shilling  
Ushs = Ugandan Shilling  
Yuan = Chinese Yuan
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