Financing Medicines through Microfinance: Successes and Challenges

Veenita Anand[*], Karikalan Nagarajan[**]

[*] National Institute of Health and Family Welfare, New Delhi, India.
[**] National AIDS Research Institute, Pune, India.

Abstract- Objective: The objective of this paper is to understand the scope of microfinance institutions (MFI) in financing medicine for health seeker of low economic strata people. The various challenges faced by the microfinance services providers in health and medicine in particular. Some Asian countries have been chosen to observe the medicine coverage strategies. This paper will use the data from national health accounts and best published inventory data from ILO for some specifics countries. This paper will enlighten the success and challenge face by various microfinance institutions.

Method: We used complementary data and information collection approaches: 1. Structured questionnaire with various MFI`s working for health and medicinal services in Asian countries about key issues related to medicines. 2. Review of articles published in British medical journal, lancet journal, New England journal of medicine, JAMA since 2000 and documents posted online by various resources, analysis of existing data bases of GIMI, WHO, and ILO.

Findings and conclusion: The main results of the studies shows that MFI's Financing the medicine with financing mechanism especially Insurance and credits system are effective in brining the health and social protection to the large number of poor people. The microfinance can be a distributive channel to supply various financial products. It shows importance in medicine coverage in OPD especially essential chronic disease and tradition medicine which is demand of the community. Covering medicine within the product of insurance, voucher or credit is possible but dealing with cost of the microfinance institution will be challenging. Further more research is required to explore the alternatives to fund the microfinance institution.

Index Terms- Micro Finance Initiatives; Medicine; Developing countries; Chronic ; Traditional medicine

I. INTRODUCTION

Financing health is a vital component of health systems which is increasingly focused upon due to the increasing cost of health care globally, especially in developing countries [1]. The solutions provided by various health care delivery models in addressing health inequalities through health financing mechanisms face their ultimate challenges in addressing the health needs of the lower income bracket [2,3]. The complimentary relationship between ill health and poverty has been elaborately documented through various quantitative studies [4,5]. The public health system in the developing countries render free health services but still due to their poor availability, accessibility and quality have always been a barrier for the population [6]. In this condition, while the financial barriers exclude the lower income bracket from accessing private health services on the other hand the costs of health including medicine, transport, buying services and losing business make them more poor to obtain complete care . According to National Health Accounts data, out-of-pocket payments account for maximum of private health care expenditures, which themselves represent over half of total health care expenditures in low-income countries [7]. One vital component of the health care cost, is the "cost of medicine" which leads to catastrophic household expenditure or avoidance of treatment.[8]The proportion of out-of-pocket health expenditures devoted to medicines is inversely more associated with income quintiles. A single bad health shock can cost thousands of rupees, undermining saving or forcing households to take loans. The low-income population groups are likely to suffer most from low level of prepayment and thus high out-of-pocket payments. In this scenario Microfinance institutions (MFIs) are involved in addressing the health needs of low income brackets, by providing financial services to the poor on a sustainable basis. Microfinance institutions are developing financial strategies products and services for very poor or difficult to reach rural populations, reducing their vulnerability and increasing their economic power to buy health[9, 10]. In this backdrop this paper investigates the success and challenge of MFI products and services that covered cost of medicines among the low bracket income group and further its impact on their access to medicine and social protection. Specifically this paper will assess the present status of health expenditure for medicines in SE region and MFI initiatives to cover the medicine cost specifically ,and their experiences of success and challenges in this initiatives which has not be done so far.

II. METHODS

Two techniques were used for this study which includes literature review and conducting secondary case studies. Literature review were done mainly using the published literatures from international labor organization STEPS initiative in inventory for microfinance in India, Bangladesh, Nepal, Pakistan and Sri Lanka[11] We have also explored the published literature from various journals like JAMA, BMJ, and science available from 2000 till 2010, using key words microfinance and medicine, health expenditures, health insurance, health resources, health services accessibility, insurance, and medicines coverage.

In addition we have also searched literature through the internet google search engines and other sources at Library of WHO [12]
Case study of MFI`s working for health and medical services was conducted using a standard methodology for four countries of Bangladesh, India, Pakistan and Sri Lanka, which all fall in the WHO South East Asia region. To have effective results within a time limit and control for the range of microfinance institution, we have targeted these countries which have the high share of disease burden and a huge population which fall under the low income bracket. These microfinance institutions working for health care services were examined to understand the business dynamics, i.e. the services available for health, mode of delivery mechanism, coverage of services among various areas.
Four MFI's selected for case studies were SEWA-India, YASURI-Sri Lanka, BRAC-Bangladesh, and AGAKHAN – Pakistan. For each low-income country selected, we extracted information and data on the basis of questionnaire which had three sections.Section-I : Details of the organization, mechanisms of operation, Population coverage, Second- II Details of Budget and expenditure for health care program includes Member contributions, Expenditure on health care functions, Section- III. Details about the spending on medicines, Medicine financing and other opinion oriented question on MFI and medicine issues.

III. RESULT

Literature review shows that key factors influencing the people's access of medicine are affordability and availability

Availability -While Public facilities are a primary treatment option for the poor, the availability of medicines in public sector was consistently low, which could be due to variations in the products included in national essential medicines lists or poor compliance with their recommendations[13]. Even when medicines are available for free or at low cost, access is limited by low availability. Private sector was consistently higher, in many countries it was also low, and high private sector prices could further hinder access. Generics were more widely available than brands in the private sector in low-income countries and lower-middle income countries, whereas in upper-middle income countries the availability of brands and generics was similar [14].

Affordability- The public system did not make enough money to pay for new drugs and administration. Reason are like huge drops of in use of health care centre, the higher treatment costs of the disease to be treated, the difficulty in monitoring the fee-for-services method and failing national drugs supply. [15]. In Benin, the *Association d'Entraide des Femmes* scheme preferentially contracts with religious health care providers, because these providers receive donations of brand name medicines that patients prefer, and sell them at discounted prices.[16]

S**cenario of access to essential medicines in South East Asia Region**

Access of essential medicine by WHO region of south east Asian shows not even a single country out of nine countries that have a high access of medicine which is worser than Africa which shows 3 countries in high access out of 45 countries. While 2 countries in of south east Asian out of 9 countries is having very less access (less than 50%) whereas its 14 for Africa. The data shows 4 countries in 50 - 80 % and 3 in 81-95 % range in accessibility of medicine in south East Asia region. Population without access of medicine in the SE region is 127 million which contribute to 26% of total. WHO regional population without access to medicines, otherwise 7% of the world population without access to medicine [17,18,19]

Chronic and complementary medicine

Chronic disease medicines were unaffordable for large proportions of the population. Increased emphasis should be placed on reducing the cost of these medicines in light of the high burden of non-communicable diseases [20].Private sector patients paid 9—25 times international reference prices for lowest-priced generic products and over 20 times international reference prices for originator products across WHO regions. Treatments for acute and chronic illness were largely unaffordable in many countries. In the private sector, wholesale mark-ups ranged from 2% to 380%, whereas retail mark-ups ranged from 10% to 552%. In countries where value added tax was applied to medicines, the amount charged varied from 4% to 15%.[21].Complementary and alternative medicines (CAM) often play a significant role in meeting individuals' needs for affordable essential medicines. In some Asian and African countries, 80% of the population depend on traditional medicine for primary health care [22]. Household surveys in Ethiopia suggest that expenditures on traditional medicine were 20 percent of total household expenditures on health, compared with 33 percent for private doctors, and 47 percent on "modern" medicines [23].

Out of pocket (OOP) expenditures and Health expenditure on medicine

National Health Accounts data estimates that out-of-pocket payments account for 88.3% of private health care expenditures for south east Asian countries including pakistan, which themselves represent over half of total health care expenditures in low-income countries [7].

Table 1

Table-1 shows, Indian contributes 77.5 percent OOP out of total expenditure on health, furthermore the drugs contribution in OPP is more in Bangladesh and Nepal and around 40 % in Sri Lanka and India. The WHO estimates that every year more than 100 million people are forced into poverty by illness and struggle to pay for health care[24] .Sources used to finance OOP include current income saving reimbursement from an insurance plan the sale of assets, money borrowed, and other. The literature suggests intra-household labor substitution is a commonly employed strategy to cope with both the direct and indirect costs of illness.

Exploring the possibility of the medicine being financed by microfinance:

MFI can be an effective tool to provide health services. Access to financial services – saving, credit, insurance and payment services which are important for poor people: saving provide a cushion that enables people to cope with unexpected events**.** The spectrum of services of Micro Insurance has constantly expanded, as schemes and terms of providing

insurances services are determined by each company individually. There are many insurance schemes running in developing countries but community health insurance plans in only one-third of low-income countries. Focus on inpatient and outpatient medicines coverage, adjusted to local circumstances, may be one strategy to encourage higher rates of voluntary enrollment in community health insurance by the poor .Medicines coverage policies have an important influence-revenue collection and strategic purchasing. Studies have shown that perceptions about quality of care affect community health insurance membership: coverage for and availability of medicines may be a key determinant of these perceptions. Community health insurance plans can also boost direct revenues by channeling subsidies from public authorities and international donors, which seems to be the case in Rwanda (25). Community health insurance plans can negotiate payments with those who purchase and supply medicines, and they can design incentives to use recommended medicines. Incentives to prescribe and use generics may help to shift market share away from commonly used brand medicines, exert pressure to reduce the prices of these brand products, and increase treatment affordability for both community health insurance plans and patients. In poor communities, Community health insurance provides a critical institutional link between patients, providers, and suppliers of medicines: it can play a key role by negotiating with medicine suppliers, by adjusting medicines coverage to local health care priorities, by disseminating education materials tailored to the community about quality use of medicines, by linking medicines coverage to treatment adherence, and by rewarding providers and community-based workers who follow treatment guidelines. The transition from collecting premium at the factory gets to group policies significantly enhanced the cost-effectiveness of the coverage **(26).**

Findings of case studies of selected MFI

Case Study I: SEWA-India working in Health

Sewa is the oldest microfinance institution in India. Since its inception in 1974, Bank has evolved to a composite financial institution and has added insurance service in partnerships with the government (Ahmadabad Municipal Corporation), private sector and non-governmental organizations. Inspired by close studies of the needs of the clients, today SEWA Bank offers more than 40 differentiated products. SEWA Bank distinguishes three broad types of needs that necessitate different financial strategies: predictable needs, unexpected shocks, and income-generating activities. SEWA Bank offers its members the means to come out of the clutches of the moneylender by taking out a low-interest (18%) loan to pay off past debt, and by enabling the woman to create her own assets through savings and insulate her from shocks such as natural disasters and sickness through insurance. There are common life-cycle needs such as pregnancy, education, marriage, old age, and various yearly festivals and ceremonies. Due to their predictable nature, these needs can be addressed with savings and SEWA Bank has designed a variety of specialized recurring deposits to allow women to plan for their future. For unexpected shocks that may throw a family back into the poverty trap or destroy its assets, SEWA Bank provides insurance.

Benefits Contributions (yearly)

Package 1:• Up to Rs. 2000 for Medicaid expenses, Rs. 3.000 for natural death, Rs. 40.000 for accidental death, Rs. 5.000 for assets and Rs. 15.000 on widowhood

Package 2:• Up to Rs. 5.500 for Medicaid expenses, Rs. 20.000 for natural death, Rs. 65.000 for accidental death, Rs. 10.000 for assets and Rs. 15.000 on widowhood

Package 3:• Up to Rs. 10.000 for Medicaid expenses, Rs. 20.000 for natural death, Rs. 65.000 for accidental death, Rs. 20.000 for assets and Rs. 15.000 on widowhood.

Case Study II: Yasiru –Sri Lanka working in Health

Yasiru started in the middle of the 1990s as an in-house insurance service in a federation of NGOs called All Ceylon Community Development Council (ACCDC). Intended target groups/clients are the rural poor without permanent employment. Actual clients are the small scale farmers, estate workers rural people with low income. Yasiru is providing insurance to over 9 000 members through its partners. It has accumulated equity and reserves of almost LKR 5 million ($50,000). The product covers death, disability and hospitalization and has a typical low-income profile. The monthly premiums vary from LKR 10 to 150 ($0.1 to $1.5) and the benefits range from LKR 3000 to 120 000 ($30 to $1,200).The NGOs have offices in rural areas and appoint "animators" who carry out the recruitment of clients and sales of policies in the field. Pricing for the insurance products includes with no deductibles or co-payments. Scheme covered Death.

Hospitalization of a covered person: Benefit is awarded once in 12 consecutive months only for one event subject to a maximum delay of 15 days per covered person. Repeat benefit claims for the same illness will be entertained once in two years. Hospitalization claims can be made only after completing 6 months of membership. If hospitalization conditions are not being met, benefit is awarded once in 12 consecutive months only for one event subject to a maximum of 10 days per covered person. Ayurvedic or similar treatment claims can be made only after completing 6 months of membership. "The main strategy for Yasiru is to cooperate with partners and to have insurance agency.. All partners offer microfinance products and are therefore well equipped to extend their services to include micro insurance. The penetration rate of the Yasiru scheme needs to be increased among the 60,000 members of its current partners. This will demand resources for marketing and for further training of staff within the partner organizations. A major challenge for Yasiru in the years to come will be to adapt to a new financial situation with reduced external support.

Case Study III: BRAC ((Bangladesh Rural Advancement Committee) working in Health

BRAC has grown to become one of the largest NGOs in the world, working in 65,000 villages in all 64 districts of Bangladesh. BRAC's microcredit program follows the Grameen Bank group-borrowing model, delivering services through at network of 1,172 branches and 155,065 Village Organizations (VO) with 5.1 million member ships. BRAC originally introduced a health 'insurance' scheme in the mid 1970s as part of a project in Sulla, in the northeast of Bangladesh. The aim was to provide affordable health care to community members. In

exchange for an annual 'premium' of one kilogram of pre-husked rice, households were eligible to receive free primary health care from BRAC paramedics. The scheme was open to all sections of the society. It was discontinued when research revealed that only landowners and established farmers were taking advantage of the scheme.

From the mid 1990s, the program was extended to include curative services to complement their existing preventative services. The first BRAC health centre or 'Shushastho' was established in response to demands of BRAC's members. Their desire to reintroduce a health micro insurance scheme grew out of the need to include this neglected segment and address the issues of equity, affordability and accessibility to health care. The BRAC Health Program focuses principally on the community, with a particular focus on women and children, though men are not specifically excluded, and is implemented through three tiers. The first tier is a cadre of part-time community health workers, called "Shashtho Shebikas" (SS), mostly front-line women workers of BRAC's Health Program.. The second tier is a cadre of health paramedics, all women, called Shashtho Kormis (SK). The third tier is a network of clinical facilities, called BRAC Shushasthos. The Shushasthos provide technical and clinical backup to the SS and SK,. The Shushasthos provide treatment and diagnostic services, have comprehensive laboratory labs, outpatient facilities, and in-patient services. There are 98 Shushasthos operating in 92 Upazilas in the country.

Table -2

Table-2 Features the BRAC MHIB scheme (2005).Benefits BRAC MHIB has three voluntary HMI packages: the General Benefit and Ultra Poor Package, Pregnancy Related Care Package and School Health Package. BRAC MHIB's first insurance scheme, the General Benefit and Ultra Poor package, provides medical consultations at BRAC Shushastho at reduced rates, discounts on pathology tests and medicines. The ultra poor get 2 post consultation home visits, and the head of the household gets a free annual check-up. In case of referral to other clinics or hospitals, the scheme reimburses between US$8.52 and US$17.04. The benefits were adopted after consulting the community's disease profile and extensive consultation with target group members. The Pregnancy Related Package, which was introduced in 2002, covers the cardholder against a number of pregnancy related complication through all stages of one pregnancy. It also covers newborns against diarrhea and pneumonia. Free iron tablets, folic acid and Safe Delivery Kit are also supplied all pregnant women covered by this scheme. The major challenge faced by the three HMI schemes today is their financial viability.

Case Study IV: **Aga Khan Agency for Microfinance (AKAM)** has taken over 25 years of microfinance activities, programmes and banks that were administered by sister agencies within the Aga Khan Development Network.. In Pakistan AKAM has been working on insurance products for the poor since mid-2005. With this funding AKAM was able to open the First Micro insurance Agency Pakistan (FMiA-P). AKAM's flagship micro insurance product is hospitalization insurance. AKAM is working from the hypothesis that the most appropriate solution for health financing involves a combination of health savings accounts and micro insurance. FMiA-P was incorporated in February 2008, offering life, savings and health insurance products to clients in Lahore, Karachi and in Northern Pakistan. As an insurance agent, FMiA-P is not the legal underwriter of the insurance policies. Rather, it manages the product development, marketing, sales, and claims management for the New Jubilee Life Insurance Company, which is majority owned by AKFED. This partnership has enabled AKAM to quickly begin providing dedicated micro insurance products to poor families.

The Aga Khan Foundation Canada and the Canadian International Development Agency are also providing some grant funding to support the "Healthy Mother/Healthy Infant" pilot project that is based on this combined savings-insurance approach. The key to providing effective insurance and a solution to the perceived health care burden is to add products and services which definitely provide value during which the premium is paid. The Medical Savings accounts with discounts on medicine purchases as well as the Dial a Doctor Service both provide value to the client during his first year of premium payment.

IV. DISCUSSIONS

Microfinance as an option for medicine:

Internationally, the microfinance business has outstanding achievement in extending financial services to the poor; and has demonstrated a significant ability to contribute to the Millennium Development Goals. Health Insurance can improve medicines access and use, systematic research is needed on medicine benefits and their performance, including the impacts of Community Health Insurance on access to, affordability, and use of medicines at the household level. (***25)*** But the industry has a long way to go – and over a billion low-income people remain unable to access formal financial services Internationally several key principles for microfinance are emerging and increasingly accepted [27]. Health insurance is booming in Asian countries. Prepayment schemes can take many forms on the road to universal coverage but the significance plans scheme is required to cover the benefits specially medicine without any co-payment and reduction to reduce the burden of medicine for covered people. Community health insurance plans can negotiate payments with those who purchase and supply medicines. The chronic medicine, traditional medicine and day care treatment are the three major services that hit the patient. In practice this could mean schemes to make chronic disease medicines available in the private sector at subsidized prices, or through the promotion of differential pricing schemes that offer reduced prices in poorer countries. Improved public sector support is needed for chronic disease medicines and insurance plan must covers chronic disease medicine. Several options are available to promote use of generics, including preferential registration procedures, ensuring the quality of generic products, encouraging price competition, and increasing the confidence of physicians, pharmacists, and patients in the quality of generics. Countries should develop and implement national policies to improve the availability and affordability of essential medicines [21]. Traditional medicine may be able to help reduce the government's financial health-care burden like some of the therapies have been used in Kenya

for more than 60 years. Traditional practitioners managed 68·7% of the disease burden compared with 31·3% addressed by government funded health centre's. In Madagascar, the government allocates 1·3% of gross domestic product for provision of healthcare services that use traditional medicine [28].Focus on inpatient and outpatient medicines coverage, adjusted to local circumstances, may be one strategy to encourage higher rates of voluntary enrollment in community health insurance by the poor **.**

Assessment of case studies: SEWA is based on insurance model where medicine is covered under hospitalization. SEWA is having a partnership with government and other private organization which make the organization sustainable. As insurance is having drawback of moral hazard, adverse selection and lack of collateral interest, Sewa is able to overcome observe the regularity of savings for six months, the loan size increases cycle to cycle to establish a credit history and regularity of the payments. Generally the loan is individual and keeps track of its portfolio and promptly notifies irregular borrowers. In case of YASURI, No staff in it has any professional experience in insurance. The general education level of the staff is A-levels or O-levels. They have m Ayurvedic or similar treatments of a covered person. As the data shows that the chronic medicine and traditional medicine are ignored part of medicine coverage but Yasuri is taking care of other prospect of medicine. But few of the dropouts will understand fully that although they have received no benefit, they were actually insured while they paid the premiums. As pointed our earlier, it is likely that many of the clients who terminate the insurance will tell their neighbors that they have paid for several years but received nothing. Yasiru's financial situation is, of course, positively influenced by the support it has received from the Rabobank, which has allowed Yasiru to build up reserves quickly. BRAC model covers medicine in their products as in 25% off in the retail price of 15 essential basic medicine and 10 % off in other. The burden of total coverage of medicine is still not observed from the model and that gives the insecurity to the patients to get complete coverage

Barriers

The cost of running an MFI is a worry of many capitalist due to competitive pressures, as more entrants into the market diversify their financial product offerings and swapped out low cost, or concessional, funding for more commercial funds in the credit boom. Financial services to low-income people have great difficulty achieving profitability, especially those serving dispersed populations in rural areas. Many MFIs are organized as NGOs; they do not have a shareholding structure, so are unable to raise equity from investors. They also cannot collect and intermediate saving. Because of these factors, their sources of finance are restricted to grants, loans, and retained earnings. These NGO-MFIs often use donor- funded credit lines to start or expand their business. Other challenges faced by the community based insurance organization is the small size, multiplicity of communities where they function, and lack of infrastructure or technical capacity.

V. CONCLUSIONS

An effective health care system is crucial to break up the vicious cycle of poverty and poor health. The Shift from user fees to pre-payment and pooling has been observed and there is a need to develop a national health insurance schemes to have more security and sustainability in expenditure in health and also the universal coverage of various Health care services.

The microfinance can be a distributive channel to supply various financial products. In medicine coverage of OPD it can of importance to essential chronic disease and traditional medicine which is the demanded by communities. Covering medicine within the product of insurance, voucher, credit is possible but dealing with cost of the microfinance institution will be challenging. Further more research is required to explore the alternatives to fund the microfinance institution.

ACKNOWLEDGEMENTS

This study done as a part of Internship project under the Health system financing department of World Health Organisation, Geneva. The Authors wish to thank WHO for rendering permission and support to this study.

REFERENCES

[1] World Health Organisation, "Trade, Foreign Policy, Diplomacy and health-Health Financing". Available at http://www.who.int/trade/glossary/story047/en/index.html. Accessed on August 8th , 2013.

[2] Tatum Anderson "Innovative financing of health care" in BMJ 2009;339:b4235.

[3] Ravindra P Rannan Eliya, "Strengthening Health Financing in Partner Developing Countries" in Global Action for Health Systems. Available at http://www.jcie.org/researchpdfs/takemi/ch3.pdf Accessed on August 8th, 2013

[4] Improving the health of the World's Poorest People. In Policy Brief Population Reference Bureau . Available at http://www.prb.org/pdf04/improvingtheHealthbrief_Eng.pdf. Accessed on August 8th , 2013.

[5] Organisation for Economic Co-operation and Development Policy briefs. "Poverty and Health in Developing Countries: Key Actions". Available at http://www.oecd.org/health/18514159.pdf Accessed on August 8th , 2013.

[6] Uma Lele, Ronald Ridker, and Jagadish Upadhyay,2002 "Health System Capacities in Developing Countries and Global Health Initiatives On Communicable Diseases". International Task Force on Global Public Goods

[7] Ravi P. Rannan-Eliya.2006 "Estimating Out of Pocket spending for National Health Accounts"-World Health Organisation.

[8] Moneer Alam R.P. Tyagi,2009"A Study of Out of Pocket Household Expenditure on Drugs and Medical Services An Exploratory Analysis of UP, Rajasthan and Delhi":. Population Research Centre .Institute of Economic Growth.

[9] Alexander S, Carrin G., Dror D, Jakab M, William H, Arhin-Tenkorang D.2002 "Effectiveness of Community Health Financing in meeting Cost of Illness". Bulletin of the World Health Organization, Geneva: WHO 80(2) 143 – 150.

[10] Dror D and Jacquier, C. 1999 "Micro-Insurance: Extending Health Insurance to the Excluded". International Social Security Review, Geneva: ISSA 52(1) 71 – 97.

[11] International Labour Organisation. Social Protection Department. Available at http://www.ilo.org/secsoc/lang--en/index.htm. Accessed on August 8th , 2013.

[12] World Health Organisation. Library Available at http://www.who.int/library/en/ Accessed on August 8th , 2013.

[13] Anita Kotwani, Margaret Ewen, Dalia Dey, Shobha Iyer, P.K. Lakshmi et al.2007. "Prices & availability of common medicines at six sites in India using a standard methodology".. Indian J Med Res 125,pp 645-654.

[14] Kaplan WA, Ritz LS, Vitello M, Wirtz VJ.2012 Policies to promote use of generic medicines in low and middle income countries: a review of published literature, 2000-2010. Health Policy. 2012 Aug; 106(3):211-24. 2012.

[15] Meuwissen.2002.Oxford university press. Health policy planning:17(3):304-313)

[16] Guerin O.2006. "Association d'Entraide des Femmes, Benin" In Case Study No. 22. CGAP working Group on Microinsurance.

[17] World Health Survey results. Available at http://www.who.int/healthinfo/survey/whsresults/en/index5.html Accessed on August 8th , 2013.

[18] World Health Organisation. Report of India Available at http://www.who.int/healthinfo/survey/whsind-india.pdf. Accessed on August 8th , 2013.

[19] Christian Lorenz Out-of-pocket household health expenditures and their use in National Health Accounts: Evidence from Pakistan. Asia Health Policy Program working paper #9. Available at http://iis-db.stanford.edu/pubs/22555/lAHPPwp9.pdf. Accessed on August 8th , 2013.

[20] Alexandra Cameron , Ilse Roubos , Margaret Ewen , Aukje K Mantel-Teeuwisse , Hubertus GM et al.2011. Differences in the availability of medicines for chronic and acute conditions in the public and private sectors of developing .Bulleting of World Health Organization. Available at http://www.who.int/bulletin/volumes/89/6/10-084327/en/index.html. Accessed on August 8th , 2013.

[21] Cameron January 2009, The Lancet, Volume 373, Issue 9659, Pages 240 - 249, 17.

[22] World Health Organisation. Traditional Medicine Strategy 2002–2005. Available at http://whqlibdoc.who.int/hq/2002/WHO_EDM_TRM_2002.1.pdf. Accessed on August 8th , 2013.

[23] Donaldson, Dayl S. and David W. Dunlop. 1987. Sector Review Ethiopia A Study of Health Financing: Issues and Options, Report No. 6624-ET, Two Vols.WAshington,DC: World Bank.

[24] World Health Organisation Diseases of poverty and the 10/90 Gap. Available at http://www.who.int/intellectualproperty/submissions/InternationalPolicyNetwork.pdf. Accessed on August 8th , 2013.

[25] Vialle-valentin.2008. Medicines coverage and community-based health insurance in low-income countries. Health Research Policy and Systems-volume 6, 6:11.

[26] N Devadasan, Kent Ranson, Wim Van Damme, Bart Criel.2004. Community Health Insurance in India An Overview. Economic and Political Weekly July 10, 2004. Available at www.researchgate.net/...Community_health_insurance.../79e4150c0d4d Accessed on August 8th , 2013.

[27] Wright. 2005. Expanding Access to Microfinance: Challenges and Actors, Paris, Microsave market led solution for financial services.

[28] World Health Organsation.2005.National Policy on Traditional Medicine and Regulation of Herbal Medicines - Report of a WHO Global Survey.168 pages.

AUTHORS

First Author – Dr. Veenita Anand BHMS, NDDY, PGDHM Institution: National Institute of Health and Family Welfare, New Delhi, India., Email ID- drveenita.anand@gmail.com
Second Author – Dr. Karikalan Nagarajan BSMS MPH PhD Institution: National AIDS Research Institute, Pune, India. Email ID- drkarikalan82@gmail.com

Correspondence Author – Dr. Karikalan Nagarajan BSMS MPH PhD: Email ID- drkarikalan82@gmail.com ; Mobile- 09890303831

Table1: Out of pocket scenario in India, Bangladesh, Nepal, Sri Lanka (World health survey 2003)

S.No.		India (%)	Bangladesh (%)	Sri Lanka (%)	Pakistan (%)
1.	Private Health Insurance Premium As Percentage of Total Expenditure	0.5	0	0.5	0.3
2.	OOP payment as a percentage of total health expenditure	77.5	64.3	48.8	81.5%
3.	Percent Distribution Of Structure Of OOP Health Payments				
3.1	IPD	25.4	6.3	28.7	18.4
3.2	OPD	16.9	8.1	14.7	9.6
3.3	Traditional	3.3	5	1.7	3.5
3.4	Drugs	44.4	67.1	36.1	64.3
3.5	Other	9.9	13.6	18.8	4.2
3.5(a)	Financial source used by households for paying for health services				
3.5(b)	Saving	11.7	4.1	6.4	3
3.5(c)	Sold items	13.7	11.4	0.8	2.5
3.5(d)	Borrow from relative	20.6	18.6	5.2	9.2
3.5(e)	Borrow from other	28.6	23.2	2.5	1.8
3.5(f)	Health insurance	0.6	0	1.4	1.3
3.5(g)	Current income	78.2	94.1	73	82.2
3.5(i)	Other	5.3	3.6	3.1	

Note. Source http://www.who.int/healthinfo/survey/whsresults/en/index5.html(06/10/09)
Pakistan- http://www.emro.who.int/emrinfo/index.asp?Ctry=pak
http://www.who.int/healthinfo/survey/whsind-india.pdf

Table-2 Product and services of BRAC

Product Détails	Product feature and Policies
Micro Insu rance Type	Préventive and curative health care
Group or Individual Product	Individual
Term	Annual
Eligibility Requirements	Must be living in target are
Renewal requirements	None
Rejection rate	None
Voulntary or Compulsory	Voluntary
Product coverage (benefits)	50% off pathology tests ; ultra poor80% off 10% off medication fée ; ultra poor80% off Free Annual check up for head of house hold For Ultra poor Atleast 2 post-consultation follow-up home visits. Free transportation to referral hospitals and clinics
Key Exclusions	No speicified exclusions
Pricing premiums(in US Dollars) for 1-5 members 6-8 members 9-12 members	 1.7/4.26/0(VO/Non VO/Ultra poor)/Per year 2.56/5.12/0(VO/Non VO/Ultra poor)Per year 3.41/5.96/0(VO/Non VO/Ultra poor)Per year
Pricing Co-payments(in US Dollars)0	0.03/0.08/0(VO/Non VO/Ultra poor)Per year
Pricing-other fees	None
Incentive to renew	25% discount on renewal if any members does not use BRAC health services in previous year.