Appendix Table 3: Reviewed studies in Africa[*,**]

Scheme	Country	Reference	Peer reviewed (P); grey literature (G)	Study type (RCT; QEx; Obs)***	Quality grade	Resource mobilization	Financial protection	Utilization	Quality of care	Social Inclusion	Community empowerment	Main results
SOCIAL HEALTH INSURANCE												
Carte d'Assurance Maladie (CAM)	Burundi	[30]	P	Obs	Medium	C	A	A	C	A	A	Premiums insufficient to fund recurrent costs of outpatient drugs; HI has valuable social equity function; Elimination of cash payments empowered women to decide the need for and timing of health care consumption without consulting male household heads. Poor financial performance; membership is low (23% HH); adverse selection, makes risk-sharing sub-optimal.
MUGEF-CI (La Mutuelle générale des fonctionnaires et agents de l'état)	Cote d'Ivoire	[46]	G	Obs	Medium					A		Impact on financing, delivery, and access to health care in the sub region is limited. Low level of dues collection; problems of marketing; low penetration of target groups
School Health Insurance Programme (SHIP)	Egypt	[127]	P	Obs	High	C	A	A		A		Significant increase health care access & reduction OOPE. Reduction of differentials in visit rates between highest/lowest income children. Only middle-income children benefit from reduced OOPE (within group equity). By targeting children through school enrolment, differentials in the average level of access between school-going children and non-going increased (overall equity). Financial sustainability volatile.
Health Insurance Organization (HIO) social insurance program	Egypt	[57]	G	Obs	Medium				C	C		Negative impact on equity: HIO disproportionately benefits urban middle classes. Targets the formal sector, so poor(est) not reached.

Suez Governorate SHI	Egypt	[115]	G	Obs	Medium		B	C	C	C		Poor performance on equity in access to care, equity in health financing, and quality of care.
National Health Insurance Scheme (NHIS)	Ghana	[145]	P	Obs	Medium					C		There is a positive association between SES and insurance coverage, i.e. the higher the SES, the higher the insurance coverage. Only 21% of poor households (low SES) were enroled into the NHIS, compared to 60% of those classified as high SES.
National Health Insurance Scheme (NHIS)	Ghana	[144]	P	Obs	High		A					Health insurance has protective effect against the financial burden of health care, reducing significantly likelihood of incurring catastrophic payment, particularly among the poorest wealth quintiles.
National Health Insurance Scheme (NHIS)	Ghana	[143]	P	Obs	High			A	A			Insured women are more likely to receive prenatal care, deliver at a hospital, have their deliveries attended by trained health professionals, and experience less birth complications. Uninsured face high payments from hospitalization resulting from birth complications with probably poor outcomes.
Obstetric Risk Insurance	Mauretania	[96]	P	Obs	Medium	A	A	A	C	A		Guarantees access to obstetric care to all women at an affordable cost; high enrolment rate; increase utilization causes decline in service quality
Mandatory insurance	South Africa	[88]	G	Obs	Medium		B					Expansion of compulsory HI creates additional financial burden, which household accommodate via expenditure substitution.
Prepayment scheme	Zambia	[79]	P	Qex	Medium			A		A		Prepayment facilitates access to care without income-related equity losses
PRIVATE HEALTH INSURANCE												
Scheme	Country	Reference	Peer (P) Grey (G)		Quality grade	Resource Mobilization	Financial protection	Utilization	Quality of care	Social Inclusion	Community empowerment	

PSEMAS	Namibia	[136]	P	Obs	High		A	A		C		PHI protects households from the most severe consequences of health shocks, but is currently unaffordable for the poor, who are significantly more likely to be HIV-infected. Uninsured seek less care than insured . In absolute terms, the insured pay up to twice as much for chronic illness and five times as much for hospitalization than uninsured, but in relative terms, the uninsured pay substantially more as a percentage of per capita consumption for both chronic and acute illness.
MicroCare Insurance	Uganda	[134]	P	Obs	Medium		A					OOP expenditure on health care (including the health-insurance premium) was lower for insured households, both at the total level of expenditures and per illness. Insured households sold assets less frequently and the amount borrowed per illness to pay for health care and health insurance was also lower.
Zambian Copper Mines scheme; PHI	Zambia	[62]	P	Obs	High		C					HI does not provide financial protection against the risk of catastrophic health expenditure; insurance increases risk
COMMUNITY BASED HEALTH INSURANCE												
Scheme	Country	Reference	Peer (P) Grey (G)		Quality grade	Resource Mobilization	Financial protection	Utilization	Quality of care	Social Inclusion	Community empowerment	
l'Union communale des groupements mutualistes de Sirarou (Sirarou UCGM)	Benin	[46]	G	Obs	Medium					C		Low penetration rates; contributions are regressive and not equitable; impact of MHOs on financing, delivery, and access to health care relatively limited;
(l'Union communale des groupements mutualistes de Sanson (Sanson UCGM)	Benin	[46]	G	Obs	Medium					C		as above

Mutuelle Ilera de Porto Novo Mutuelle du cabinet médical St Sébastien (Ilera MHO)	Benin	[46]	G	Obs	Medium					C		as above
Mutuelle Alafia de Gbaffo	Benin	[46]	G	Obs	Medium	C	C			C		as above
Mutuelle Famille Babouantou de Yaoundé	Cameroon	[36]	P	Obs	Medium	C		C		C		Inequitable: scheme favours the relatively well of; decreasing membership;
Mutuelle générale des résidents d'Abobo centre	Cote d'Ivoire	[46]	G	Obs	Medium					C		Low penetration rates; contributions are regressive and not equitable; impact of MHOs on financing, delivery, and access to health care relatively limited;
Le Cercle des Amis de la Rue de Dimbokro (CARD)	Cote d'Ivoire	[46]	G	Obs	Medium					C		as above
L'Amicale de la Bagoué–Commune de Koumassi	Cote d'Ivoire	[46]	G	Obs	Medium					C		as above
L'Amicale des mamans du Canal 36 (MC36)	Cote d'Ivoire	[46]	G	Obs	Medium					C		as above
Les Intimes du nouveau quartier	Cote d'Ivoire	[46]	G	Obs	Medium					C		as above
Bwamanda	Congo /Zaire	[11]		Obs	Medium			A		A		Utilization higher among insured; improved the access to justified hospital care; relative increase is only slightly influenced by distance
Bwamanda	Congo /Zaire	[13]	G	Obs	High	A		A		A		High social acceptability of scheme. Reliable/stable local source of funds; premiums regressive and inequitable
Bwamanda	Congo /Zaire	[27]		Obs	Medium	A						Scheme successful in enrolling 60% of population; hospital cost recovery successful; judicial setting of premiums; good fund management; high satisfaction and confidence level of beneficiaries

Bwamanda	Congo /Zaire	[14]		Obs	High	A		A		A		Increasing membership shows appropriateness; doubling recovery of of hospital operating cost; hospitalization rate of members significantly higher than for non-members. Health zone may be an appropriate level for the organization of a regional pre-paid health plan.
Masisi district scheme	Congo /Zaire	[13]	G	Obs	High			A				Scheme data deficient; HI increases hospital utilization rates; family subscriptions and waiting periods counter adverse selection
Masisi district scheme	Congo /Zaire	[87]		Obs	Medium	C		A				very high hospital utilization rates are seen among subscribers; notable moral hazard; scheme unsuccessful.
Nkoranza	Ghana	[48]	G	Obs	Medium		B		C			Successful in terms of sustainability and making quality care affordable for vulnerable households; coverage low due to inappropriate registration period, community misconceptions and massive adverse selection; benefits package lacks coverage for MCH; lack of operational transparency and management skills
Nkoranza	Ghana	[15]		Obs	High		A	A		B		CBHI positively associated with use of maternal health services; potential demand-side mechanism to increase maternal health care access. Complementary supply-side interventions to improve quality of and geographic access to health care are also critical for improving health outcomes
Nkoranza	Ghana	[55]	P	Obs	High		B	A		C		higher enrolment of wealth off HH and is linked to proximity of health services; feasibility of MHOs is limited in isolated areas; limited effect on reducing OOPE on OPD curative care, but effective in reducing CHE for hospitalization

Nkoranza	Ghana	[36]	P	Obs	Medium	C		A		A		Inequitable: scheme favours the relatively well of; possibly overutilization of services; relatively low population coverage (23-32%)
Nkoranza	Ghana	[132]	G	Obs	High		A	A		C		NHIS has inequitable enrolment. Exemptions for the indigents are not well-targeted. Adverse selection is a problem (people with chronic illness more likely to enrol). Utilization of curative services at modern facilities increased significantly and decline in informal/traditional care. No impact on MCH use. Positive impact on financial protection. NHIS package is unsustainable over time with increased enrolment and exemptions.
Offinso District MHO	Ghana	[132]	G	Obs	High		A	A		C		As above
West Gonja scheme	Ghana	[46]	G	Obs	Medium					C		Low penetration rates; contributions are regressive and not equitable; impact of MHOs on financing, delivery, and access to health care relatively limited;
Teachers' Welfare Funds	Ghana	[46]	G	Obs	Medium					C		as above
Duayaw Nkwanta Dagaaba Association)	Ghana	[46]	G	Obs	Medium					C		as above
RCT free health children	Ghana	[131]		RCT	High			A				removing OOPE had impact on health care-seeking behaviour but not on the health outcomes measured; utilisation not good proxy for improved health outcomes
MHOs in Ghana (unspecified)	Ghana	[84]	G	Obs	Medium			B				MHO coverage not a positive predictor of receiving curative care (Ghana, Senegal) but positive in Mali; financial risk protection limited

Maliando MHO	Guinea-Conakry	[35]		Obs	Medium		C		C	C		community participation increases understanding of HI; poorest cannot afford premium; quality of service & staff perceived as poor by community
18 village health posts (USBs) prepayment scheme	Guinea-Bissau	[61]	G	Obs	Medium	C		B	C			low cost recovery; but community contributions for management in-kind and labor understated; high level of satisfaction with scheme; drug stocks outs; WTP linked to quality of service; flat-fee prepayment only type of cost recovery feasible
SAIDIA Scheme, Samburu District	Kenya	[83]		Obs	Medium	B						Sustainability: scheme covering emergency transportation costs seems sustainable (but data deficient); Equity: use of sliding premium scale ineffective; community contributions (premiums + user fees) between 5-8% of total recurrent health costs
Centre santé de la MUTEC	Mali	[46]	G	Obs	Medium					C		Low penetration rates; contributions are regressive and not equitable; impact of MHOs on financing, delivery, and access to health care relatively limited;
Centre de santé de référence du cercle de Kolokani	Mali	[46]	G	Obs	Medium					C		as above
MHOs Bougoulaville, Wayerma, Kemeni, Blaville	Mali	[55]	P	Obs	High		B	A		C		Women headed HH more likely to enrol; education and income level correlated with higher enrolment; members more likely to seek formal health care in Ghana and Mali. HI offers protection against hospitalization CHE; No effect on OOPE for curative OPD care.
MHOs Bougoulaville, Wayerma, Kemeni, Blaville	Mali	[15]	P	Obs	High			A		C		CBHI positively associated with use of maternal health services; potential demand-side mechanism to increase maternal health care access. Complementary supply-side interventions to improve quality of and geographic access to health care are also critical for improving

												health outcomes
Keneya Ton de Wayerma, Sikasso town	Mali	[65]	G	Qex	High		A	A		B		membership increases utilization of modern health care services and MCH; Higher SES as significant predictor of care seeking behavior is unclear
Keneya Ton de Bougoulaville, Sikasso town	Mali	[65]	G	Qex	High		A	A		B		as above
Lafia de Blaville, Bla town	Mali	[65]	G	Qex	High		A	A		B		as above
Danaya de Kéméni, Kemeni village, Bla District, Mali.	Mali	[65]	G	Qex	High		A	A		B		as above
MHOs in Mali (unspecified)	Mali	[84]	G	Obs	Medium			A and B		A		MHO coverage is positive predictor of receiving curative care; financial risk protection limited
JAS Community Partners for Health	Nigeria	[46]	G	Obs	Medium					C		Low penetration rates; contributions are regressive and not equitable; impact of MHOs on financing, delivery, and access to health care relatively limited;
Lawanson Community Partners for Health	Nigeria	[46]	G	Obs	Medium					C		as above
COWAN Health Development Fund	Nigeria	[46]	G	Obs	Medium					C		as above
Ibughubu Improvement Union	Nigeria	[46]	G	Obs	Medium					C		as above
Muranda	Rwanda	[13]	G	Obs	High	C		A			C	Scheme is inequitable (poor subsidize the wealthy); resource mobilization capacity weak; increased utilization, not sustainable as costs exceed income; low community participation;

3 pilot CBHI district schemes (Byumba; Kabgayi; Kabutare)	Rwanda	[97]	G	Obs	Medium		A	A		A		probability of enrolling in prepayment schemes is equal among all income groups, determined households' distance to the health centre, exposure to awareness campaigns, age, gender, education and trust and sentiments of ownership. Equity in financial access to care significant and HI reduces financial barrier for poor
3 pilot CBHI district schemes (Byumba; Kabgayi; Kabutare)	Rwanda	[101]	G	Qex	Medium	A	A	A	A			progress in reaching goals of greater financial access to basic services, financial sustainability of health centres, community participation and democratic governance
54 schemes in districts: Kabutare, Byumba and Kabgayi	Rwanda	[99]	P	Obs	High		A and B	A		A		health spending has small impact on SES of uninsured and insured households; however, this is at the expense of horizontal inequity in utilisation of care for user-fee paying individuals; benefit package insufficient for financial protection
54 schemes in districts: Kabutare, Byumba and Kabgayi	Rwanda	[98]		Obs	High	A	A	A	A	A	A	members' annual per capita contributions are 5x higher than those of non-members
54 schemes in districts: Kabutare, Byumba and Kabgayi	Rwanda	[74]	G	Obs	Medium		A	A		A		Social inclusion-design and implementation of CBHI and community characteristics important in achieving good targeting outcome; community involvement alone does not guarantee social inclusion. Financial protection-prepayment and risk sharing, even on a small scale, reduce financial access barriers
Mutuelles de Santé Kabutare	Rwanda	[86]	P	Obs	High			A		C		Membership biased towards larger households and higher income (more than US$230 per annum). Members higher utilization, but spend less on health care

CBHI Rwanda	Rwanda	[146]	P	Qex	Medium		A	A				Utilization of modern health services for those indicating they were ill, was higher among the insured compared to uninsured. Spending per episode among the insured population in 2005 is half that, of the uninsured.
CBHI Rwanda	Rwanda	[137]	P	Obs	Medium				A			Uninsured women are significantly more likely to deliver at home by an unskilled birth attendant/unassisted. The odds of being delivered at home decrease significantly as the level of household socioeconomic (wealth quintile) status improves. Odds of delivering by unskilled birth attendant/unassisted increases with poverty.
Mutuelle des volontaires de l'éducation	Senegal	[46]	G	Obs	Medium					C		Low penetration rates; contributions are regressive and not equitable; impact of MHOs on financing, delivery, and access to health care relatively limited;
Mutuelle FAGGU	Senegal	[46]	G	Obs	Medium					C		as above
Mutuelle de Lalane Diassap	Senegal	[46]	G	Obs	Medium					C		as above
MHOs Thies region Senegal	Senegal	[55]	P	Obs	High		B	A		C		Women headed HH more likely to enrol; education and income level correlated with higher enrolment; HI offers protection against hospitalization CHE; No effect on OOPE for curative OPD care. Enrolment in top SES quintile higher than in lowest quintiles
MHOs Thies region Senegal	Senegal	[34]	P	RCT	High		A	A		C		Members have higher probability of using hospitalization services than non-members and pay substantially less. Poorest of the poor remained excluded.
MHOs Thies region Senegal	Senegal	[47]	G	Obs	Medium	B and C	A	B	B	C		financial instability due to adverse selection, low dues recovery, unrecovered loans, frequent changes to benefit package without concurrent premium changes, limited use of basic financial tools; weak financial

												management
MHOs Thies region Senegal	Senegal	[15]	P	Obs	High		A	B / A		C		HI has no effect on seeking adequate prenatal care; women who are CBHI members have higher odds of delivering at health facility compared to non-members and members without delivery coverage.
MHOs in Senegal	Senegal	[74]	G	Obs	Medium		A	A		C		Social inclusion-design and implementation of CBHI and community characteristics important in achieving good targeting outcome; community involvement alone does not guarantee social inclusion. Financial protection-prepayment and risk sharing, even on a small scale, reduce financial access barriers
MHOs in Senegal (unspecified)	Senegal	[84]	G	Obs	Medium			B				no significant effect of insurance status on utilization; coverage not positive predictor of receiving modern/ formal care for curative illness and injury; caretaker education and being in a female-headed household are positive predictors tend to confirm that MHOs offer a benefit to children
Community Health Fund	Tanzania	[77]	G	Obs	Medium		A	A		C		Income most important factors determining household participation; poorest not reached. Membership has no effect on overall amount of health expenditure and use of preventive measures, but the sick more likely to get treatment than those in non-member households; members better financially protected against health shocks

Community Health Fund (PLWHAs)	Tanzania	[54]	G	Obs	Medium	A		B and C				Membership stimulates utilization of OPD care; members have less utilization of IPD care; Total cost of care used by individual PLWHA is average 65 percent of the annual HH premium
Community Health Fund	Tanzania	[56]	G	Obs	Medium	A		A	A			low enrolment but increase in utilization; weak financial management and information systems; improvement of health facilities due to CBF funds (purchase drugs, equipment, refurbishment); limited community particpation and understanding of CHF management
Ishaka Scheme	Uganda	[49]		Obs	Medium						B	Limited success of scheme at demand and the supply side of health care delivery due to demand side: lack of basic information on the scheme's design and operation, little understanding of CHI principles, limited community involvement; lack of trust in the management; problems in people's ability to pay premium. Supply-side: limited interest and knowledge of health care providers and managers of CHI; absence of coherent policy framework for CHI development
Save for Health	Uganda	[49]		Obs	Medium						B	as above
Kisiizi Hospital Society Health Plan/Microcare Health, Ltd	Uganda	[126]	G	Obs	Medium		A					Member households have lower OOPE; members have less CHE, relied less often on risk-coping strategies; HI has positive effect on the economic status of the low-income segment in the short-term and in the long-term
Voluntary HI program (Zambia Copper Mines)	Zambia	[62]	P	Obs	High		A					HI does not provide financial protection against the risk of catastrophic health expenditure; insurance increases risk

* Only includes studies of medium quality of higher. See text for more detail on quality assessment.

** In the table, A denotes a positive effect, B no effect and C a negative effect.

*** RCT is randomized controlled trial design; QEx is Quasi-experimental design; Obs is observational design.

Appendix table 3: Reviewed studies in Asia

Scheme	Country	Reference	Peer reviewed (P); grey literature (G)	Study type (RCT; QEx; Obs)	Quality grade (High/Medium)	Resource mobilization	Financial protection	Utilization	Quality of care	Social Inclusion	Community empowerment	Main Results
SOCIAL HEALTH INSURANCE												
Government health insurance (Gongfei)	China	51	P	Obs	Medium		A	A				Positive association between utilisation of delivery services and financing variables (amount of savings in the bank, maternal pre-payment schemes and health insurance). Also shows the critical importance of out-of-pocket, fee-for-service payments for maternity care as a barrier to the utilisation of these services.
Government health insurance (Gongfei)	China	52	P	Obs	High			A				Positive association between the degree of insurance coverage and utilization of surgical delivery.
Government health insurance (Gongfei)	China	58	P	Obs	High		C	C				Insured had a lower number of drugs and a higher drug expenditure per visit than the uninsured, implying the use of more expensive drugs per visit than the uninsured. Also significant differences in number of drugs and drug expenditures per visit between different types of insurance. Results imply that uninsured patients do not receive the same care as the insured do, even if they have same needs. Fee-for-service financing for hospitals and health insurance have changed health providers' and consumers' behaviour and resulted in the increase of medical expenditure.

Government health insurance (Gongfei)	China	67	P	Obs	Medium		A					No evidence on difference between access to medical care between insured and uninsured. Some evidence that average cost of drugs per outpatient and inpatient was influenced by the system of finance of health services. Evidence suggests that it will be feasible to develop local insurance schemes to cover health care services in the richer countries. It will be more difficult to design prepayment schemes in the poorer areas to cover the full range of health services.
Government health insurance (Gongfei)	China	116	G	Obs	Medium		C					Health insurance does not always reduce financial risk. Results from two separate surveys suggest that during the 1990s China's government and labor insurance schemes increased financial risk associated with household health care spending. Evidence on the success of the rural cooperative medical scheme (CMS) in reducing financial risk is mixed. The welfare implications of the findings are not clear-cut.
Labour health insurance (Laobao)	China	51	P	Obs	Medium		A	A				Positive association between utilization of delivery services and financing variables (amount of savings in the bank, maternal pre-payment schemes and health insurance). Also shows the critical importance of out-of-pocket, fee-for-service payments for maternity care as a barrier to the utilization of these services.
Labour health insurance (Laobao)	China	52	P	Obs	High			A				Positive association between the degree of insurance coverage and utilization of surgical delivery.
Labour health insurance (Laobao)	China	58	P	Obs	High		C	C				Insured had a lower number of drugs and a higher drug expenditure per visit than the uninsured, implying the use of more expensive drugs per visit than the uninsured. Also significant differences in number of drugs and drug expenditures per visit between different types of

												insurance. Results imply that uninsured patients do not receive the same care as the insured do, even if they have same needs. Fee-for-service financing for hospitals and health insurance have changed health providers' and consumers' behaviour and resulted in the increase of medical expenditure.
Labour health insurance (Laobao)	China	116	G	Obs	Medium		C					Health insurance does not always reduce financial risk. Results from two separate surveys suggest that during the 1990s China's government and labor insurance schemes increased financial risk associated with household health care spending. Evidence on the success of the rural cooperative medical scheme (CMS) in reducing financial risk is mixed. The welfare implications of the findings are not clear-cut.
Maternal and Child Health prepay scheme	China	78	G	Obs	Medium			A and C	C			The prepaid scheme does provide an impetus to local MCH personnel to provide primary services in poor areas. Services promised by scheme are all routine MCH preventive services required by Health Bureaus and monitored by the target-oriented management system, which acts as an added incentive for providers to try their best to reach certain targets for MCH care even if there is no contribution. Findings suggest the need for more innovative systems in order to improve MCH services in the region.
Rural Cooperative Medical Scheme (RCMS)	China	50	P	Obs	Medium		A					Findings support hypothesis that cooperative health insurance will induce higher growth of health care expenditure and reduce financial barriers to access care. Cooperative health insurance will lead to a shift from preventive medicine to curative medicine and to a higher level of tertiary curative care expenditure.
Rural Cooperative Medical Scheme (RCMS)	China	51	P	Obs	Medium		A	A				Positive association between utilization of delivery services and financing variables (amount of

												savings in the bank, maternal pre-payment schemes and health insurance). Also shows the critical importance of out-of-pocket, fee-for-service payments for maternity care as a barrier to the utilization of these services.
Rural Cooperative Medical Scheme (RCMS)	China	52	P	Obs	High			B				Positive association between the degree of insurance coverage and utilization of surgical delivery.
Rural Cooperative Medical Scheme (RCMS)	China	53	G	Obs	Medium		A					General finding is that population structure by occupation and income varies, and that RCMS has adapted itself to this variety. It is also confirmed that the burden of health care costs on families was reduced, more so in some counties than in others, but reduction has been modest. Variation in benefits for township and county level outpatient and inpatient care is very wide. Ample room for improvement, (population coverage via better registration system, restructure reimbursement with emphasis on primary curative services so to simulate PHC and reduce the need for more costly hospitalization).
Rural Cooperative Medical Scheme (RCMS)	China	58	P	Obs	High		C	C				Insured had a lower number of drugs and a higher drug expenditure per visit than the uninsured, implying the use of more expensive drugs per visit than the uninsured. Also significant differences in number of drugs and drug expenditures per visit between different types of insurance. Results imply that uninsured patients do not receive the same care as the insured do, even if they have same needs. Fee-for-service financing for hospitals and health insurance have changed health providers' and consumers' behaviour and resulted in the increase of medical expenditure.
Rural Cooperative Medical Scheme (RCMS)	China	67	P	Obs	Medium		A	C				No evidence on difference between access to medical care between insured and uninsured. Some evidence that average cost of drugs

												per outpatient and inpatient was influenced by the system of finance of health services. Evidence suggests that it will be feasible to develop local insurance schemes to cover health care services in the richer countries. It will be more difficult to design prepayment schemes in the poorer areas to cover the full range of health services.
Rural Cooperative Medical Scheme (RCMS)	China	71	G	Obs	Medium		A	A and B		C		Utilization of outpatient services at village level by CMS members had increased (reduced costs and strengthened scheme management). Establishment of CMS cannot in itself overcome basic deficiencies in service provision to poorest households. It would seem that funding from a higher level may be the only possible means of achieving this objective.
Rural Cooperative Medical Scheme (RCMS)	China	73	P	Obs	Medium	A	A and B	A				Utilization rates of the RCMS hospitals were twice that of the non-RCMS hospitals for both outpatients and inpatients, but are still low for western standards. RCMS hospitals seemed to have benefited greatly from community financing. Low-premium insurance scheme contributed little to establishing equitable health services for rural population. Requires community contributions that are substantially higher, complemented by subsidies from higher levels of government. Average costs for inpatient services and hospitalization did not differ significantly between RCMS and non-RCMS facilities.
Rural Cooperative Medical Scheme (RCMS)	China	110	P	Qex	High		A					Out-of-pocket medical expenditure remains a burden for rural households. RCMS provides modest financial protection with an average reimbursement of 17.8%. Scheme should restructured to provide better benefits to those in most need.
Rural Cooperative Medical Scheme	China	116	G	Obs	Medium		C					Health insurance does not always reduce financial risk. Results from

(RCMS)												two separate surveys suggest that during the 1990s China's government and labor insurance schemes increased financial risk associated with household health care spending. Evidence on the success of the rural cooperative medical scheme (CMS) in reducing financial risk is mixed. The welfare implications of the findings are not clear-cut.
Rural Cooperative Medical Scheme (RCMS)	China	120	G	Qex	High		B and C	A and B				Enrollment is lower among poor households, and higher among households with chronically sick members. Scheme has increased outpatient and inpatient utilization (by 20-30%), but has had no impact on out-of-pocket spending or on utilization among the poor. Program has increased ownership of expensive equipment among central township health centers but has had no impact on cost per case.
Rural Cooperative Medical Scheme (RCMS)	China	122	P	Obs	Medium		A	B and C	A			Project reduced out-of-pocket spending, and incidence of catastrophic spending and impoverishment through health expenses. Little impact is detected on use of services, and while evidence points to the project reducing sickness days, evidence on health outcomes is mixed.
Rural Cooperative Medical Scheme (RCMS)	China	128	P	Obs	Medium		A					RMHC is more effective at reducing medical impoverishment than NCMS. Primary reason for this is that NCMS does not address a major cause of medical impoverishment: expensive outpatient services for chronic conditions.
SHI (Public and worker compensation insurance)	China	139	G	Obs	Medium		A					Health insurance significantly increases the probability of positive OOP health care expenditures in China. Insurance significantly reduces the OOP spending levels of people requiring health care: conditional on having positive OOP health expenses, health insurance

												reduces the level of OOP spending by 11.4 − 13.6 percent, which is highly significant.
Urban Employees' Basic Health Care Insurance System	China	82	P	Qex	High			A				Study concludes that new insurance model is more equitable in ensuring access to primary care at outpatient settings than the previous Government Insurance Program and Labour Insurance Program. Reform lessened the extent of horizontal inequity, while maintaining the degree of vertical equity in access to primary care services. Reform led to a great reduction in the across-group difference for use of outpatient care, directly contributing to goal of achieving more equitable access to basic care under the reform initiatives.
New Co-operative Medical Insurance Scheme (NCMS)	China	148	P	Obs	Medium		C					Financial burden of chronic disease is heavier for the poorest, with a greater proportion of NCMS members in the poorest quintile facing catastrophic expenditure as compared to those in the richest quintile. Coverage for chronic disease OPD care is low /non-existent causing high OOPE.
New Co-operative Medical System (NCMS	China	142	P	Obs	High		A					Total expenditure on a facility-based delivery (both vaginal and Caesarean) increased markedly between 2002-2007. OOPE also increased, but less substantially. Having health insurance was associated with reduced out-of-pocket expenditure on a facility-based delivery, particularly on a Caesarean delivery.
New Co-operative Medical System (NCMS	China	141	P	Obs	Medium		A					The expenditure for facility-based delivery increased between 2002-2007, but OOPE for delivery as a percentage of the annual household income decreased. Facility-based delivery increased from 45% to 80% (difference 35%, 95% CI 29-37%); and differences in using pre-natal and delivery care between the income groups narrowed.

Medical Insurance Program (MIP)	Georgia	138	P	Obs	Medium			A		A		Medical Insurance Program has significantly increased beneficiaries' utilization of public health insurance for acute surgeries and inpatient services. Benefits have reached the poorest among the beneficiaries.
Employees' State Insurance Scheme (ESIS)	India	68	G	Obs	Medium		A and C	C				Negative effect outreach of ESIS health insurance scheme to urban and rural population in Ahmebadad district (Gujarat). Decrease in out-of-pocket expenditure for urban ESIS households in Ahmebadad district. Negative effect on out-of-pocket expenditures for Mediclaim insured households for acute and chronic morbidity and hospitalisation in Ahmebadad district. Mediclaim per capita out-of-pocket expenditure for rural population is higher than out-of-pocket expenditure for urban population Ahmebadad district.
Mediclaim	India	68	G	Obs	Medium		C					As above
ASKES	Indonesia	72	P	Obs	High		A	C				Mandatory insurance scheme for civil servants (Askes) had a strongly positive impact on access to public outpatient care, while a mandatory insurance scheme for private employees (Jamsostek) had a positive impact on access to both public and private outpatient care. Greatest effects of Jamsostek were observed amongst poor beneficiaries. While distribution of both insurance schemes was concentrated among the rich, largest effects of insurance (particularly Jamsostek) were observed among individuals in the lowest income groups. Neither Askes nor Jamsostek had a positive effect on equity in access. The study suggests that HI has a negative impact on equity.
Jamsostek	Indonesia	72	P	Obs	High		A	C				As above
Jaminan Kesehatan Masyarakat	Indonesia	149	P	Obs	Medium		C			A		Jamkesmas (tax financed targeted scheme for the poor: per capita

(Jamkesmas)												government subsidy is only US$6 per year for a package of OPD and IPD services (relative to a total health expenditure of $41·8 per capita): this can result in a low level of service provision and financial protection. OOPE remains high. Insurance coverage of the poor is successful but challenges remain as to coverage of the informal sector.
ASKES	Indonesia	133	G	Obs	Medium		A	A				HI increases use of IPD and OPD care during period of the panel, for both adults and children. HI reduces probability of health spending but while the effect on amount of spending is negative it is not significant. Lower income groups have slightly higher utilization when insured and impacts are higher in rural areas than urban. For health status and HI, results are inconsistent and show little relationship with insurance coverage.
Jamsostek	Indonesia	133	G	Obs	Medium		A	A				As above
Mediclaim	India	93	P	Obs	Medium		A					Mediclaim, Jan Arogya and WWF offer higher level of financial protection whereas SEWA provides lowest level of financial protection. Rates of hospital utilization among insured individuals by SEWA and TF schemes revealed they were no more likely to have reported hospitalization over a 1-year period than the non-insured.
National Health Insurance Program	Philippines	31	P	Obs	Medium		C	C		A		PhilHealth has a positive effect on number of indigents covered. Scheme has a limited negative effect on utilization of medical care mainly to be attributed to lack of facilities. A good part of the low utlization of of medical care can be attributed to simple lack of facilities. Considerable uncertainty for patient about extent of out-of-pocket payments and effectively bearing risk of uncontrolled pricing (no quantification). Indigents are not

												charged any of the surpluses over and above PhilHealth ceilings, but there is a completely free market for the private hospitals with no price regulation.
Philippine Medicare Plan	Philippines	66	G	Obs	Medium	A and C	B					Public hospitals charge insured patients' marginal cost, but subsidize costs of uninsured patients and charity patients. In public hospitals all patients receive a subsidy. Private hospitals do not use the profits from insured patients to cross-subsidize the care of charity patients. Out-of-pocket payments for insured and uninsured patients are about the same in both public and private hospitals.
National Health Insurance Program	Philippines	32	P	Obs	Medium	A	A	C		A and C		Enrolment rate of indigents of individual payment program (IPP) decreased from 2003 to 2004 but increased membership in 2005. Membership of indigent program increased from 2003 to 2004 but fell in 2005 due to lower indigent enrolment levels. Indigents funded under Plan 5/25 were not eligible for outpatient consultation and diagnostic package. Private employees are major net contributors to the NHIP, while nonpaying members and IPP members are the main net recipients.
National Health Insurance Program	Philippines	91	P	Obs	High			A				Underutilization declined over time. Among insured hospitalized children, increasing length of stay in hospital and mother's education, were associated with less underutilization. Being in a Quality Improvement Demonstration Study intervention site was also associated with less underutilization and partially accounts for the downward trend in underutilization over time.
National Health Insurance Program	Philippines	100	G	Obs	Medium			A and C				Indigent population (IP) in areas with high IP enrollment report significantly higher visit rate compared to members living in low IP enrollment areas. Curative visit rates for entire

												population are twice as high than visit rates reported by the IP-insured members indicating IP enrollment does not improve access to care in rural health units for low income groups. Higher IP discharge proportions and higher hospital revenues from PhilHealth suggests that the IP insurance does positively affect hospital care.
Phil Health	Philippines	149	P	Obs	Medium		C			C		Coverage of the poor and informal sector insufficient and is major challenge. PhilHealth does not provide adequate financial protection for its members as OPD services are not covered and IPD care is reimbursed up to a maximum amount, leading to balance billing, when patients pay additional bills beyond the level of reimbursement. The share of social health insurance in total health expenditure was 11% in 2005 and declined to 8·5% in 2007,36–38 indicative of increasingly restricted financial protection to members.
National Health Insurance Program (PhilHealth)	Philippines	140	P	Obs	High				A			PhilHealth insurance program scale-up was associated with increased odds of receiving at least four prenatal visits (OR 1.04 [95% CI 1.01-1.06]) and receiving a visit during the first trimester of pregnancy (OR 1.03 [95% CI 1.01-1.06]).
Health Card Fund	Thailand	74	P	Obs	Medium					B		Membership Health Card Fund is equally accessible for poor and better off. Community financing can be inclusive of the poorest even in most economically deprived context but depends on key design and implementation characteristics of schemes. Community financing reduces financial barriers to health care as demonstrated by higher utilization and lower out-of-pocket expenditure.
Health Card Fund	Thailand	89	P	Obs	Medium			A				Utilization rate voluntary health card higher than that of compulsory

												(social security) scheme. Among three variants of health cards, voluntary health cardholders used health services twice to three times more than community and health volunteer cardholders.
Health Card Fund	Thailand	111	P	Obs	Medium			A				Study looked at health card purchase and utilization patterns. Results show adverse selection; families with symptoms of sickness are more likely to buy cards, resulting in greater use of health services. Results also show improvement in accessibility to health care and high level of satisfaction among card holders.
Health Card Fund	Thailand	112	G	Obs	Medium			A				Study looked at health card purchase patterns and health card utilization patterns (health utilization behavior). Clearly demonstrated that health card purchase in Khon Kaen has been influenced by proportion of employed persons to total family members, education, and presence of illness (adverse selection).
Universal coverage	Thailand	70	P	Obs	Medium			A				Increase in outpatient visits at health centres and district hospitals and decrease in outpatient services provided by general hospitals, reflecting an effective gate keeping system that emphasizes primary medical care.
Universal coverage	Thailand	81	G	Obs	Medium		A	A				Comparisons of benefit incidence across three public insurance schemes revealed that progressivity of outpatient (OP) subsidies were consistent across all schemes. OP subsidy seemed pro-poor only for Civil Servant Medical Benefit scheme (CSMBS) beneficiaries. Resource mobilization between rich and poor in all schemes. Incidence of catastrophic health expenditure reduced.
Universal coverage	Thailand	81	G	Obs	Medium		A					As above
Universal coverage	Thailand	130	P	Obs	Medium		C	A				Non insured less likely to be admitted to hospital than insured.

												Underprivileged were more likely to pay out-of-pocket and to pay out of proportion to their household income when compared with more privileged groups. Underprivileged were least likely to be covered by government health benefit schemes, in contrast to civil servants.
Universal coverage	Thailand	130	P	Obs	Medium							As above
Universal coverage	Thailand	90	P	Obs	Medium		C	C				Richer end-stage renal disease (ESRD) patients received more treatment than poorer patients. Nearly all patients faced situation of financial catastrophe as a result of treatment costs.
Universal coverage	Thailand	109	P	Obs	High		A					Universal coverage policy is effective in preventing impoverishment due to decline in out-of-pocket payments for health care.
Universal coverage	Thailand	109	P	Obs	High		A					As above
Universal coverage	Thailand	113	P		Medium		A	C		C		Insured were concentrated among better off whereas uninsured were concentrated among poor. Probability of seeking treatment at health facilities was lower among uninsured than insured. People with primary education were more likely to seek care than those without primary education, whereas those who had education in vocational school or higher than secondary school had lower probability of seeking care. Average medical expenditure for insured significantly lower than non-insured.
Universal coverage	Thailand	113	P	Obs	Medium					B		As above
Universal coverage	Thailand	149	P	Obs	Medium		A			A		Thailand has reached a HI coverage for the whole population. OOPE have decreased from 33% of total health expenditure in 2001 to 17·7% in 2008. The reduced incidence and intensity of catastrophic payment has especially benefited the poor population.
Universal coverage	Thailand	147	P	Obs	High		A					UC has increased access to health

												services, and enabled impressive strides toward the reduction of catastrophic health spending, particularly among the poor. Poor have less OOPE and CEE than the richer quintiles. The latter voluntarily utilize more costly private providers, and are unlikely to have catastrophic consequences such as permanent impoverishment
Bao Hiem Y Te (voluntary component)	Vietnam	6	G	Obs	Medium		A					Vulnerable and poor are financially protected in Boa Hiem Y Te (Vietnam) scheme. Indigents in Tarlac Health Maintenance Programme (Philippines) are subsidized. In Sewa (India) needs of women not taken into account in scheme design.
Health Care Fund for the Poor (HCFP)	Vietnam	117	G	Obs	Medium		A and B	A				HCFP has a positive effect on inclusion of the poor. HCFP appears to be increasing utilization of services quite considerably, and reducing the risk of catastrophic out-of-pocket spending. There is no perceptible impact on (average) out-of-pocket spending, and even with HCFP coverage poor households are left spending a high share of their modest income on out-of-pocket health expenses at considerable risk of catastrophic spending.
Health Care Fund for the Poor (HCFP)	Vietnam	118	P	Obs	High		A	B		A and C		HCFP has a positive effect on social inclusions of disproportionately poor The results suggest that HCFP has had no impact on use of services, but has substantially reduced out-of-pocket spending.
Social health insurance	Vietnam	75	P	Obs	High		A					Whilst income inelastic, health expenditures are found to be significantly influenced by an individual's level of income, irrespective of insurance status. Despite this, insurance reduces expenditures significantly more for the poor than for the rich.
Social health insurance	Vietnam	76	P	Obs	High			A				Results indicate that, overall, insured patients are more likely to use

												outpatient facilities and public providers. Effect is particularly strong at lower income levels.
Social health insurance	Vietnam	105	P	Obs	Medium			A	A			Average number of hospital contacts per capita for the insured is nearly three times that for the uninsured. In the second poorest expenditure quintile, hospital contacts of the insured are four times that of the uninsured. Insured have an average rate of admission nearly twice that of the uninsured population. Average length of stay is higher than for uninsured.
Social health insurance	Vietnam	103	P	Obs	High		A and C					Insurance reduces out-of-pocket payments. Reduction is more pronounced for individuals with lower income that those with higher income. Insurance tends to reduce the out-of-pocket expenditure more for middle-income quintiles than in top quintiles. Insured patients of the poorest income quintile spend more than the uninsured poor (adverse selection).
Social health insurance	Vietnam	104	P	Obs	High			A and C	A	C		Influence of health insurance on hospital admission and length of stay (LOS) varies across insurance schemes. Compulsory insurance scheme and the insurance scheme for poor increase expected LOS while voluntary insurance scheme has minimal effect on the expected LOS. Insurance also increases the likelihood of hospital admission far more for compulsory members than for members of the other two insurance schemes. While compulsory and voluntary schemes increase likelihood of hospital admission more for lower and middle income individuals, influence of compulsory scheme on expected LOS is more pronounced for patients in the middle income groups.
Social health insurance	Vietnam	102	P	Obs	Medium			A	C			Insured with no education are more likely to access their insurance

												benefits than their counterparts with secondary/post-secondary education. Insured poor are using more health services than insured rich. Care is perceived to be of inferior quality when insurance card is used.
Social health insurance	Vietnam	114	G	Obs	High		B	A	A			Insurance has a positive effect on hospital utilization between insured and uninsured. Probability of hospital admission is higher for insured than for uninsured. Positive effect on health expenditures for insured. No effect on reduced out-of-pocket expenditure. Average length of stay in hospital is longer for insured than uninsured.
Social health insurance	Vietnam	119	P	Obs	Medium		A and C					Out-of-pocket payments diminished for insured, particularly the poor. Poverty impact of out-of-pocket payments is primarily due to poor people becoming even poorer rather than non-poor being made poor. It was not expenses associated with inpatient care that increased poverty but rather non-hospital expenditures.
Social health insurance	Vietnam	121	G	Qex	Medium		A	A				Results suggest that among young children, VHI increases use of primary care facilities. Among older children and adults, VHI results in a marked increase in use of hospital inpatient and outpatient departments. VHI causes a reduction in annual out-of-pocket expenditures on health and increase in non-medical household consumption.
Social health insurance	Vietnam	149	P	Obs	Medium		A and C			A		Full coverage of formal sector and the poor but coverage of informal sector remains major challenge. SHI has not reduced average out-of-pocket spending and has had negligible effects on use among the poorest population, although it has substantially increased overall service use and reduced the risk of catastrophic spending.

PRIVATE HEALTH INSURANCE												
Scheme	**Country**	**Reference**	**Peer reviewed (P); grey literature (G)**	**Study type (RCT; QEx; Obs)**	**Quality grade (High/Medium)**	**Resource mobilization**	**Financial protection**	**Utilization**	**Quality of care**	**Social Inclusion**	**Community empowerment**	
Private health insurance scheme	China	58	P	Obs	High		C	C				Insured had a lower number of drugs and a higher drug expenditure per visit than the uninsured, implying the use of more expensive drugs per visit than the uninsured. Also significant differences in number of drugs and drug expenditures per visit between different types of insurance. Results imply that uninsured patients do not receive the same care as the insured do, even if they have same needs. Fee-for-service financing for hospitals and health insurance have changed health providers' and consumers' behaviour and resulted in the increase of medical expenditure.
COMMUNITY BASED HEALTH INSURANCE												
Scheme	**Country**	**Reference**	**Peer reviewed (P); grey literature (G)**	**Study type (RCT; QEx; Obs)**	**Quality grade (High/Medium)**	**Resource mobilization**	**Financial protection**	**Utilization**	**Quality of care**	**Social Inclusion**	**Community empowerment**	
Gonosasthya Kendra (GK)	Bangladesh	23	P	Obs	Medium	A		A		A		Enrolment is fairly high. Utilization rates of insured are higher than for non-insured; however, the available data on the current use pattern adjusted for need (expressed as illness incidence per person-year) does not show that the poorer households are particularly protected through the GK Health Insurance Scheme, nor through the Grameen Health Plan. As to community mobilization, key findings include that subscribers are currently not actively participating in scheme management, nor in overall health care management (2) The schemes' potential for community involvement

												could be enhanced.
Grameen Health Plan	Bangladesh	23	P	Obs	Medium	A		B		A	C	As above
CBHI of the township of Fengshan	China	124	P	Obs	Medium		A	A and C		B and C		First, income is an important factor influencing farmers' decision to join a CBI despite the premium representing a very small fraction of household income. Secondly, both income and health status influence enrollees' utilization of health services: richer/sicker participants obtain greater NB from the CBI than poorer/healthier members, meaning that the poorer/healthier participants subsidize the rich/sick. Thirdly, wealthy farmers benefit the most from the CBI with low premium and high co-payment features at every level of health status. In conclusion, policy recommendations related to the improvement of the benefit distribution of CBI schemes are made based on the results from this study. (author's)
Rural Mutual Health Care	China	125	P	Obs	High	C				A		Positive effect on enrollment of households. RMHC has a negative effect on resource mobilization with high medical expenditures and deficit.
Rural Mutual Health Care	China	123	P	Obs	High		B		A	B		RMHC has a positive effect on health status of participants.
Rural Mutual Health Care	China	128	P	Obs	Medium		A					Insurance has a positive effect on financial protection, diminishing catastrophic health expenditure and impoverishment.
Rural Mutual Health Care	China	129	P	Obs	Medium					A and B		Scheme has a positive effect on enrollment of elderly, women and people with chronic illnesses but no effect on enrollment of pre-school children. People with medium and high income are more likely to enroll in the scheme than people with lower income.
Rural Mutual Health Care Scheme (RMHC)	China	150	G	Q-Exp	Medium		A	A				RMHC improved insured populations access to basic health care, and reduced risk of catastrophic health expenditure.

Accord	India	1	P	Obs	Medium		A					ACCORD and SEWA schemes have a positive effect on protection for out-of-pocket payment reducing the magnitude.
Jan Arogya	India	93	P	Obs	Medium		A					Mediclaim , Jan Arogya and WWF offer higher level of financial protection whereas SEWA provides lowest level of financial protection. Rates of hospital utilization among insured individuals by SEWA and TF schemes revealed they were no more likely to have reported hospitalization over a 1-year period than the non-insured.
SEWA	India	1	P	Obs	Medium		A					ACCORD and SEWA schemes have a positive effect on protection for out-of-pocket payment reducing the magnitude.
SEWA	India	69	G	Obs	Medium		C	C		A		Community plan fairly addresses equity in enrollment for rural and urban women. Income is not a significant predictor on enrollment rates. In terms of providing financial protection, social insurance coverage is much more successful.
SEWA	India	74	P	Obs	Medium		A	A and B		B		Membership Health Card Fund is equally accessible for poor and better off. Community financing can be inclusive of the poorest even in most economically deprived context but depends on key design and implementation characteristics of schemes. Community financing reduces financial barriers to health care as demonstrated by higher utilization and lower out-of-pocket expenditure.
SEWA	India	10	P	Obs	Medium		A and C			A		Positive effect enrollment of poor women and reduction of catastrophic health expenditures for hospitalization. Lag time appeared to be longer for claimants who lived in rural areas than for those in urban areas and longer for those who worked as farmers or agricultural labourers than for those working in non-agricultural sectors
SEWA	India	93	P	Obs	Medium		A	B				Mediclaim , Jan Arogya and WWF

												offer higher level of financial protection whereas SEWA provides lowest level of financial protection. Rates of hospital utilization among insured individuals by SEWA and TF schemes revealed they were no more likely to have reported hospitalization over a 1-year period than the non-insured.
SEWA	India	92	G	Obs	High		A	B		A		Membership Health Card Fund is equally accessible for poor and better off. Community financing can be inclusive of the poorest even in most economically deprived context but depends on key design and implementation characteristics of schemes. Community financing reduces financial barriers to health care as demonstrated by higher utilization and lower out-of-pocket expenditure.
SEWA	India	94	P	Obs	Medium			C		A and C		Vimo Self-employed Women's Association (SEWA) scheme is inclusive of poorest. Submission of claims for inpatient care is equitable in urban areas, but inequitable in rural areas. Financially better off in rural areas are significantly more likely to submit claims than are the poorest, & men are significantly more likely to submit claims than women. Members living in areas that have better access to health care submit more claims than those living in remote areas. Variety of factors prevent poorest in rural & remote areas from accessing inpatient care or from submitting a claim. Scheme does not address the major barriers to accessing (inpatient) health care and process of seeking reimbursement under the scheme is burdensome for the poor.
SEWA	India	95	P	RCT	Medium					B		Mean socio-economic status of SEWA Insurance members (relative to the rural population) increased significantly. However, no association between interventions and either changes in enrolment rate

												or change in socioeconomic status of members.
SEWA	India	106	P	Obs	Medium			C				Scheme provides access barriers to health services for poorer people.
SEWA	India	107	P	Obs	Medium		C	C		A		Urban members benefited much more from the scheme than rural members. While the scheme provided considerably higher benefit to poor within urban areas, rural poor benefited far less than the better-off rural members.
SEWA	India	108	P	Obs	Medium					B		Scheme has no clear effect on social inclusion or exclusion of poor. Almost all socio-economic indicators suggest that members were less poor than dropouts, but differences were not significant.
SEWA	India	135	P	Obs	Medium			A				Of insured women, 9.8% of rural women and 5.3% of urban women had had a hysterectomy, compared to 7.2% and 4.0%, respectively, of uninsured women. In Ahmedabad district (rural), insured women were slightly more likely to have had a hysterectomy (RR=1.37, 95% CI 1.04 to 1.81, p<.05). No difference in urban area.
Sewett	India	6	G	Obs	Medium						C	Vulnerable and poor are financially protected in Boa Hiem Y Te (Vietnam) scheme. Indigents in Tarlac Health Maintenance Programme (Philippines) are subsidized. In Sewa (India) needs of women not taken into account in scheme design.
TF-old / TF-new (Sardar Patel Insurance scheme)	India	93	P	Obs	Medium			B				Mediclaim , Jan Arogya and WWF offer higher level of financial protection whereas SEWA provides lowest level of financial protection. Rates of hospital utilization among insured individuals by SEWA and TF schemes revealed they were no more likely to have reported hospitalization over a 1-year period than the non-insured.
Vimo SEWA trial	India	85	P	RCT	High					A		Scheme has a positive effect on social inclusion and access to health care services.

WWF	India	93	P	Obs	Medium		A					Mediclaim, Jan Arogya and WWF offer higher level of financial protection whereas SEWA provides lowest level of financial protection. Rates of hospital utilization among insured individuals by SEWA and TF schemes revealed they were no more likely to have reported hospitalization over a 1-year period than the non-insured.
Yeshasvini Health Insurance Scheme	India	80	P	Obs	Medium			A		A		Scheme as a positive effect on social inclusion of rural farmers and peasants. In terms of utilization surgeries performed and patients receiving outpatient care increased significantly.
Davao City MMG-CHP	Philippines	60	P	Obs	High			A				Being insured is related to higher hospitalization rates, higher rates of professionally-attended deliveries, lower rates of delivery at home, a higher frequency of primary-care physician encounters, a higher rate of diagnosed chronic diseases, and better drug compliance among chronically ill. However, this was not due to adverse selection.
Guimaras Health Insurance Program	Philippines	60	P	Obs	High			A				As above
Health Saver	Philippines	63	G	Obs	Medium					C		Scheme had a negative impact on enrollment levels as drop-outs were higher than projected. Since the plan could not reach a break-even level of enrollment it was decided halt the program, serving existing members but discontinuing efforts to recruit new members.
La Union OHPS	Philippines	60	P	Obs	High			A				Being insured is related to higher hospitalization rates, higher rates of professionally-attended deliveries, lower rates of delivery at home, a higher frequency of primary-care physician encounters, a higher rate of diagnosed chronic diseases, and better drug compliance among chronically ill. However, this was not due to adverse selection.
Micro health insurance units	Philippines	59	P	Obs	High			A and B		A		Insurance status with MIUs improved the social inclusion and equality of

(MHUs)												access to two major health benefits: hospitalization and medical consultation. On the other hand, study suggests that affiliation with MIUs did not increase equality in access to professional attendance in deliveries; necessary data to examine equality in drug utilization unavailable.
Quezon City–Novaliches NOVADECI-NHCP	Philippines	60	P	Obs	High			A				Being insured is related to higher hospitalization rates, higher rates of professionally-attended deliveries, lower rates of delivery at home, a higher frequency of primary-care physician encounters, a higher rate of diagnosed chronic diseases, and better drug compliance among chronically ill. However, this was not due to adverse selection.
Tarlac Health Maintenance Program	Philippines	6	G	Obs	Medium					A		Vulnerable and poor are financially protected in Boa Hiem Y Te (Vietnam) scheme. Indigents in Tarlac Health Maintenance Programme (Philippines) are subsidized. In Sewa (India) needs of women not taken into account in scheme design.
VALDECO-DPK	Philippines	60	P	Obs	High			A				Being insured is related to higher hospitalization rates, higher rates of professionally-attended deliveries, lower rates of delivery at home, a higher frequency of primary-care physician encounters, a higher rate of diagnosed chronic diseases, and better drug compliance among chronically ill. However, this was not due to adverse selection.

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