ROLE OF COMMUNITY BASED HEALTH FINANCING IN DELIVERING HEALTHCARE SERVICES

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Abstract

Introduction: CBHF is effective in reaching a large number of low-income populations who would otherwise have no financial support against the high cost of illness. These schemes are systematically reported to minimize the out-of-pocket spending of beneficiaries while increase their utilization of health care services.

Objectives: One of the main problems in providing basic healthcare to people is financing. To some extend this problem can be addressed through Community Based Health Financing (CBHF) mechanism. This paper carefully examines the meaning, function and challenges of CBHF models in addressing healthcare delivery system in developing and under-developed Countries.

Methodology: The paper is developed through extensive literature review. Various CBHF models were studied to understand the operational method and different activities involved.

Findings: The Community Based Health Financing (CBHF) as a method of raising funds at the community level, was initiated by UNICEF in 1987 under its Bamako Initiative for Africa. CBHF refers to schemes that have common objective for its beneficiaries, e.g. to meet unmet health needs, increase financial access to health services, local control and low cost of treatment.

Conclusion: The success of CBHF schemes depends on the number of beneficiaries enrolled and the government financial subsidy. A disturbing factor in majority of the CBHF programmes is the very low claim ratio.

Key words CBHF, WTP, Premium, Beneficiaries

Introduction

Community-Based Health Financing (CBHF) broadly covers a wide spectrum of healthcare instruments like micro-insurance, community health funds, mutual health organizations, rural health insurance, revolving drug funds and community involvement in user fee management, have all been loosely referred to as community-based health financing (Preker et al., 2002). CBHF schemes differ from other health financing mechanisms in terms of their ownership structures, funding flows, benefit package composition and membership. CBHF schemes have become an increasingly common feature of health financing environments today in under-developed and developing countries. Currently, there are 22 voluntary CBHF programmes in India initiated and administered by various NGOs and non-profit organizations; and of these 10 are active as of today. In many schemes, the community is also involved in various activities, such as creating awareness, collecting premiums, processing claims and reimbursements, and managing the scheme (deciding on the benefit package, the premiums, etc.). A conceptual framework for examining interactions between Community Based Health Financing (CBHF) schemes and other aspects of the health care financing system is important, in order to understand some of the key policy issues.

During the last few decades, we have seen a number of advancements in this part of the world, not just in terms of technology but also in terms of how the innovative policies have contributed to gains in healthcare services. It has been possible due to improvements in health-enhancing social policies and many community-health and welfare programs. We might be proud of the achievements; however, there are millions of people who still have not been able to reap the benefits of such policies. In many low-income countries, the overwhelming demand and very limited

financial resources lead to serious drug shortages, equipment breakdowns and lowering of hygiene standards.

According to Rao (2004), who discussed the issues and challenges for health financing sector in India, says financing is one of the most important components to improve health system in India. She was of the view that various health financing mechanisms should be given high priority by the government. Schemes were also successful where issues like adverse selection, irregular and non-cash revenue of members and financial coverage for the poorest of people were taken into consideration. Nowadays, despite effective interventions for many health problems in developing and under developed countries where prices are reducing and funds are increasing, progress towards agreed health goals is very slow. Though there is widespread consensus that stronger health systems are a key to achieve improved healthcare results, there is no clarity on the steps needed to strengthen them. A part of the challenge is to get existing and emerging knowledge about more effective strategies into practice. The forthcoming Ministerial Summit on Health Research seeks to help define a learning agenda for health systems, so that by 2015, substantial progress will be made in reducing the system constraints to achieve the Millennium Development Goals.

Background

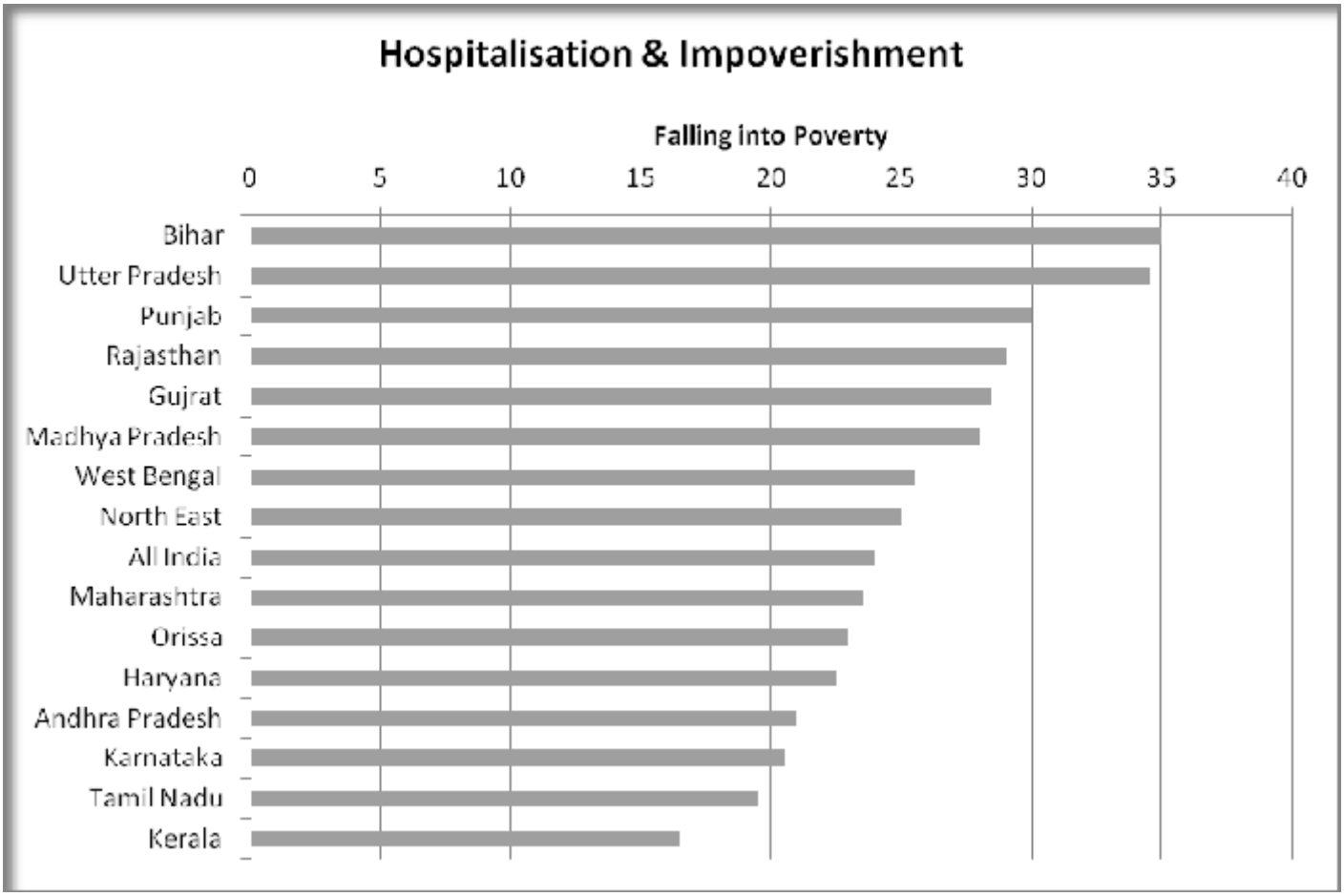
The most important and critical issue which we face today is financing and providing health care for the 1.3 billion strong poor population that lives in low and middle income countries across the world (Jutting, 2005). These poor people live from hand-to-mouth and their health financing relies on out-of-pocket payments, which are insufficient. On the poor, the burden of a disease is far more critical (Ahuja, 2004). One of the difficult processes in providing the basic medical care is identifying the groups that need subsidized care. In low-income countries, only 2% of World Health Survey (WHS) respondents with voluntary insurance belong to the lowest income quintile, reflecting very low Community Health Insurance (CHI) penetration among the poor. According to the WHS, medicines are the largest reported component of out-of-pocket payments for healthcare in these countries (median 41.7%) and this proportion is inversely associated with income quintile (Catherine et al., 2008). Publications have mentioned over a thousand CHI schemes in 19 low-income countries, usually without in-depth description of the type, extent, or adequacy of medicines coverage. Medicines may represent up to 80% of CHI expenditures (Paul, 2008). Evidence from the literature is scarce about how coverage affects utilization of medicines or how schemes use cost-containment tools like co-payments and formularies.

In India national health expenditure, when taken as a proportion of GDP at factor cost, was 5.2 percent. Since 1995-96, household expenditure on health has been growing at the current rate of approximately 14% overall. In 1995-96, households in India spent an estimated Rs.33,253 crores at nominal prices which is estimated to have increased to Rs.72,759 crores in 2001-02. With an overall growth rate of 14%, household spending is likely to be close to Rs.100,000 crores in nominal terms during 2003-04 (National Health Profile 2005). The burden of the diseases on the poor and allocation of healthcare resources across the world also display a similar pattern. 84% of the world's poor carry 93% of the global burden of the diseases. Of the total, only 11% of global health spending (US$ 2800 billion) occurs in low- and middle-income countries (Preker et al., 2002). In India, as per the report of the National Commission on Macroeconomics and Health-2005, the various redesigned schemes have covered only 44,000 BPL populations till 31 January 2005. Out of the total routine ailments treated in rural areas, only 5% were treated in PHCs. The remaining 95% were accounted for, by a number of players i.e. 20 % either went to city's public hospitals or dispensaries, 59% went to private practitioners and 16% healthcare seekers went to private hospitals (Duggal and Nandraj, 1996). Studies also suggest that income is one of the most important determinants of purchase of any form

of health insurance (Ensor and Cooper, 2004).

The cost of healthcare, especially hospitalization leads to catastrophic expenses and impoverishment of approximately 24 % households in India (Peters et al., 2002). The graph no. 1 shows the state wise information of impoverishment due to high expenditure on hospitalization

Graph 1:- Cost of hospitalization leading to impoverishment in different states of India



(Source: Peters et al., 2002)

Accessibility has direct influence on utilization of public healthcare system (Sekhrie and Savedoff, 2005). The organizational structure requires a villager to travel an average distance of 2.2 km to reach the first health post for getting a Paracetamol; over 6 km for a blood test and nearly 20 km for hospital care (Gupta et al., 2011). Given the poor road connectivity, the unreliability of finding the provider at the health centre, the indirect costs for transport and wages foregone, the marginal cost of availing a public service outweighs that of getting some treatment from the local quack. Further, even if it is accessible, there is no guarantee of proper and sustained care. Majority of the Public expenditure on health is for preventive, promotional and primary care programs, while private expenditure is mainly curative, consultative, diagnostic and in-patient care (Bautista, 2001). This private, out-of-pocket expenditure imposes a financial burden on individuals. This situation of health finance in India raises a number of issues such as:

(a) Increasing healthcare costs,

(b) High financial burden on the poor,

(c) Increasing danger of new diseases, and

(d) Low level of public expenditure on healthcare.

Considering the above issues, health insurance can be one of the suitable options of financing healthcare (Chikodikar, 2007). Recent research has documented that most of the changes in health insurance coverage can be attributed to higher health care costs (Chernew, Cutler and Keenan, 2002). Only easy, accessible and low cost healthcare services can protect the households from catastrophic expenditure arising from high medical expenditures. But, these schemes also have some challenges like low coverage, low financial protection, exclusion of pre-existing or chronic conditions, poor managerial capacity, etc. Community based health financing is very effective in reaching low income population that would not otherwise have financial protection against the cost of treatment (Currin, 2003). Improved financial protection was achieved by reducing scheme members' out-of-pocket spending, while increasing their use of health care services. A research suggested that the poor and socially excluded groups were often not included in community-based financing initiatives for the protection of health care expenditure (Jakab and Krisnan, 2004). Another study done on the utilization pattern of health insurance revealed that due to 'adverse selection' beneficiaries were not charged a premium equal to the expected marginal cost of their insurance. As a result, 'high risk' consumers find insurance most attractive and will tend to take out more generous and expensive policies relative to 'low risk' consumers (Cutler, David and Zeckhauser, 2000).

Community Based Health Financing- Success and Challenges

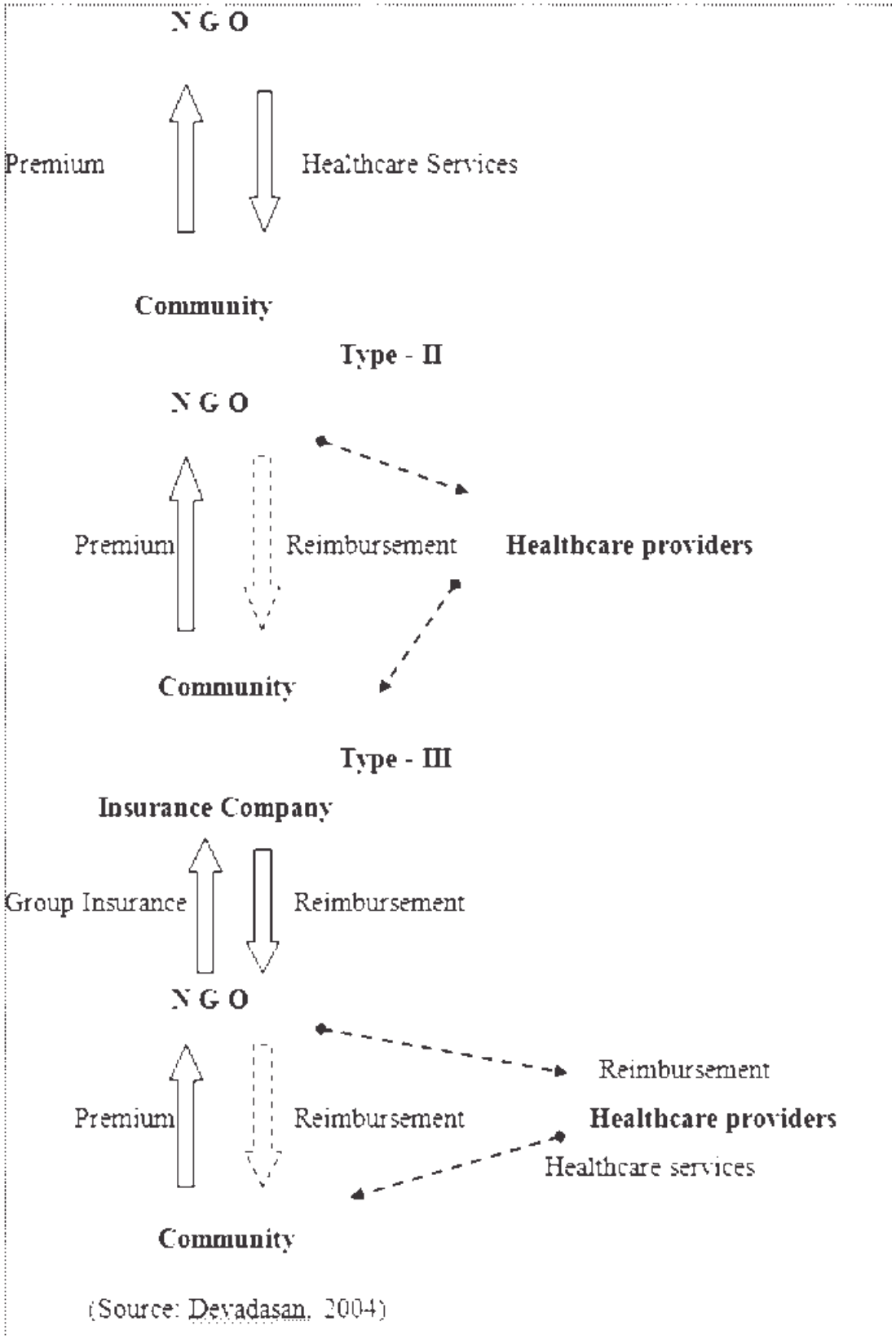
Community Based Health Financing (CBHF) is a method of raising funds at the community level to strengthen healthcare services. It was initiated by UNICEF in 1987 under its Bamako Initiative for Africa. It was initiated with objectives to revitalize public health systems, decentralize decision-making, mobilize resources to support local operating costs etc. The mechanism encouraged community participation through management of services and locally generated funds.

The introduction of CBHF in many parts of Nigeria, with its benefits of protection from payment at the point of use of health services, is expected to be received well as it has the capacity to improve access to better quality health care services. Segments of the population that are chronically dependent on out-of-pocket spending for health care payment may be willing to pay for CBHF membership because it helps to avoid paying at the time of health service use (McIntyre et al., 2005). However, studies show that health insurance of any form is used by a very insignificant proportion of people in Nigeria (Onwujekwe and Uzochukwu, 2005; Onwujekwe and Velenyi, 2006). While the CBHF movement is vibrant in Africa, it is slowly picking up momentum in India. India's voluntary sector demonstrates considerable experimentation and innovation with community and self-financing methods, including user charges, community-based prepayment schemes, fund raising, commercial schemes, and in-kind contributions, (Dave, 1991). (Devadasan et al.,2004) identified three broad types of community health insurance (CHI) schemes as discussed below and analyzed their structures and basic features:

Type I – where the provider of health care plays the dual role of providing care and running the insurance programme;

Type II - where a voluntary organization or NGO is the insurer, which purchases care from independent providers (e.g. Tribhuvandas Foundation, DHAN Foundation); and

Type III - an intermediary design - where an NGO plays the role of the agent purchasing care from providers and insurance companies (TPA, e.g. SEWA, Karuna Trust, BAIF)



(Source: Devadasan, 2004)

Most such CBHF schemes operate in rural areas and enrolment is usually facilitated by membership of organizations, e.g. micro finance groups, cooperatives, trade unions. The annual premium ranges from Rs 20 to Rs 150 per individual. The unit of enrolment is usually an individual and the membership is voluntary. Most of the schemes offer preventive care, OPD and IPD services and majority of the providers are either NGOs or non-profit organization.

The diversity of CBHF schemes means that different schemes will contribute to the overall financing system in different ways. State and National governments are increasingly recognizing that CBHF schemes can be part of a national health financing strategy: Ghana and Tanzania are in the process of developing a health financing policy that will, most likely, give a key role to CBHF schemes. The objectives and origins of various CBHF scheme are also diverse. For example, some schemes (such as Nkoranza in Ghana) were promoted by private non-profit groups seeking initially to secure their revenue base; others (such as SEWA in India) grew from micro-credit schemes that added health insurance activities to protect their members and workers. However, even where CBHF schemes are not explicitly viewed to be part of government policy, in most cases they implicitly interact with government financing policy. While CBHF schemes still tend to cover a small proportion of a country's population, in some countries this picture is changing – and changing fast. In Ghana, it is now estimated that there are 157 Mutual Health Organizations (MHOs) which is a particular form of CBHF scheme, up from just four, two years ago (Atim, 2005). Standard insurance theory suggests that such health financing schemes should focus upon unpredictable, low risk, high cost events; in practice however, CBHF schemes cover a variety of benefit packages, as observed in this research. A system-wide approach to understanding CBHF would reveal that even if there is no formal coordination between CBHF schemes and a government financing system, individuals will seek out and prefer those CBHF schemes that offer some complementary risk protection provided by government. There are three key parameters determining what constitutes 'complementary' risk coverage: the extent of co-payment (user fees) for government-subsidized services, the extent of the benefits package or essential package provided by government, and user perceptions of the relative quality of care in public and private sectors. If CBHF scheme beneficiaries have access to services that are heavily subsidized by government, they are more likely, than non-members to capture the government subsidies. Similarly, if a majority of the population cannot afford to join a CBHF scheme, even with government subsidies to the scheme, then those who can afford it will utilize the maximum subsidies. In the Community Health Fund in the Hanang district of Tanzania, scheme beneficiaries remained very low (less than 5 percent of the district population); so that those who did join the scheme benefitted from two forms of government subsidies: (1) those provided directly to providers and (2) those provided directly to the Fund (Tabor, 2005).

A study was conducted in both Anambra and Enugu states, South-East Nigeria for examining socio-economic status (SES) and geographic differences on willingness of respondents to pay for Community-Based Health Financing (CBHF). It involved a rural, an urban and a semi-urban community in each of the two states. A pre-tested questionnaire was used to gather information from a total of 3070 households selected by simple random sampling and it revealed that 40% of the respondents were ready to pay for CBHF membership for themselves or other household members. The proportion of people who were ready to pay was much lower in the rural communities, which was less than 7%. The respondents were willing to pay an average monthly premium ranging from 250 Naira (US$1.7) in a rural community to 343 Naira (US$2.9) in an urban community for themselves. Similarly, the urban people stated higher Willingness to Pay (WTP) compared with peri-urban and rural dwellers. Therefore, we can conclude that economic status and place of residence amongst other factors matter in peoples' WTP for CBHF membership.

Previous studies have found that most people were willing to pay for CBHF (Arhin, 1995; Dong et al., 2003) but the mean willingness-to-pay (WTP) amounts were low and depended on factors like socio-economic status (income), gender, education and place of residence. In

particular, (Dong et al., 2005) found that WTP for CBHF in Burkina Faso was dependent on the socio-economic status of respondents. They recommended the premium for CBHF to be adjusted for income; otherwise a lower proportion of poor people will enroll. Though the above mentioned logical argument holds water, much of the research on community-based health Financing (CBHF) has focused upon individual CBHF schemes themselves and the extent to which particular schemes are equitable, sustainable or efficient (Diop et al., 2006; Jakab et al., 2004). A clear and comprehensive exposition of the nature of the interactions between CBHF schemes and the broader health care financing system is missing. For example, a recent review of 258 community-based health financing schemes asserts the need for analysts to adopt a societal view in evaluating the impact of CBHF schemes, but found that: 'Almost all studies are focused on the scheme and the scheme members with only marginal or no analysis of the impact of the scheme in the population at large and the possible effects of the schemes beyond their members' (ILO Report, 2002).

In India, the SEWA scheme complements government health care financing in a different way. The government of India along with state governments offers an extensive package of services, with zero co-payment but the quality of these services is widely perceived to be low and informal charges are widespread. Benefits under the SEWA scheme cover most primary care services, but allow members to seek private sector care and quality of care is relatively better (Ranson and Acharya, 2003). SEWA also covers some hospital services, but puts a cap on the benefit package wherein severe cases are thrown back into the government risk pool where they are entitled to get free hospital care. Main focus in delivery of medical care through any form of financing would be on equity implications. In existing CBHF schemes, we need to stress on what happens to non-members and more broadly, the effectiveness of government targeting strategies because in most contexts where functional CBHF schemes exist, non-members do not get access. For example, the Thai Health Card scheme explicitly targets the rural middle class (Supachutikul, 1995). The government operates a parallel system of programs to provide free health care services for the under-privileged, elderly, school going children and the poorest households. In this context, high membership amongst very poor households in CBHF schemes would be counter to equity issues. Studies that compared the level of financial protection of scheme members with that of non-members found that belonging to some form of prepayment scheme reduced the financial burden of seeking health care as the success rates of various such schemes are based on resource mobilization and financial protection (Jakab and Chitra, 2001). We have an example from Karnataka, where the United Nations Development Program (UNDP) decided to assume the cost of insurance premiums for three years in the CBHF initiative launched by Karuna Trust. Outreach workers initially signed up 82,000 participants, and UNDP paid the entire Rs.30 premium for participants who belonged to low castes or tribes and Rs.15 for other families living below the poverty line (Cohen, 2006). This proves that trained and competent management with strong involvement and ownership of the community and support from government demonstrated greater sustainability

In India, Yashaswani, an insurance scheme for farmers, designed and implemented by the Government of Karnataka, has been one of the most successful and widespread. The Yeshasvini scheme targets all co-operative society members in rural areas having a minimum 6-month membership. Age group of beneficiaries varies from infants to 75 years. The scheme is open to members on a voluntary basis. The administration of the scheme is outsourced to the TPA 'Family Health Plan Limited' (FHPL). A network of accredited hospitals provides the health services, some of these hospitals are affiliated to Narayana Hrudayalaya hospital in Bangalore. Yeshasvini's insurance is distributed through the cooperative structure in Karnataka. The trust has also partnered with the Karnataka Department for Cooperation for the promotion of healthcare services. For defined healthcare procedures, which are about 800 in number, all associated hospitals are paid a fixed tariff which is 40-50% of the "fixed" tariff charged by private hospitals, OPD care is provided free of cost and some diagnostic tests are done on discounted rates. Some network hospitals also provide discounts on hospital stay. A member can approach a network hospital for any surgical

intervention. The beneficiary need not pay for surgery if the cost is below Rs.1.00 lakh for a single surgery and up to Rs.2.00 lakh for multiple surgeries (Karnataka Human Development report 2005).

Over a five-year period, a total of 2.318 million beneficiaries were enrolled, some 135,000 surgical interventions performed, many of these life-saving. The scheme also covered some 500,000 OPD consultations provided through wide network of hospitals. The Yeshasvini health financing scheme may rightly claim to be one of the most cost-effective insurance schemes throughout the world. In third year, the Administration Cost Ratio (ACR) was 1.5% only, while the Administration Cost per Insured (ACI) was kept at the amazingly low level of Rs 2.3 per beneficiaries (Yeshaswini Co-operative Farmers Health Scheme, Karnataka, Report of ILO, Sub-regional offices for South Asia). Nearly 1.10 lakh beneficiaries have used the healthcare services under this scheme and about 86,000 free out-patient consultations and 24,122 surgeries have been conducted during 2003-04 and 2004-05. A payment of about Rs.28.56 crore has been made to network hospitals against the payment towards providing healthcare services (Karnataka Human Development report 2005).

The SEWA or Self Employed Women's Association was founded in 1972 by Ela Bhatt in Ahmedabad (Gujarat) and even today it's the main centre of SEWA's activities. Beginning with a small group of women, today it has become a major social movement with more than 2,00,000 women members. These members-workers include the self-employed, employees without a formal contract or unpaid family members. SEWA's experiences suggest that for health insurance to be affordable, it has to be controlled and monitored by the users themselves. The SEWA is an independent body managed by these women beneficiaries itself. The group negotiates fees, treatment regimens etc. with healthcare providers both in public and private sector. Quality services are regularly monitored and failure to meet the quality standards leads to the exclusion of the service provider from the system. It has also resulted in the public health system gearing itself up to provide the care required, with the public charitable trust hospitals serving as a backup or alternative to the public and private-for-profit health providers. SEWA covers only hospitalization and not outpatient care because the latter is provided through SEWA's own primary health care network of curative, preventative and educational services. The hospitalization expenses cover is seen as complementary to the services offered by SEWA's health care network. Under these schemes, people always look for total coverage, including access to both primary health services and hospitalization for rarer conditions that are more expensive to treat. In the context of extreme resource constraints, this created a trade-off between prepayment for basic services and the need for insurance coverage for rarer, more expensive and life-threatening events that might only occur once or twice in a lifetime. The results of the macro-level cross-country analysis gave empirical support to the hypothesis that broad risk-sharing in health financing had a significant impact on the level and distribution of health, financial fairness and responsiveness indicators. Moreover, risk-sharing through resource pooling outweighed the negative effect of overall income inequality. This would mean that financial protection against the cost of illness might be a more effective strategy for poverty alleviation than direct income support. Evidence from eight countries with Social Health Insurance (SHI) schemes for which sufficient information is readily available—Austria, Belgium, Costa Rica, Germany, Israel, Japan, Republic of Korea (ROK) and Luxembourg, shows that the transition period (defined as the number of years between the first law related to health insurance and the latest law enacted to implement universal coverage) is 79 years (Austria), 118 years (Belgium), 20 years (Costa Rica), 127 years (Germany), 84 years (Israel), 36 years (Japan), 26 years (ROK) and 72 years (Luxembourg). These countries embarked on SHI when their economies were still underdeveloped (Carrin and James, 2004).

The community financing studies done in Mayange, rural Rwanda show that household income was a significant determinant for membership of a prepayment scheme suggesting that community financing structures did remove financial barriers to risk protection in the sample of schemes that were analyzed and it resulted in increase of additional annual visit for curative care

(Dhillon et al., 2011). In three of the surveys done in African countries, members of community financing schemes reported higher use of health care and at the same time lower out-of-pocket expenditures. This confirmed the original hypothesis that prepayment and the pooling of risk reduced financial barriers to health care. Furthermore, the analysis indicated that, even when individuals were members of a community financing scheme, being poor and lacking the ability to pay additional out-of-pocket charges remained a significant barrier to access (The world health report 2000). Also responsible for the same was lack of regulations and control on provider behavior, unaffordable premiums and high claim ratios, reluctance of the health insurance companies to promote their products and lack of innovation, too many exclusions and administrative procedures, co-variate risks and inadequate supply of services (Rao, 2004)

Main findings of public sector management reforms in Africa, Economic commission revealed that despite income being a key constraint, the poor were willing to and able to participate if their contributions were subsidized by public or donor funds. In fact they were more likely to enroll if client households were directly involved in the design and management of the schemes and if the premiums were based on prior assessments of local residents paying capacity to pay and easy access to a network of health providers

Conclusion

Community financing mechanism provides a positive contribution to the financing of health care at low income levels, improves people's access to medicines, primary healthcare and in-patient care and enables them to raise more healthcare resources. But there are variations in the success of different schemes to raise the money needed to afford medical care in the poor and low income community. The main constraint is the earning of the contributing population especially when all the beneficiaries are below the poverty line (Jonathan, 2001). A disturbing factor in majority of the CBHF programmes is the very low claim ratio, ranging from 0.25 to 0.66 percent, which indicates that the scheme is not able to overcome the barriers hindering access or that the cover provided is too inadequate or that members are too ignorant about their entitlements. It is also seen that the poorest of the poor get excluded on account of their inability to pay their share within the specified time limit. Again, some of the schemes cover very small numbers and so the potential for scaling-up is restricted. Finally, many of the schemes see health insurance as an end in itself and do not seek to either promote preventive health care or extend adequate provider linkages.

There is no exhaustive evaluation of the CBHF schemes in India due to the lack of uniformity in Management Information System (MIS), so more research needs to be done to see if these models can be implemented and replicated in India. There is no clarity on the costs to administer such schemes, or their impact on strategic purchasing of services, developing provider networks or depending on the local quack, or the problems for up-scaling and finally whether the scheme has helped protect the poor from penury and if so, how it can be sustained if NGOs withdraw their support, etc. The main strengths of the CBHF schemes are that they have been able to reach out to weaker sections of society and provide some form of health security; increase access to health care; and protect households from catastrophic health expenditures and consequent impoverishment or indebtedness. They also provide limited protection in view of the very low cross subsidies between the rich and the poor. This results in a small size of revenue pool, which in turn mitigates against obtaining a better bargain from providers.

Reference

Ahuja, R. (2004), 'Health Insurance for the Poor', Economic & Political Weekly, Vol.39, No. 28, July 10

Arhin, ClaSs. (1995), 'Rural health insurance: a viable alternative to user fees? A review and evidence from three countries', PHP Departmental Publication no 19. London: London School of Hygiene and Tropical Medicine: Department of Public Health and Policy;

Bautista, V. (2001), 'Challenges to sustain Primary Healthcare in the Philippines', WHO, 2001

Catherine, E., Vialle-Valentin., Ross-Degnan, D., Joseph, N. and Anita, K. W. (2008), 'Health Research

Policy and Systems Research; medicines coverage and community-based health insurance in low-income countries', Health Research Policy and Systems 2008, 6:11

Chernew, M., Cutler, D. and Keenan, P. S. (2005), 'Rising health care costs and the decline in insurance coverage', Health Services Research, 2005.

Cutler., David, M. and Zeckhauser, R. J. (2000), 'The Anatomy of Health Insurance', In Handbook of Health Economics, Volume 1A, ed. Anthony J. Cuyler and Joseph P. Newhouse, 563-637. New York, Elsevier Science B. V.

Carrin, G. and Chris, J. (2004), 'Reaching universal coverage via social health insurance', Discussion paper 2, Papers on Health Financing and Contracting, WHO.

Dave, ParT. (1991), 'Community and self-financing in voluntary health programmes in India', health policy and planning, Oxford Journals, Volume 6, Issue1, pp. 20-31.

Devadasan, And., Kent, R., Damme, W. V. and Criel, B. (2004), 'Community Insurance in India: An overview', EPW, July, 2004

Diop, F., Sulzbach, S. and Chankova, S. (2006), 'The impact of Mutual Health Organizations on social inclusion, access to health care, and household income protection', Evidence from Ghana, Senegal and Mali. In Partners for Health Reformplus. Bethesda, MD, Abt Associates, Inc;

Dong, H., Kouyate, B., Cairns, J. and Sauerborn, R. (2005), 'Inequality in willingness to pay for community based health insurance', Health Policy 2005;72:pp149-156

Gupta, S. K., Kumar, D. P., Tiwari, R., Garg, R., Sarawagi, R., Kumar, A., Shrivastava, P. and Gupta, P. (2011), 'Assessment of Janani Suraksha Yojana (JSY) – in Jabalpur, Madhya Pradesh', knowledge, attitude and utilization pattern of beneficiaries: a descriptive study, International Journal of current biomedical sciences, . 2011; 1(2): pp 06 – 11

Guy, Class. (2003), 'Community Based Health Insurance Schemes in Developing Countries: Facts, Problems and Perspectives', Discussion Paper No. 1, (Geneva: World Health Organization)

'Health Finance Indicators', National Health Profile (2005)

Jakab, M. and Krisnan, ClaSs. (2004), 'Review of the strengths and weaknesses of community financing', Health Financing for Poor People: Resource Mobilization and Risk Sharing. Edited by Preker, A. and Carrin, G. The World Bank, Washington, DC; 2004:53-117

Jakab, M., Preker, A., Krisnan, C., Schneider, P., Diop, F., Jutting, J. and Gumber, A. (2004), 'Analysis of community financing using household surveys', In Health Financing for Poor People: Resource Mobilization and Risk Sharing, Edited by Preker, A. and Carrin, G. The World Bank, Washington, DC; 2004:201-230

Jakab, M. and Krishnan. (2001), 'Literature Review on Community Financing', Washington: World Bank.

Jonathan, M. (2001), 'Analysis of the Effects of Microfinance on Poverty Reduction', The Canadian International Development Agency, November, 2001.

Jütting, J. (2005), 'Health Insurance for the Poor in Developing Countries', Ashgate, Burlington

'India: Yeshaswini Co-operative Farmers Health Schemes (Karnataka)', Building a Public Private Community Partnership Model, Social Security Extension Initiatives in South Asia, ILO.

'Investing in Human Development', Karnataka Human Development Report, 2005

Makarand, ClaSs. (2007), 'Health Insurance for the Poor - Status & Issues', Shree Damodar College of Commerce & Economics, Goa

Margot, ClaSs. (2006), 'Community Based Health Insurance promises in India', Population reference bureau.

Nandraj, S. and Duggal, R. (1996), 'Physical standards in the private health sector', Radical Journal of Health 2(2/3):141-84.

Onwujekwe, O. and Velenyi, E. (2006), 'Feasibility of voluntary health insurance in Nigeria', The World Bank, Washington, DC.

Peters, D. H., Yazbeck, A. S., Sharma, R., Ramana,

G.N.V., Pritchett, L. and Wagstaff, A. (2002), 'The Functioning of the Private Health Market - Better Health Systems for India's Poor: Findings, Analysis, and Options', Washington, DC: World Bank.

Paul, And. (2008), 'Medicines Coverage and Community-Based Health Insurance in Low-Income Countries', Health Research Policy and Systems 2008, 6:11 doi:10.1186/1478-4505-6-11

Preker, A., Carrin, G., Dror, D., Jakab, W., Hsiao, W., and Arhin-Tenkorang, D. (2002), 'Effectiveness of community health financing in meeting the cost of illness', Bulletin of the World Health Organization, 80, 143-150

Ranson, K. and Acharya, A. (2003), 'Community based health insurance: The Answer to India's Risk Sharing Problems?', Health Action, March, 2003

Ranu, S. D., Matthew, H. B., Max, F., Donald, N. and Josh, R. (2011), 'The impact of reducing financial barriers on utilisation of a primary health care facility in Rwanda', Global Public Health, Routledge Publication

Sekhrie, N. and Savedoff, W. (2005), 'Private health insurance: Implications for developing countries; policy and practice', Bulletin of the World Health Organization. 85:127—34

Steven, R. and Tabor, S. (2005), 'Community-Based Health Insurance and Social Protection Policy Social Protection Discussion', Paper Series, No. 0503, World Bank

Rao, S. (2004), 'Health insurance: Concepts, issues and challenges', EPW, August 2004

Supachutikul, A. (1996), 'Situation analysis on health insurance and future development Bangkok:': Health Systems Research Institute. 1996

Tim, E. and Stephanie, ClaSs. (2004), 'Overcoming Barriers to Health Service Access and Influencing the Demand Side Through Purchasing', Discussion Paper - Health, Nutrition, and Population Family (HNP) of the World Bank's Human Development Network

WHO. (2000). The world health report 2000. Health systems: measuring performance. Geneva: World Health Organization; 2000.

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OUTSOURCING STRATEGIES AND MARKETING PERFORMANCE OF FAST FOOD INDUSTRY

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Abstract

There is now more pressure on marketing practioners to justify that marketing function contributes to shareholders value by the firms. Management of firms are interested in assessing the extent to which cost of business can be minimized and how that could help in reducing marketing expenditure and ultimately increase return on marketing investment (ROMI). It is as a result of this that the study attempted to ascertain the link between outsourcing and marketing performance. The study is limited to the fast food industry in Nigeria. Copies of questionnaire were distributed 'purposively to ten fast food outlets in Lagos, Nigeria. Two hypotheses were developed and were subjected to descriptive and regression analysis. It was discovered that outsourcing contributed to increase in marketing performance.. The study makes useful policy recommendations for marketing professionals, entrepreneurs and top executives of fast food outlets in Nigeria.

Keywords: Business Outsourcing, Knowledge process outsourcing, Marketing performance.

Introduction

The Fast Food industry in Nigeria today is a beehive of activities and is gaining a lot of attention both within and outside the country. Industry trends such as rapid outlet expansion, strategic alliances (especially with companies in downstream sector of the oil and gas industry), and entrant of foreign players amongst others lends credence to these assertions. There exist in every economy, (whether developed, developing or less), various type of industries; manufacturing, service, food and beverage, textile and chemical. These industries compete among themselves for resources, infrastructure, market share and relevance, for successful competition, companies use creative and innovative weapons to compete favourably for profit maximization.

However the concept of outsourcing has not received a lot of attention as considered to be important elements that account for the growth and remarkable performance of the fast foods industry in Nigeria. Also the effects of outsourcing on firms' performance are not completely clear. Previous outsourcing studies show contradictory results; while some claim a positive relationship between outsourcing and performance outcomes, others report no significant or even negative effects. (Rothaermel and Deeds (2001).

Outsourcing without proper management control could sometimes result in job losses, According to Ghodeswar and Vaidyanathan (2008) a large number of employees whose organizations outsource their business activities may have similar problems to those employees that have undergone downsizing, while organizations claim that the basis for outsourcing is to increase business efficiency. however employees who are lucky to remain in the company after outsourcing effects believe that the possibilities of them staying in the company is low, because they could be the next in line to lose their jobs. Hammer (2001) posits that in situations where the outsourcer is not satisfied with the service, it could be difficult to break the contract because outsourcing contracts usually require a stipulated period. It will be costly to reverse the situation and return the services in-house. Nevertheless, extant literatures and observed online interviews of business executives have shown that the positive outcome of outsourcing as a platform for reducing cost of production and for increasing the profit of firms. However, limited study have been able to link it with returns on marketing investment. Return on marketing investment (ROMI) is the contribution attributable to marketing (net of marketing spending), divided by the marketing 'invested' or risked. ROMI is a relatively new metric. It is not like the other 'return-on-