Introduction

In 2005, World Health Organisation (WHO) member states committed to achieving universal health coverage (UHC) to ensure that all people have access to quality health services in times of need and are protected from the financial hardships of health care costs (WHO, 2005). This commitment was reaffirmed in the World Health Report 2010, which stated that health-financing systems should be designed with the aim of reaching universal health coverage (WHO, 2010) and was further supported in a 2012 United Nations General Assembly Resolution that highlighted the critical role it could play in helping to meet the Millennium Development Goals and alleviate poverty (UN, 2012). By supporting the progression to UHC, nations are acknowledging the need to honour everyone’s fundamental right to health care (Chan, 2012).

Reaching universal health coverage is now a critical goal of health systems in all countries irrespective of income status (WHO, 2013). To meet the dual UHC aims of universal access to health care and financial protection from health care expenditures, many low- and middle-income countries (LMIC) have therefore initiated a number of ambitious health-financing reforms that aim to introduce prepayment at affordable prices for low socio-economic groups and targeted subsidies for indigents and other vulnerable populations. However, while such reforms have led to increased utilization of health care, it is often the case that the poor, informal sector workers and other marginalised people continue to be excluded from coverage. Furthermore, out-of-pocket payments in most LMIC continue to constitute a large proportion of total health expenditure, reaching over 50% of total health payments.
in many low-income countries in Asia and Africa (van Doorslaer, 2006; WHO, 2013). Health-care patterns thus remain inequitable with the economic burden falling disproportionately on the poor. Where user-fees are charged, it becomes impossible to reach UHC, as many vulnerable people either risk financial catastrophe from paying health care costs or are prevented from accessing health services altogether.

In order to reduce the reliance on OOP payments, it is essential that health systems introduce prepayment methods that ensure risk pooling and cross-subsidization between the rich and poor and healthy and sick (WHO, 2013). This can be achieved through a variety of health-financing mechanisms such as tax-funded national health insurance (NHI), contribution based social health insurance (SHI), exemption policies and community based health insurance (WHO, 2013). These programmes aim to trigger the necessary structural transformations to enhance people’s access to care, hence making health systems more equitable (Michielesen et al., 2010). However, although many low- and middle-income countries have implemented a variety of these financing mechanisms to initiate a progression to UHC, current evidence on their effectiveness shows mixed results at best, with many studies indicating that programmes have failed to reach their assigned objectives (Derbile & Van Der Geest, 2013; Witter et al., 2007; Spaan et al., 2012).

Despite considerable efforts, it is clear that few low- and middle-income countries have reached near universal coverage (WHO, 2013). There is, therefore, an unquestionably urgent need to develop and reform financing models for accessible health care in low- and middle-income countries. However, to do so, it is first important to understand why many recent health-financing reforms have failed to ensure equitable access to health care, particularly for the poorest and most vulnerable populations. It was with this aim in mind that a multi-country research project, Health Inc (Financing health care for inclusion), was devised to examine the performance of a number of social health protection policies that were implemented to counteract inequities in access to health care services in LMIC. In particular, the Health Inc project sets out to explore the role of a specific, critical factor that may be limiting the success of recent health financing initiatives: social exclusion.

Combating social exclusion has been identified as a key goal for health systems by organizations such as the International Labour Organization (ILO, 2007) and the WHO, whose 2008 World Health Report calls for “reforms that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection” (CSDH, 2008). Furthermore, the Commission on Social Determinants of Health (CSDH) has emphasized the need to evolve “health equity intervention research” through the development of “evaluation methodologies that capture contextual and other critical influences to understand what works to make significant progress towards UHC” (CSDH, 2008). Following these calls, the Health Inc project posited that the social exclusion concept was a relevant framework through which to analyze several SHP programmes and their effectiveness. We did so in four different settings: two states of India (Karnataka and Maharashtra) and two West African countries (Ghana and Senegal). In this book, we present evidence from the Health Inc project to show how social exclusion restricts access to health services for vulnerable groups in these settings, despite recent health financing reforms. Based on this evidence, we propose strategies and policies that can enhance the inclusiveness of social health protection schemes.

The Health Inc Project

As its starting point, the Health Inc project put forward the hypothesis that social exclusion is an important cause of the limited success of recent health-financing reforms. Firstly, social exclusion can explain barriers to accessing health care. Social exclusion from health care provision may be due to disrespectful, discriminatory or culturally inappropriate practices of medical professionals and their organisations within the context of poor accessibility and quality of care. Social exclusion from health care services means that removing financial barriers does not necessarily guarantee equitable access to health care.
Secondly, social exclusion can explain barriers to accessing the health-financing mechanism itself. There are underlying social, political and cultural reasons for lack of financial coverage. Differential access to information, bureaucratic processes, complex eligibility rules, and/or crude and stigmatizing criteria for means-testing prevent socially excluded groups from enrolling in financing schemes that provide access to health care at an affordable price (e.g. community health insurance) or even free of charge (e.g. user charges exemptions). Leakage, on the other hand, may explain why more powerful and vocal groups are able to capture the benefits of targeted schemes that aim to cover the poor.

To explore whether social exclusion is in fact limiting the success of health-financing reforms, the Health Inc project undertook primary research in a number of geographical settings on a variety of social health protection schemes. In two states of India, Maharashtra and Karnataka, research was conducted on the RSBY insurance scheme. In West Africa, the National Health Insurance Scheme (NHIS) in Ghana and the Plan Sesame exemption scheme for older people in Senegal were investigated. These locations provided ideal settings for the research, as they are all experimenting on a large scale with a variety of financing mechanisms that offer tax funded subsidies to indigents and vulnerable groups and/or contributions set at a low, supposedly “affordable” price. These locations and an overview of the financing mechanisms studies are explored in part I of this book: Country Case studies.

The results and conclusions from the Health Inc project that are presented in this book aim to address a number of complex questions. What are the indicators of social exclusion in LMIC? Are vulnerable groups such as women, scheduled castes and older people, excluded from social health protection schemes? If so, through what processes does this occur? Are vulnerable groups at greater risk of exclusion than other groups? Can social exclusion explain patterns of enrolment and utilisation of health care and unmet need? What is the potential of health policy makers to reduce social exclusion in health care financing arrangements? Can anything be learnt about the influence of social exclusion on health care financing from a cross-country comparison of the health-care financing arrangements studied? By answering these questions, this book aims to provide an explanation of the mechanisms that shape social exclusion in health and to propose fundamental policies that will reduce inequalities in access to social health protection and health-care services. Before presenting these results and discussing what can be done to improve social inclusion in health-financing schemes through a social exclusion lens.

Social health protection in LMIC

Quality, appropriate and affordable health care in times of need should be available to all people. However, estimates suggest that more than 1 billion people worldwide currently lack access to affordable health care, and 150 million annually face financial catastrophe as a consequence of paying health care costs (Xu 2005). These persistent inequalities in health-care access and lack of financial risk protection violate the key principles of universal health coverage that ensures ‘access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access’ (WHO 2005).

In light of distinct and inequitable gaps in health systems coverage, the United Nations General Assembly has called on governments worldwide to significantly scale-up efforts towards achieving UHC for their populations (United Nations 2012). To do so, it is essential that countries develop efficient and effective social health protection systems. As illustrated in the WHO’s famous cube diagram (figure 1), reaching universal SHP requires the provision of sufficient coverage in three dimensions:

- breadth of coverage (size of the population covered)
- depth of coverage (the range of benefits covered)
- height of coverage (the share of total costs covered)
When UHC is reached, the entire population will be covered by a comprehensive set of health interventions with few OOP expenditures for accessing those interventions (Jamison 2013). It is important that SHP incorporate the objectives of burden sharing, risk pooling, empowerment and participation, and embody the values of solidarity, social justice and equity in terms of access to good quality services according to need and regardless of income level, social status or residency (ILO 2007). When these objectives are fulfilled, SHP instruments should enrol even the most poor and vulnerable groups and ensure equitable access to essential health care services.

The goals of UHC and SHP can be met through a variety of health-financing mechanisms (WHO 2010). These include: tax-funded national health insurance (NHI); contribution-based mandatory social health insurance (SHI) financed by employers and employees; mandated or regulated private health insurance (PHI); and mutual and community non-profit health-financing schemes such as community-based health insurance (CBHI), conditional cash transfers (CCT) or subsidized vouchers. By nature, these initiatives to remove financial barriers to accessing health care fall under the umbrella of Social Health Protection programmes, defined by the International Labour Organisation as:

“a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings, or the cost of necessary treatment that can result from ill health.” (ILO, 2007)

Each mechanism’s potential strengths and weaknesses in terms of the goals of equity, efficiency and quality of care have been well documented in LMIC, and while many pathways can be taken to expand coverage, it is generally acknowledged that a mixture of mechanisms is necessary to achieve UHC (Gottret 2006; McIntyre 2007).

In recent years, and despite considerable resource constraints, many LMIC countries have accepted the call to transition towards UHC and have introduced a variety of social health protection systems. In 2003, Ghana implemented the National Health Insurance system that offered coverage to the entire population with enrolment fees waived for indigents. By 2010, it was estimated that about 50% of the population were active members with valid membership cards (Ministry of Health 2011). However, less than 10% of the revenue generated by the NHIS comes from voluntary payments, as enrolment for the informal sector and indigents remains low (Ministry of Health 2011). The Philippine National Health Insurance Program, “PhilHealth”, has, in contrast, proved more successful.
at expanding health insurance coverage to indigents. The Sponsored Program within PhilHealth that extends free coverage to indigents had achieved coverage rates of 85% in 2008 (Manasan 2011). However, in 2009 and 2010, enrolment figures reached 140% and 154% respectively, indicating poor targeting and leakage of benefits to non-eligible individuals (Manasan 2011).

Other countries have experimented with insurance schemes that only target vulnerable groups. In India, the RSBY scheme was introduced in 2008 to provide subsidies for private health insurance for people below the poverty line (BPL). However, enrolment rates remain consistently low. In a study carried out in districts in Maharashtra state, the proportion of poor families enrolled in the scheme was only 39% (Narayana 2010). Similarly, official RSBY figures show that enrolment among eligible households in the second year of implementation in Karnataka state was 41.2% (Rajasekhar 2011). In addition to low enrolment rates, results from an evaluation study suggest that only 1.8% of cardholders in Maharashtra have actually utilised health-care services (Jain 2011).

Similar issues of low and inequitable enrolment have been seen in many CBHI schemes. For example, in Senegal, Mali and Ghana, community health insurance (CHI) schemes have low rates of coverage of the national population and higher enrolment rates among the better-off than the poor (Jütting 2004; Chankova 2008). Furthermore, although these schemes have been shown to increase health-care utilization for members, they often provide limited financial protection and do not reduce out of pocket expenditures (Chankova 2008).

It is clear that LMIC have introduced a wide variety of SHP schemes in efforts to achieve universal coverage. However, in many schemes, the most vulnerable population groups continue to be excluded from coverage even when free or subsidized enrolment is available and remain less likely to access health care than other population groups. As previously hypothesised, one critical factor that may limit the ability of health-financing mechanisms to extend coverage and benefits to vulnerable populations is social exclusion, a concept explored in the next section.

### The concept of social exclusion

Social exclusion is a widely-used term today, but not necessarily a clear-cut concept. It can varyingly be considered as a condition/status or as a multidimensional and dynamic process. When viewed as a condition/status, it is seen as an outcome where some individuals and groups are excluded, as they are unable to fully participate in society as a result of their social identity (gender, religion, race) or social location (remote areas, segregated territories, low paid jobs). Alternatively, social exclusion can be viewed as a multidimensional and dynamic process where social interactions and organizational/institutional barriers hamper individuals from attaining a decent livelihood, a country to reach a sufficient level of human development and a state to offer equal citizenship to its citizens. Social exclusion therefore generates, sustains and reproduces poverty, enhances inequalities, and restricts social, political and economic participation for some marginalized individuals or groups and prevents them from accessing institutional sites of power or engaging with powerful organizations.

These definitions of social exclusion have emerged after several decades of debate and revision, primarily in Europe and North America. The first use of the term is commonly attributed to the French politician René Lenoir (Lenoir, 1974), although underlying and related concepts had been part of European sociological inquiry for a long time (Elias, 1965). Lenoir, then Secretary of State for Social Action, dealt with social exclusion in the specific context of a welfare state and attempted to put vulnerable groups excluded from social protection into the ‘spotlight’. He did not provide an unambiguous or new definition, but deserves credit for bringing into view the notion of something wider than monetary poverty and opening the door to a great debate on the concept in Europe (Ben Aziza 2004).
By the end of the 20th century, the use of the term social exclusion was widespread among social scientists and policy-makers, often without a common definition. Anthony Atkinson postulated that the term might “have gained currency in part because it has no precise definition and means all things to all people”. Yet, Atkinson also identified three recurrent characteristics within a variety of definitions of social exclusion: relativity, agency and dynamics. Relativity refers to a particular place and time (as opposed to an absolute approach in poverty measurement); agency (not identical to the term used in the capability framework) refers to exclusion as dependent on the activities of others; and dynamics refer to the relevance of future prospects beyond current circumstances (Atkinson 1998).

Ruggeri Laderchi and colleagues classify social exclusion as one of four approaches to poverty, alongside monetary, capability and participatory approaches (Ruggeri, 2003). Amartya Sen doesn’t entirely agree and posits that “the perspective of social exclusion reinforces – rather than competes with – the understanding of poverty as capability deprivation” (Sen, 2000). Guildford describes how terms and emphases changed while the concept of social exclusion travelled the world. In France, and subsequently in the work of the European Union, the term ‘social exclusion’ is most often used. The United Kingdom similarly embraced the ‘social exclusion’ concept, establishing the Social Exclusion Unit that viewed exclusion as ‘what can happen when people or areas suffer from a combination of linked and mutually reinforcing problems’ in areas such as poverty, employment, housing and health (Bradshaw, 2004). Yet, the European Anti-Poverty Network prefers ‘poverty and social exclusion’; in Scotland, emphasis was put on ‘social inclusion’; and Canada launched the term ‘social and economic inclusion’. As Guildford notes, behind different terms a common understanding seemed to have emerged: “Exclusion is the problem; inclusion the solution” (Guildford, 2000). Ronald Labonte welcomes the twinned concepts of social exclusion and inclusion, which he describes as a conceptual sophistication over social capital and social cohesion, while remarking on the complexity of inclusion into social systems stratified by exclusion (Labonte, 2004).

When the concept of social exclusion eventually transferred to the less developed countries, it was initially met with scepticism. Originally defined within the context of a European welfare state and often expressed in numbers of people lacking social security or employment, its applicability to developing countries with high unemployment levels and numbers of unprotected individuals was questioned (Saith, 2001). Arguably, Saith could not foresee that social exclusion would gradually adopt a much less restrictive definition. His apprehension of social exclusion being an impractical concept for dealing with large groups is understandable, as there was a long transitional period where the shift in focus from outcome to process was welcomed but rarely applied. Indeed, it took researchers and policy actors quite some time to go beyond counting outcomes and instead to begin analyzing processes. As late as 2005, some international development actors still regarded social exclusion as much an outcome as process. Today, process thinking prevails and most scholars agree that social exclusion, far from being carved in stone and without being a conceptual newness, is a highly relevant approach in development because it underscores the processes of deprivation, its relational aspects and the need for transformation (Sen, 2000).

Social exclusion in health and social exclusion from social health protection

Although the concept of social exclusion quickly gained momentum in development circles in the aftermath of the 1995 World Summit for Social Development, it was only more than a decade later that – under the impulse of the WHO’s Commission on Social Determinants of Health (CSDH) – it started permeating the field of health. In 2008, the third and last overarching recommendation of the CSDH was “to measure and understand the problem and assess the impact of action”, including what was termed “health equity intervention research” (CSDH, 2008). The 2011 World Conference on Social Determinants of Health reiterated the CSDH’s recommendations and made a plea for “research on the relationships between social determinants and health equity outcomes” (WHO, 2011). The CSDH therefore established a set of key transversal themes to be investigated in order to better understand the causes and consequences of inequities in health. At the core of these themes was the concept of social exclusion.
In order to explore the issue of social exclusion in health, the commission established the Social Exclusion Knowledge Network (SEKN) whose aim was to present a framework for understanding and tackling social exclusion. The SEKN network clearly framed it as a process with the specific request to “unravel unequal power relationships” that may affect the effectiveness of equity-oriented interventions (Mathieson et al., 2008). In the SEKN’s Final Report to the CSDH, social exclusion was defined as: “dynamic, multidimensional processes driven by unequal power relationships interacting across four main dimensions – social, political, economic and cultural – and at different levels including individual, household, group, community, country and global levels” (Popay 2008). It is this definition of social exclusion that was adopted by the Health Inc. project.

Based on SEKN’s understanding of social exclusion, the Health Inc consortium developed an analytical framework that aimed to highlight exclusion from effective coverage and to capture causes and risk factors across four dimension of power relationships that constitute the continuum from inclusion to exclusion: economic, political, social and cultural (Popay 2008). Given the complex, multidimensional, dynamic nature of social exclusion, ‘risk-factors’ or ‘drivers’ of social exclusion in each dimension interact and are often mutually reinforcing in their impact on social exclusion. The key characteristics of each dimension are described below:

- The social dimension is constituted by proximal relationships of support and solidarity (e.g. friendship, kinship, family, clan, neighbourhood, community, social movements) that generate a sense of belonging within social systems. Along this dimension, social bonds are strengthened or weakened.
- The political dimension is constituted by power dynamics in relationships which generate unequal patterns of both formal rights embedded in legislation, constitutions, policies and practices and the conditions in which rights are exercised – including access to safe water, sanitation, shelter, transport, power and services such as health care, education and social protection. Along this dimension, there is an unequal distribution of opportunities to participate in public life, to express desires and interests, to have interests taken into account and to have access to services.
- The economic dimension is constituted by access to and distribution of material resources necessary to sustain life (e.g. income, employment, housing, land, working conditions, livelihoods, etc.).
- The cultural dimension is constituted by the extent to which diverse values, norms and ways of living are accepted and respected. At one extreme, along this dimension, diversity is accepted in all its richness; at the other, there are extreme situations of stigma and discrimination.

The SEKN Final Report also highlights the importance of social exclusion in health and health care. The “dynamic, multidimensional processes” that drive social exclusion lead to “a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities” (figure 2).
The social exclusion lens is increasingly recognized as a relevant concept through which to analyze Social Health Protection programmes, as it presents a framework through which the social, political, economic, cultural and institutional dimensions of society shape human vulnerabilities (Babajanian, 2013). For Health Inc research, the social exclusion perspective was adopted, as “it can help not only examine the effects of social protection on different dimensions of deprivation, but also expose its ability to tackle broader factors and conditions that produce and reproduce deprivations” (Babajanian, 2013). Ultimately, the social exclusion lens can expose the social and institutional factors that prevent some SHP programmes from extending protection to the most vulnerable individuals.

**Social exclusion as a cause of the limited success of health financing reforms**

Social exclusion can help cause or enhance inequity in health financing in two main ways. Firstly, social exclusion can explain barriers to accessing health care. Social exclusion from health-care provision may be due to disrespectful, discriminatory or culturally inappropriate practices of medical professionals and their organisations. This problem may be experienced within the broader context of poor accessibility and quality of health care (WHO 2000; Carrin G 2008). Unfortunately, it is often those who need health care the least that use services more, and more effectively, than those with the greatest need, a paradox known as the “inverse care law”. The inverse-care law is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served (Hart 1971). Those with the greatest need are often poorer and socially excluded population groups. The inverse-care law also means that removing financial barriers through tax funded systems, or via any other financing arrangement, does not necessarily guarantee equitable access to health care. Reducing financial exclusion is a necessary but by no means a sufficient condition to make sure that people in need can access quality health care.

In addition to barriers to accessing health care services, social exclusion may also, more directly, restrict access to health-financing mechanisms. Underlying social, political, economic and cultural barriers may result in insufficient breadth, depth and height of coverage. For example, one barrier to accessing a social health protection scheme may be that the steps required to access a health financing mechanism are socially unacceptable. Evidence suggests social exclusion is embedded in organisational structures and processes, such as differential access to information,
complex eligibility rules and crude and stigmatizing criteria for means testing (Popay 2008). Free health care through means-tested subsidies, such as vouchers or subsidised premiums, may in theory promote greater financial inclusion, but social exclusion has been found to restrict the reach of targeted policies disadvantaging those in most need (Mkandawire 2005). This partly explains why, even if possession of a voucher or exemption card makes care available free of charge, often only a small proportion of the eligible population enrols in user charges exemption schemes (Willis 1995; James 2006).

Social exclusion may also have an important impact on contributory schemes. If the insurance is organised in a way that is socially, politically or culturally inappropriate, unacceptable or inaccessible, enrolment may be low even if the premium is affordable to poor and informal sector workers. For example, a study in Ghana found that more than 20% of the respondents reported that they had not heard about the National health Insurance Scheme (NHIS), and the majority of these were concentrated among the poor population. Others did not register because they did not trust the genuineness of NHIS (Asante 2008). In India, research done at a community health insurance programme found that while both the poor and the better-off populations enrolled in equal proportions, the better-off tended to use the services more than the poor. This was mainly because of the bureaucratic barriers to reimbursement faced by the poor (Ranson, 2006). Leakage, which is understood as an inclusion error in means-testing (Peyre Dutrey, 2007), and unequal distribution of capabilities and access to information may explain why more powerful individuals and groups are able to capture the benefits of targeted schemes that aim to cover the poor.

**Extending the scope of research on social exclusion into health financing in LMIC**

Social inclusion has long been a concept used in research in high-income countries, but large gaps in knowledge remain in terms of health-financing policy in LMIC. While studies on social exclusion in LMIC and health are available, they do not focus specifically on health financing. There are almost no systematic studies of how social, political or cultural exclusion occurring in the broader environment may affect access to equitable health-financing arrangements. Instead, studies tend to focus more narrowly on the negative effects of poverty measured in terms of income, expenditure or assets, and the poor quality of health care, or on community participation in health-financing arrangements. These barriers are clearly important, but there has been a lack of attention paid to explaining why the financing system has been unable to overcome them.

Limited attention has also been paid to assessing the “human component” of health systems development (CSDH 2008). The WHO Commission on Social Determinants of Health report (2008) argued that as well as studying the social determinants of health, “research and policy need to focus on the human component of health-systems development”. The report further argues that understanding this aspect of health systems is crucial since “processes of management and decision-making within the health system itself are important avenues for reducing inequity and empowering the excluded and marginalised” (CSDH 2008). A recent review has also highlighted the need for “systematic and coherent bodies of work underpinned by both the intent to undertake rigorous analytical work and concern to support policy change” in this field (Gilson and Raphaely 2008).

The Health Inc project has responded to these gaps in evidence, both in terms of analysis and policy, by identifying how social exclusion influences equity objectives of health-financing policies and recommending policies that can enhance social inclusion. Commonalities across geographical contexts were also explored through a comparative analysis of the complex processes by which social exclusion prevents access to health care in diverse locations, including Ghana, Senegal and the Indian states of Maharashtra and Karnataka. As explained previously, these locations provided ideal settings for the research, as they are all experimenting on a large scale with financing mechanisms that aim to increase access to health care for vulnerable groups. The schemes also differ markedly in
terms of funding mechanisms, targeted beneficiaries, enrolment procedures and benefit packages and provide a variety of social, political and cultural dimensions that intersect within these financing arrangements. Lastly, the different schemes have experienced different levels of success, which provides a rich environment for studying both positive and negative cases.

By undertaking this research, the Health Inc project has provided much needed evidence on the role social exclusion can play in causing and enhancing inequities in health and health-care access. The results and conclusions in this book show how social inclusion/exclusion can help account for successes and failures in the development and implementation of policies which can result in accessible and acceptable health-financing mechanisms that serve vulnerable groups. The policy recommendations for combating social exclusion and enhancing social inclusion can help shape necessary reforms that will ensure equitable health systems that advance the cause of universal access and social health protection (CSDH, 2008).

Outline of the book

In this introductory chapter, we have provided the rationale for the Health Inc project and the need to study health and social health protection through a social exclusion/inclusion lens. We have explored social health protection in low- and middle-income countries and the concept of social exclusion and social exclusion as it related to health care. In the remainder of this book, we present results from the four Health Inc study sites before bringing together this evidence to help us present recommendations for reducing social exclusion in health-financing schemes.

Following this introductory chapter, we first present the methodological framework, the SPEC-by-step tool that guided Health Inc research. In chapter two we show how the SPEC-by-step tool was developed by grafting the SEKN’s Social, Political, Economic and Cultural (SPEC) conceptual framework on social exclusion onto a step-by-step deconstruction of the health-financing scheme under study. We show how this tool enabled us to study who was excluded at each implementation step – from being aware of a scheme through to enrolment, receiving membership cards, utilising health care and receiving financial protection – and how and why this exclusion occurred.

The remainder of the book is then divided into three further sections. In part II, which contains four chapters, we introduce Country Case Studies that explore the study settings, detail the research methods used and present a brief overview of key results in each location. In chapter three we present the Ghanaian country context and an overview of the National Health Insurance Scheme (NHIS). In chapter four we next review the Senegalese context and the Plan Sesame. Next, we provide an overview of the RSBY insurance scheme in Maharashtra in chapter five before exploring the Karnataka context and RSBY in chapter six.

In part III of the book, we explore in-depth the results presented in the Country Case Studies by analysing the different steps of the SPEC-by-step tool in detail. In chapter seven, we explore enrolment in RSBY in Karnataka. Using a mixed methods analysis, we explore if and how the design and implementation of the enrolment process in RSBY influences who gets in to the scheme and who does not, given the existing social exclusionary process in the community. We next analyse enrolment in RSBY in Maharashtra in chapter eight using a mixed methods approach to estimate enrolment rates and to determine whether social exclusion is correlated with enrolment of households. In chapter nine, we explore utilisation of health care within the context of NHIS in Ghana. Using regression models, we explore the impact of socio-economic factors on the utilisation of public and private outpatient healthcare services in Ghana.
In part IV of this book, we explore the social exclusion of specific vulnerable groups from the health-financing schemes being studied. In chapter ten, we present comparative evidence from Ghana and Senegal to test the hypothesis that socially-excluded older people are less likely to enrol in NHIS and Plan Sesame. In chapter eleven, we assess whether Ghanaian women are excluded from participating in the NHIS, analyse the types of women that are excluded and explore the processes by which this exclusion occurs. In chapter twelve, we attempt to establish the generative mechanisms that explain exclusion of indigenous people from social health protection in rural Karnataka.

In part V, the final section of our book, we bring together the results presented in parts II, III and IV to draw conclusions on social exclusion in health. In chapter thirteen, we explore the “mechanisms” shaping social exclusion in health and assess their “confrontation” with the existing body of knowledge on this issue. Finally, in chapter fourteen, we draw the book to a close by presenting the overall conclusions from the Health Inc project suggesting policy recommendations and the way forward for combating social exclusion and enhancing social inclusion in low- and middle-income countries.

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