

COMMUNITY BASED HEALTH INSURANCE: HOW CAN IT CONTRIBUTE TO PROGRESS TOWARDS UHC?



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Organization

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Key Messages

- Much hope has been put into Community Based Health Insurance (CBHI), with both donors and governments promoting their establishment. However, the impact of CBHI on financial protection and access to needed health care are moderate.
- Both theory and evidence suggest that a CBHI model, relying only on voluntary, small-scale schemes, can play only a very limited role in helping countries move towards UHC. In most countries, enrolment in such CBHI schemes has been very low and the poorest remain excluded. Voluntary CBHI suffers from adverse selection: people who do not have specific or frequent health needs tend not to join on a voluntary basis. There is usually little or no subsidization for poor and other vulnerable groups.
- For countries with established CBHI schemes, a desirable option is to integrate and merge existing schemes into a single national pool (possibly with decentralised arms) or closely interconnected pools that can provide similar benefit packages and act as strategic purchasers of health services, while maintaining local accountability. As such, CBHI can have a positive impact on institution-building and governance as part of a journey towards UHC.

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1 WHAT IS A COMMUNITY-BASED HEALTH INSURANCE (CBHI)?

CBHI schemes (*mutuelles de santé* in French), as they spread in the 1990s, have generally been characterized by the following institutional design features:

- The community is involved in driving its setup and in its management;
- It is a prepayment mechanism with pooling of health risks and of funds taking place at the level of the community or a group of people, who share common characteristics (e.g., geographical or occupational);
- Membership premiums are most often a flat rate (community-rating) and are independent of individual health risks;
- Entitlement to benefits is linked to making a contribution in most cases;
- Affiliation is voluntary;
- The CBHIs operate on a non-profit basis.

Given CBHI's participatory decision-making and management structures, they might be more transparent and accountable and enhance community empowerment as well

as voice. Another argument in their favour is that they can help build trust and encourage familiarity with the concept of insurance (WHO 2010).

In many countries, informally-employed people are excluded from payroll based health insurance schemes due to the informal nature of their occupation. They tend to incur high out-of-pocket expenditure when seeking healthcare in both the public and private sector. Over the past 25 years, CBHIs often came into place as an attempt to fill the gaps in access to services and to provide financial protection. Evidence from many countries shows that it is difficult to make substantial progress towards UHC through a CBHI approach because of several limitations discussed below. This brief assesses CBHIs from a health financing perspective solely, without denying many other positive effects, such as community development and local accountability of health care providers.

2 WHY IS IT IMPORTANT TO REFLECT ON THE ROLE OF CBHIS WITH RESPECT TO UHC?

Much hope has been put into CBHIs, with both several donors and governments promoting their establishment. However, the results and impact achieved through CBHI with respect to financial protection and access to needed care are often moderate for those enrolled. From a systems perspective, CBHIs are limited, as those who cannot afford to pay premiums do not get enrolled. The poor and other vulnerable population groups often remain excluded. The small size of CBHIs makes it challenging to achieve the intermediate UHC objective of equity in resource distribution given their fragmented nature. They are usually small, separate pools with little capacity for redistribution of risks. There is

usually no mechanism of risk equalization, through which differences in health risks could be balanced across multiple pools. The rationale of pooling at a level close to the community is contradictory to the principle of accumulating funds and sharing risks in a large pool.

In view of this, one may question the reliance of numerous countries on CBHIs as a core pillar for moving towards UHC, especially for people working in the informal sector, often the largest part of the population. What role CBHIs can and cannot play in contributing to progress towards UHC is a key policy question.

3 HOW DOES CBHI FIT WITHIN HEALTH FINANCING POLICY?

Most CBHIs are usually voluntary health insurance schemes. They provide a defined benefit package against the payment of premiums. The key characteristics of CBHI

and its effects on progress towards UHC are summarized according to health financing functions in the table below.

Table 1: Effects of CBHI on progress towards UHC	
	Key characteristics and effects of CBHI on progress towards UHC
Revenue collection	<ul style="list-style-type: none"> - Premiums are prepaid, which may reduce out of pocket for those who are enrolled; - Community rated premiums are often regressive, when independent of household income; - Overall revenues collected often remain limited in light of low premiums.
Pooling	<ul style="list-style-type: none"> - Voluntary prepayment creates adverse selection, i.e. people who do not have specific health needs tend not to join on a voluntary basis, thus resulting in an unbalanced risk pool; - Pools are small, fragmented and unlinked with each other with low redistributive capacity.
Purchasing	<ul style="list-style-type: none"> - There is a purchaser-provider split and CBHIs can negotiate with local providers; - Due to the small size of pools, CBHIs' purchasing power usually remains moderate.
Benefit Package	<ul style="list-style-type: none"> - Benefit packages can reflect local priorities; they often differ across pools. - With limited revenues collected, the range of services covered is restricted, often not enhancing financial protection, especially for high cost services.
Governance	<ul style="list-style-type: none"> - Community involvement in the management, such as participatory decision-making, can enhance accountability, transparency and community empowerment; - CBHIs can more easily provide effective voice mechanisms and build trust in prepayment and pooling.

Source: based on Soors et al. 2010

4 WHAT WE KNOW ABOUT CBHI FROM THEORY AND PRACTICE?

WHAT IS THE IMPACT OF CBHI ON POPULATION COVERAGE, UTILIZATION OF HEALTH SERVICES AND FINANCIAL PROTECTION?

Enrolment rates of the target population in CBHI schemes have remained very low in most countries (Vialle-Valentin 2008, Soors et al. 2010), largely due to the voluntary nature of enrolment. Evidence generally shows a positive impact on utilisation rates following the introduction of CBHI (Mebratie et al. 2013). The poorest of the poor tend to remain excluded as they cannot afford to pay premiums (Acharya 2012, Carrin 2005, Vialle-Valentin 2008).

When the membership premiums are kept at a low monetary level to allow wider enrolment of poor people, the financial capacity of the pool remains low. This means the level of financial protection and benefits offered are relatively small, which ultimately limits the attractiveness of the scheme. Overall evidence of CBHIs improving financial protection is rather mixed (Chuma et al. 2013).

HOW DID COUNTRIES TRANSFORM THEIR CBHI MODEL INTO A NATIONAL SCHEME?

Two countries – Ghana and Rwanda – built their health financing reforms around existing CBHIs, progressively integrating these into a comprehensive approach. Two critical innovations were to channel government tax revenues to expand the funding base, and to link the CBHIs into a national system to increase pooling and reduce fragmentation respectively. In Rwanda, participation has been made compulsory by law. Until 2012, premiums were fully subsidized for about a quarter of the population who was considered as poor and vulnerable, and partially subsidized for the rest.¹ The subsidies and legal changes were supported by political incentives given to local government authorities to enhance enrolment. Likewise, in Ghana, enrolment is in principle mandatory and specific population groups, including the poor, are subsidized. In both countries, the CBHIs became part of a national scheme with linked or integrated pools, creating a national pool even though there remains strong local management and governance. Other countries, such as Mali and Senegal are exploring a similar scaling up strategy and provide state budget transfers to subsidize CBHI members' premiums

1 This system was subsequently abolished in July 2015.

Conducive institutional design features in health financing to make progress towards UHC:

The following institutional design features can be considered critical for moving from small CBHI schemes towards a national health financing system for UHC:

- Mandatory enrolment of the population
- Government revenues to subsidise contributions to improve coverage of vulnerable and poor people
- Larger/more diverse pool (e.g., by increasing the number of enrolled people, pooling beyond local pools, or a single national pool, or through reinsurance)

HOW TO PROTECT SMALL SEPARATE POOLS FROM VOLATILE EXPENDITURE?

One problem with small pools is that they may risk going bankrupt as their expenditures can be volatile. One strategy to avoid this is to reduce fragmentation, i.e. link or integrate sub-pools by pooling parts of or all funds at higher levels, to ultimately move towards a national pool. This is what Ghana and Rwanda have done, as outlined above, and a path that more and more countries are choosing.

Another option is reinsurance. Reinsurance has been discussed as a way to offset the risk of small pools in that liability is transferred to another insurer. It is a mechanism “for enlarging the risk pool and spreading risks

across larger population groups, which no single micro-insurance scheme could do on its own” (Dror/Preker 2002). As such, a virtual larger pool is created. But reinsurance also suffers from market failures and the reinsurance premium may increase costs (Preker et al. 2008). Moreover, in practice, reinsurance has not played a big role for community-based health insurance in low-income countries. This is also because the profit related to the micro-insurance market has been considered as too small to be attractive for commercial reinsurers (Lagomarsino et al. 2008). Last but not least, reinsurance does not solve the other key challenge, namely the need for mandatory enrolment and for subsidization of those unable to contribute.

5 WHO'S PERSPECTIVE

Although CBHIs are one way to organize community initiatives, both theory and evidence suggest that a CBHI model, relying only on voluntary, small-scale schemes and small pools with little or no subsidization of poor and vulnerable groups, can play only a very limited role in helping countries move towards UHC. Theory and practice suggest that reinsurance via commercial companies has not been the solution either and seems less viable than choosing the path of creating multiple layers of pooling or national pooling. More potential is seen in financial protection arrangements based on large pools and mandatory or automatic participation funded from some form of taxation to subsidize those unable to pay. Indeed, some countries have transformed their earlier CBHI model and moved into that direction.

For countries with established 'traditional' CBHI schemes, the government could capitalize on the positive results of

improved local governance capacity and public acceptance of prepaid insurance contributions. Here, an option is to integrate or merge existing schemes into a single national pool with decentralised arms or closely interconnected pools beyond the community level, which can provide similar benefit packages and act – with national support – as strategic purchasers of health services, while maintaining local accountability. This could also promote quality gains and efficiency while guaranteeing higher levels of redistributive capacity and financial protection. Strong and good governance, including citizen participation and mechanisms for voice at the local level, e.g. through district and sub-district level governing bodies, is needed for national pooling arrangements to overcome the potential trade-off between increased redistributive capacity of a larger pool against the loss of control and participation by lower levels and the communities themselves.

REFERENCES

- Acharya, A., S. Vellakkal, F. Taylor, E. Masset, A. Satija, M. Burke, and S. Ebrahim, 2012. *The Impact of Health Insurance Schemes for the Informal Sector in Low- and Middle-Income Countries: A Systematic Review*. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
- Carrin, G., M.-P. Waelkens, and B. Criel, 2005. Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems, *Tropical Medicine and International Health*, Vol. 10 (8): 799-811.
- Chuma, J., Mulupi S., McIntyre D. Providing financial protection and funding health service benefits for the informal sector: Evidence from sub-Saharan Africa. RESYST Working Paper 2. Nairobi: KEMRI.
- Churchill C (ed.), 2006, *Protecting the poor. A microinsurance compendium*. Geneva: International Labour Organization.
- Dror, D., Preker, A. (ed): *Social Reinsurance: A New Approach to Sustainable Community Health Financing*. Washington: World Bank and Geneva: ILO.
- Lagomarsino G. and S. Kundra, 2008. *Overcoming the Challenges of Scaling Voluntary Risk Pools in Low-Income Settings*. Technical partner paper 6. Results for Development Institute: Washington DC.
- Mebratie, A. D., R. Sparrow, G. Alemu, and A.S. Bedi, 2013. *Community-Based Health Insurance Schemes: A Systematic Review*, Fourth Amhara Regional Conference. Proceedings. Addis Ababa: Ethiopian Economic Association.
- Preker A., R. Scheffler, and M. Bassett, 2007. *Private Voluntary Health Insurance in Development: Friend or Foe?* World Bank: Washington DC.
- Soors, W., N. Devadasan, V. Durairaj, and B. Criel, 2010. *Community Health Insurance and Universal Coverage: Multiple paths, many rivers to cross*, World Health Report 2010 Background Paper 48, Geneva: World Health Organization.
- Spaan, E., J. Mathijssen, N. Tromp, F. McBain, A. Have, and R. Baltussen, 2012. The impact of health insurance in Africa and Asia: a systematic review, *Bulletin World Health Organization*, Vol. 90 (9): 685-692.
- Vialle-Valentin, C., D. Ross-Degnan, J. Ntaganira, and A. Wagner, 2008. Medicines coverage and community-based health insurance in low-income countries, *Health Research Policy and Systems*, Vol. 6(11).
- WHO, 2010. *The World Health Report – Health Systems Financing: the path to universal coverage*, Geneva: WHO.



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