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Community Based Health Insurance Schemes (CBHIs) in Health Care Financing: Review of Experiences of the Asian and African Economies

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Abstract - **The WHO World Health Assembly and the World Health Report (2010) have called for all health systems to move towards universal health coverage. This is a challenge for the resource-scarce low and middle income countries. Health related expenses remain the most important reason for households being pushed below poverty line (Xu *et al;* 2003, 2007). One alternative to covering poor people in the informal sector is to involve them into Community Based Health Insurance Schemes (CBHIs). Scholars and practitioners have expended substantial effort on investigating the effectiveness and sustainability of CBHIs, the challenges faced by them, the solutions for improvement and the potential role of the CBHI in a national financing strategy to achieve universal coverage in low income countries. The present paper first describes the development of CBHIs through an evolutionary perspective and then highlights the significant factors essential to integrate the CBHI into the national financing strategy (Bennett, 2004;Wang and Pielemeier, 2012). Using this framework, the second section undertakes a review of CBHIs in selected countries in Asia and Africa to identify key contributing and/or challenging factors faced by CBHIs in each stage. The study provides recommendations on how to adopt characteristics to transform fragmented CBHI initiatives towards achieving universal coverage.**
Key words - **CBHIs, community health insurance, health care in Asia and Africa, health insurance, community financing**

I. INTRODUCTION

The World Health Assembly held in Geneva in 2005 and the World Health Report, 2010 both had emphasised that all countries should expedite the movement towards 'Universal Health Coverage'. The tax-based financing system and the Social Health Insurance schemes (SHIs) had proved inadequate in developing countries due to the low income levels, improper identification of the target population and a huge informal sector. In the recent past, roughly 10% of the population of these countries in general had some form of health protection against sudden onslaught of a health crisis. There was a high impoverishment due to health related catastrophic expenditure (Xu *et al,* 2003). The Community based Health Insurance schemes (CBHIs) could be a source of providing health protection to the poor.

CBHI is a financial instrument in the form of a micro insurance scheme that enables the poor households to manage their health related financial risks and save them from sudden crisis. It is based on voluntary membership, non-profit objective, predominant community leadership and management and the ethics of mutual solidarity. In most developing countries absence of ready cash prevents a timely treatment. Most health related expenditures are also out-of-the-pocket and are the major cause of impoverishment. Health Insurance can reduce the barriers to poor people to receive affordable treatment. In countries with large formal sectors, insurance contributions can be easily collected through payroll deductions or taxation. In many developing countries, large proportions of the population work in the informal sector, limiting the ability to generate financial resources through payroll deductions or taxes.

Community-based health insurance (CBHI) collects resources from individuals who voluntarily enrol and are often employed in the informal sector. CBHI thus offers an alternative for health insurance in settings where taxes are paid on only a small portion of national income. In CBHIs, members of a community who are often linked by geographical proximity or through employment-based relationships such as local trade unions, pool resources to share the financial risk of ill health. Through enrolment in CBHI, a disassociation of payment from the time of health care use is generated, facilitating the development of a financial buffer between service fees and seasonal fluctuations in income in communities. There are various types of CBHI financing, including private hospital-sponsored insurance (covering their own hospital-based services, such as the Community Financing Scheme in Nkoranza, Ghana), NGO-sponsored insurance to cover services delivered by their own clinics [Bangladesh Rehabilitation Assistance Committee (BRAC) in Bangladesh], [Action for community organization, rehabilitation and development (ACCORD)] in India or by private providers [Development of Humane Action (DHAN) Foundation and KadamalaiKalanjiaVattaraSangam (KKVS), both in India], cooperative sponsored as in [Self Employed Women's Association, SEWA in Gujarat], India and through community funds, where members prepay for services provided by government [AssuranceMaladie a Base Communitaire (AMBC) in Burkina Faso and Blaville in Mali]. CBHI schemes in low-income countries are often beneficiaries of donor support, such as in the case of micro-health insurance schemes in Rwanda and Community Health Funds in Afghanistan (Devadasan, 2006).

A. Evolution of the Structure of the CBHIs

There was been a gradual evolution of CBHI schemes around the globe. With a change in time and need different extensions were added to the original way of functioning of the CBHIs. The Basic Model shows households enrolled in the scheme pay premiums into the CBHI fund. In turn the scheme pays healthcare providers for their services and in return, these providers offer healthcare services to scheme members. The first extension (Extension 1) to the model came when non-members were allowed to avail the services of the providers of the scheme by paying user fees to the providers. This implied that the providers then had a greater chance of recovering costs not only by insurance payments but also by the user fees paid by the non-members. After this the government entered the scene of the CBHI in a very significant way. In most developing countries public facilities received some sort of government subsidies and in many sub-Saharan countries many private producers also received subsidy from the government to maintain the viability of the CBHI schemes (Extension 2). The third extension to the model is Extension 3. In this model the government made a matching contribution to the premiums paid by the households to the CBHI scheme. Sometimes CBHI funds also get enhanced through external donor support. Since this was mostly a one-time grant, it is not shown in the diagram. The fourth and final extension to the basic model (Extension 4)illustrates the situation where there are multiple risk pooling schemes present in the same country. In the diagram multiple risk pools are shown by multiple CBHI schemes but in reality it may include Social health insurance schemes (SHIs) by the employers or/and government financed schemes.

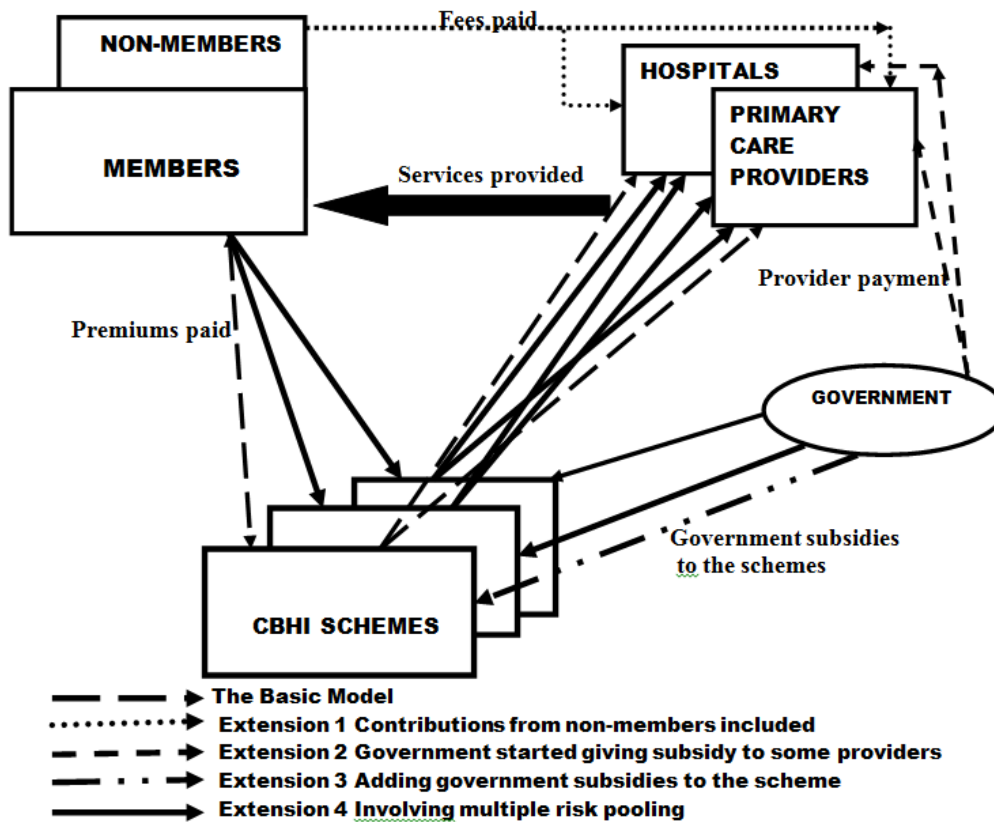

Fig. 1 Functioning networks of a CBHI

The Basic Model Extension 1 Contributions from non-members included Extension 2 Government started giving subsidy to some providers Extension 3 Adding government subsidies to the scheme Extension 4 Involving multiple risk pooling

B. Significant factors in the functioning of a CBHI scheme

At present there is a very serious attempt made by the different countries of the world to reach out to the goal of "Universal Health Coverage". For this it is necessary to integrate the CBHIs into the national health financing strategy. The comprehensive factors significant in the proper sustainability of a CBHI scheme in order to make it functional at the nation-wide level are shown in Table I.

TABLE I KEY CHARACTERISTICS OF A NATIONWIDE MODEL OF CBHI

	Political commitment, Legislation, Strong community supports		
Health Financing Methods	Revenue collection	Participation	Target population at national level
		Source of Revenue	Government financial subsidy
	Risk pooling	Risk pooling	Cross subsidy with risk equalisation
		Fund Management	Professional management with the strength of community participation
	Service Purchasing	Service coverage	Standardised comprehensive benefit package
		Purchase mechanism	Capitation, case based payment, global budget or/and performance based payment

Source: Adapted from Wang, H. and Pielemeier, N. (2012)

In order to make the CBHIs function fruitfully as a micro-insurance programme the entire system of health insurance financing of a country should be integrated. Government and political commitment, leadership, legislation and funding support, regional level professional management and continuing community level mobilisation and support is a summary of the key characteristics necessary for a vibrant CBHI system. The risk pool should be increased to create a target population at the national level. However there can be cross-subsidisation between high and low risk groups across regions. It will be very necessary to supplement the CBHI scheme budget with government funding as very few CBHI do really have enough funds to fully finance their own care. Government finances are important to increase participation and coverage of the people. In this nation-wide model there is a need for the CBHIs to initiate professional management into the system to reduce costs and manage finances well. There should also be strategic purchasing of benefit packages to maximise client benefits. On the side of the government regular monitoring and evaluation will keep the efficiency level optimum. For long term sustainability the CBHI schemes should be integrated with other existing insurance schemes that are tax-basedand/or employer-based. The community continues to play a very significant role in linking the prospective member into a "group" using its social capital that is the extent to which the group is prepared to share value and pool resources.

The lack of ability of the people to pay full insurance premium is considered the rational for providing external funding or subsidies on behalf of the state. Ahuja and Jutting (2003) hints at the various forms that subsidies can take without distorting incentives. Probably the best form of giving subsidy is in meeting start-up costs that are essentially of fixed-cost nature, and therefore, distort the incentives the least. By the same reasoning, subsidy can also be given for meeting certain recurring administrative expenses such as salaries of personnel, maintaining accounts, medical vehicle as well as equipment and so on. Furthermore, given the low capital base of the schemes, subsidy can also take the form of making funds available at low interest costs to cover the premium shortfall. The government can help to strengthen the support of health services. At institutional level, too government has a role in providing legal status to the scheme. Currently, most CBHI schemes have little or no legal standing, which tends to create some uncertainty in the minds of the public about the continuity of schemes. Providing legal status may inspire confidence among the local public, resulting in higher membership. Government can improve the risk management strategies of the poor through improved functioning of the labour, credit and product markets. Similarly, health security needs to be integrated with other government programs aimed at building income and health security for the poor. Across the world, the implementation of the CBHIs has been mixed. In Africa and Asia, there are some countries which have tried to successfully follow the nation-wide model in their countries.

C. CBHIs in Africa and Asia

In developing economies like the continents of Africa and Asia, the linkage with government is very beneficial for the sustainability of the CBHIs, for example in Tanzania (Community Health Fund) and in Thailand (Health Card Scheme). There are also various forms of risk pooling mechanisms in these countries though in very rudimentary levels. In Tanzania, the Community Health Fund covers rural communities and the mandatory insurance schemes in the workplaces covers urban-based workers and the civil servants. In many Sub-Saharan countries like Ghana (Nkoranza) receive some form of government subsidy. In many Sub-Saharan countries again non-members can access the health care system of a CBHI by paying user-fees. This pools in risk and helps in cost sharing (WHO, 2014). Again in countries like Ghana, Kenya, Malawi, Tanzania and Zambia, the governments provide subsidies to private non-profit healthcare providers supplying services to the CBHI beneficiaries (van Ginneken, 1999).

In Ghana (Nkoranza), the St. Teresa's hospital, the main service provider receives subsidies in the form of staff salaries from the government (USAID, 2013). Sometimes the government also contributes directly to the CBHI fund. For example in Thailand, the government submits a matching amount in the premium paid by households to the Community Health Fund of the scheme. This decision by the Thailand government protects the equity aspect of any health financing system. This is because the government subsidises the social health insurance schemes targeted at the formal sector workers and thus it is very reasonable to contribute to the health insurance premiums of a lesser

affluent group who were members of a CBHI (Health Card Scheme). Such matching premium contributions are also given by the Tanzanian government. This also made the premiums affordable to the poor households who otherwise would have opted out of the scheme. Thus this also preserved enrolment and hence the viability of the scheme. Sometimes many CBHIs also receive many donor subsidies as they are community based micro interventions typically attracting the national and foreign donors. Mostly they receive a one-time grant(unlike government subsidies) for technical assistance and/or operating costs.

A very significant feature for any successful CBHI is the extent of multiple risk-pooling schemes within a CBHI or between CBHIs and SHIs and/or government schemes. In Tanzania this exists (McCord and Osinde, 2003). The Community Health Fund operates parallel with the Social Health Insurance schemes and with different community health funds in different districts. But very little empirical evidence is there to understand the benefits in such a system. The fact that the insurance agents can resort to cost shifting and reclassification of patients is a significant benefit in multiple risk pooling mechanisms. In Thailand for example, there are different insurance schemes providing different benefits and modes of payment and thus there is an incentive to the healthcare providers to weigh one insurance scheme against another to get the maximum revenue. Sometimes one patient may be covered in more than one scheme.The healthcare providers can then reclassify the patients according to the various health packages and get an incentive in terms of increased profits.In Tanzania problems are scarce because there are distinct geographically segmented markets of risk pools with the various district level Community Health Funds (van den Heever, 1997)).

Flexibility in the designing of the package of services is also another very essential characteristic feature of a good CBHI. In less developed countries there is already a significant area of basic health services already covered by the government and the demand for any CBHI programme will be greatly influenced by the planning and health coverage by the government. The CBHI schemes need to adjust to the changing policies of the government. For example in Ghana, the government has recently decided to devolve the teaching hospitals and grant them more independence in terms of deciding their pricing policies. This has the impending possibility of increased prices and reduced coverage of the poorer sections of the population (Ahuja and Jutting, 2003). The CBHIs then can try to make their package more attractive to the group of people left out from government services.

Community based Health Insurance schemes are in operation in India for quite some time. However it suffers from taking the advantage of a positive inter-linkage with the broader healthcare system (Bennett, 2004; ILO, 2005; Purohit, 2014). There has been no attempt to devise a link between the CBHI scheme and the broader government financing system. Thus enrolment remains arbitrary and incidental. However there are challenges to this system too to integrate it to a national level. Firstly, administrative costs in the scheme level may be achieved easily but managing such costs in the national level is difficult. Moreover regarding the sustainability of the CBHI, at the scheme level it may achieve an apparent sustainability by restricting severe or chronic patients from joining it and hence including them in the government financing system affecting overall sustainability of the health financing system of the country. From another angle sustainability at the scheme level may also affect equity concerns. Exclusion, high premium and restrictions on the benefit package may have severe consequences on the poorest people. Having a multiple risk pool may be problematic in India due to a weak government capacity. There is also limited understanding on the management of such funds by the insurance personnel of the less developed countries. The demand for CBHIs in any country will be based on the local income levels and the supply environment. In areas which are relatively urban the demand will be for additional insurance services outside the standard packages. While in areas that are predominantly rural and poor the demand will be more for the standard services which are obtained in the government hospitals on the payment of a user fee. The case of SEWA in India is interesting as its insurance package offers a wide range of basic services which come with almost nil co-payment in the government hospitals (Carrin *et al,* 2005). However the beneficiaries prefer to get the same service from the private health care providers by being in the insurance package because of a better quality of service received in the private hospitals and nursing homes.If countries are willing to use CBHI to accelerate achievement of universal coverage, then it is important to plan for a process that will harmonize the contributions and benefits over time. Notice must be kept on the poorer sections of the population so as to have an equitable arrangement for the whole population.

II. SUGGESTIONS AND RECOMMENDATIONS

It is indeed true that the concept of arriving at universal health insurance coverage through the facilitation of small community based micro-insurance efforts is still at its dormancy. However it is also true that the concept is slowly making inroads into academic dialogue and analysis of successful case studies in different countries. To make a CBHI successful there is a very important need to focus on its management. A holistic approach at involving different stakeholders and a continuous feedback from experts can help the concept flourish in the future. Following are some important areas of intervention in CBHIs.

A. Importance of Networking and Advocacy

The concept CBHIs is still in the necessity of national dialogue to widen its coverage. There is also the need for developing appropriate methodologies in health financing, collection of revenues, risk pooling and purchasing of services, designing benefit packages and engage in fund

management activities. Continuing dialogue with the national and international development thinkers can encourage flow of information about the different approaches followed in different countries and devise an effective methodology. A strong networking with the academic and government institutions can produce relevant evidence on feasibility, costs and benefits of social protection systems.

B. Monitoring and Evaluation

Any group activity that involves a revolving fund needs constant monitoring and evaluation. The same is the case with Community based health insurance systems. Whereas monitoring can be an initiative specific to a country, evaluation can have broad international parameters. Benchmarks for specific targets like reduction in out-of-pocket expenditures and increase in healthcare expenditures can be specified to make the processes uniform.

C. Development of Capacities and Skills

A CBHI is a result of s continuous dialogue and development of knowledge. Sharing of experiences followed by adapting of the strong points of some of the success stories can be very easily done with the help of a trained team of dedicated workers. This requires skill development of people from the community who show the potential to lead. At another level, the analysis of socio-economic consequences and examination of linkages has to emanate from the resources within the community to make them successful and sustainable.

D. Importance of Trained Facilitators

The nightmare of a failed cooperative movement still haunts us. A community based health insurance scheme is built much across the same ideology. It is an organised endeavour to involve specific communities to participate in the keeping of their own good health. It is a simple core ideology that the poor must be protected, particularly those who are unable to withstand the sudden onus of lump sum payments for medical expenditure. Resource personnel who are trained in field practices and welfare ideologies are significant in promoting and protecting the safe working of such community organisations. The trained social workers appropriately fit in such positions. The community based health insurance organisations provide a fertile ground for the exercise of an interdisciplinary endeavour of social planning, social leadership, social mobilisation of capital, medicine, management and of course social work.

A social worker has the potential to hold a central role in the community based health insurance organisations. The worker can serve as an important link with the community to communicate effectively as regards the requirements, problems and suggestions from the community to the CBHI. They can contribute to the planning, designing, deciding parameters and documenting for the CBHI directly. They can also support the functioning of the health insurance schemes in collecting the premiums, doing a need-based analysis of the exact requirements of the community, preventing adverse selection and moral hazards.

The more the members the better will be the capital base. Thus, the worker can with his casework, group work and community organisation skills increase the array of members. The state as a stakeholder can do its bit by legalising the CBHIs, which will automatically bring in a sense of security in the minds of the members. The worker can actively advocate for such a necessary step as well as for providing incentives to the non members as well as the members to collectively make the scheme a success by joining in it and remaining as active members in it. Community health insurance schemes can be initiated by linking up with existing NGOs, cooperatives, hospitals, self-help groups etc. It may also be judiciously tied up with government schemes like the Rashtriya Swasthya Bima Yojana (RSBY) as a first step towards universal health care.

III. CONCLUSION

In conclusion it can be said that a better inclusion of the poor is perhaps possible with a wider network that is with a more heterogeneous population. This has to be carefully balanced to suit the convenience of administration of a larger group by the members. Inclusion of the poorest of the poor is another challenge that these organisations have to improve upon. The family was mostly seen as the unit of enrolment to lower adverse selection. Most of the CBHIs have been successful when they have connected with some of the existing organisations like self-help groups, trade unions, cooperatives, NGOs and of course hospitals. Depending on such existing resources, the design of the model is worked out. The community is the best advisor in terms of suitability of the premiums, their collection and evasion of moral hazard. Whereas the linked model turns out to be rigid, it has the least exclusions. Linkage with a hospital is vital and for this, many NGOs become providers of medical care themselves or link up with a private or non-profit organisation. In terms of collection, administration and verification, community control of fraud is very effective. Regular feedbacks from the community increase the acceptability of the scheme. The efficiency of a scheme is enhanced with a better negotiation skill of the members of the community with the providers. An effective management information system that is suitable for the communities is necessary to keep a personal account of the transactions so that the negotiations with the providers can be done judiciously.

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