



Community-Based Health Insurance and Social Protection

Health risks pose a grave threat to lives and livelihoods, especially those of the poor. Health shocks add additional expenditures to the burden of the poor precisely when they can least afford it. Even minor health shocks can have a major impact on a poor person's ability to work, and hence on their earning capacity. In some countries, public health care systems provide minimal services and few governments are able to meet all healthcare needs. Oftentimes, "free" health care delivery systems don't work, and in practice, are never free, as they involve transaction costs, such as transport from the home to service providers, require side-payments, and entail long waiting times.

Recently, health insurance has emerged as part of the drive to reform the way that health care is financed in many countries. Health insurance can improve the financing of health care by generating more money for health care and providing greater value for health spending. Further, it can reduce the need for precautionary savings or coping mechanisms that ultimately exacerbate poverty. One type of health insurance is programs managed and operated by a community-based organization: Community-Based Health Insurance (CBHI).

CBHIs tend to be pro-poor because they strengthen the demand for health care in poor rural areas, and enable low-income communities to articulate their own health-care needs. Prepayment and risk sharing through community involvement in health care financing—no matter how small—increases access by poor populations to basic health services and protects them to a limited extent against the impoverishing effects of illness. Where CBHIs have been successfully introduced, they have reduced the amount that the poor pay in out-of-pocket payments when they seek care and they have contributed to more

frequent utilization of health services. Members of CBHIs are less likely to need to borrow or to sell assets to cover health costs and they are also less vulnerable to social pressure to contribute to the health financing requirements of others.

CBHIs are well-established in Central and West Africa, Bangladesh, China and Argentina; however, most CBHIs in developing countries are small with membership generally confined to the better-off rural population.

CBHI Characteristics

CBHIs help cover the costs of health care services through risk-pooling and beneficiaries are involved in the management of community-based schemes, at least in the choice of the health services covered. Voluntary in nature and formed on the basis of an ethic of mutual aid, they provide a variety of benefit packages. They may be organized around geographic entities, professional bodies or health care facilities.

CBHIs are designed to be simple (flat premiums, one-size benefit packages), and easy-to-use. Written contracts, if used, are brief, forms are kept short, and record keeping is generally manual. The benefit package for a CBHI depends on what the beneficiaries want, and the size of the benefit packaged is capped by the resources that they can commit. Without the need to receive approvals from outside regulators or supervisors, benefit packages can be changed rapidly. Where management is conducted on a voluntary basis, administrative expenses represent a small portion of the premiums.

Though their benefits are many, CBHIs face risks of moral hazard (people may act differently if they are insured), ad-

verse selection (people with a high likelihood of making claims are more likely to join, thus driving up premiums and discouraging low risk individuals from joining as a result), fraud, and cost-escalation. Table 1 illustrates how these problems can be addressed.

Challenges to Building Effective CBHIs

CBHIs face a number of challenges. Annual member contributions to CBHIs are generally less than \$1,000 which limits their ability to cover major health risks. The average share of health costs covered by a CBHI is 25%, and few cover more than 50%. Many CBHIs depend on continuing access to some form of external subsidy, and almost all

depend on public sources of health care financing. Many suffer from weak management capacity, which can result in a failure to adequately manage insurance risks, unrealistic premiums, the absence of a community business culture, low controls for fraud, and limited coverage (and hence high risk of adverse selection). Because they are financed by users, CBHIs tend to exclude the ultra-poor.

Since they are community-based, they are unable to exploit network economies, have small risk pools, and are unable to provide the more comprehensive benefits associated with formal-sector health insurance.

Table 1: CBHI Approach to Managing Risks Inherent to Insurance Schemes

| Insurance Risk | CBHI Management Strategies |
|-------------------|--|
| Moral Hazard | Peer-monitoring, use of pre-selected providers, claims limits, co-payments, exclusions, capitation payments, payments per service provided or case treated, and proof of health service events. |
| Adverse Selection | Requiring a minimum pool size, whole family membership, use of pre-existing groups, waiting periods before benefits come into effect, use of community suasion to encourage solidarity amongst those of high and low health risks to join. |
| Fraud | Encouraging a high level of community participation and oversight, specification of suitable management policies and procedures, proper record keeping and accounting, regular member review of CBHI accounts, requiring members to be physically identified before receiving service, verifying all expenses, setting coverage limits, and canceling services when fraud is detected. |
| Cost-Escalation | Use of co-payments, deductibles, and ceilings on benefit cover to discourage frivolous claims. Use of capitation payments with providers, pre-set drug lists and schedules of pre-determined approved treatments, negotiated discounts, operating own-clinics, and posting CBHI staff at hospitals to verify and approve treatments on-site. |

Further, experience suggests that it is not easy to scale-up one successful CBHI experience to another. The very contextual factors that determine a CBHI's success—social capital, local leadership and volunteerism—may be difficult to replicate.

How Governments and Development Agencies can support the Growth of CBHIs

CBHIs should be regarded as a complement to, not as a substitute for, strong government involvement in health care financing and risk management related to the cost of illness. Governments and development agencies can

support CBHIs by:

- Ensuring a satisfactory supply of appropriate health services
- Subsidizing start-up costs and premiums paid by the poor
- Assisting in building technical and managerial competence
- Helping foster the development of CBHI networks
- Facilitating links with formal financial institutions and health care providers

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