Institutionalizing Community Health Conference

27-30 March 2017 | Johannesburg, South Africa

#HealthForAll

ichc2017.org

USAID
FROM THE AMERICAN PEOPLE

Health Finance & Governance
Expanding Access. Improving Health.

Overview of Community Based Health Insurance Lessons

Presented at the Institutionalizing Community Health Conference

Hailu Zelelew, MA
Abt Associates

March 28, 2017
Johannesburg, South Africa

Abt Associates Inc.
In collaboration with:
Broad Branch Associates | Development Alternatives Inc. (DAI) | Futures Institute | Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D) | RTI International | Training Resources Group, Inc. (TRG)

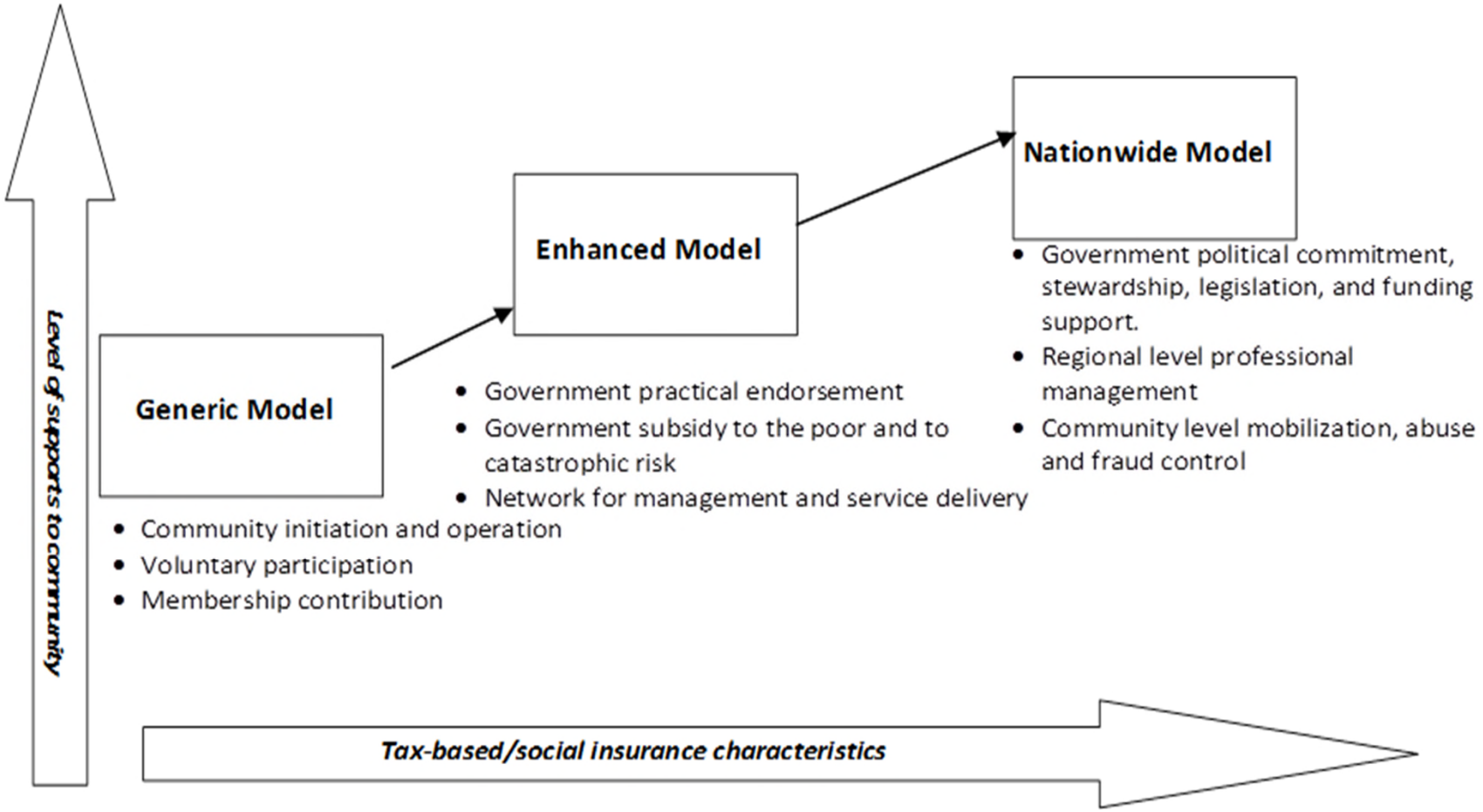
Presentation Outline

- CBHI: Background and definition
- Three-step CBHI evolution process
- Country experiences and lessons (Rwanda, Ghana and Senegal)
- Summary: Strengths and weaknesses of CBHI schemes
- Overall lessons

CBHI: Background and definition

- CBHI emerged as a response to market and government shortfalls
- CBHI schemes are diverse in nature, size, capacity and focus
- Important features: community-based membership, participation in decision-making and management, and membership contributions
- Broadly, CBHI aims to provide members with the financial risk protection from healthcare costs
- **Definition:** any scheme managed and operated by an organization, other than a government or private for profit company, that provides risk pooling to cover all or part of the costs of health care services.

Three-step CBHI evolution process



Adapted from Hong Wang and Nancy Pielemeier (2012)

Evolution of CBHI

- Earlier small scale insurance initiatives in Germany, Japan, the UK and elsewhere had CBHI characteristics
- CBHI initiated in West and Central Africa
  - Senegal, Benin, Burkina Faso, Cameroon, DRC, Mali and Togo, and later spread to Eastern Africa.
  - About 900 CBHI schemes in Sub-Saharan Africa in 2009
- The evolution of health insurance in Europe and elsewhere may not be feasible in African settings

Country experience: Rwanda

Background (Pre-CBHI):

- 1960s: Free health services
- 1970: User fees introduced
- 1994 (Following the genocide: Free health care and then user fees re-introduced after 2 years)
  - Rising poverty (60% poverty rate)
  - Poor health outcome indicators
  - A sharp drop in demand for health care (From a visit of 1 out of 3 in 1997 to 1 out of 4 in 1999)
- 1999-2000:
  - Piloted CBHI in 3 of 40 health districts
    - 54 schemes in the catchment of 54 health centers (and 3 referral hospitals)
  - Quasi-experimental design to assess coverage, equity, health service utilization, community participation

Rwanda (cont.)

CBHI Scale-up

- Based on the pilot: CBHI introduced by some local governments
- A development policy document produced in 2004 (basic tool for implementation of CBHI).
- 2005: CBHI officially launched
- Rwanda passed the mutual health insurance law in 2007 (provides legal framework and for standardization and regulation)

Year	Coverage (in %)
2003	7%
2004	27%
	44%
2006	73%
2007	75
2008	85%
2009	86%

Source: MOH (2010): Rwanda Community Based Health Insurance Policy

Country experiences: Ghana

- **Pre-2003:**
  - Free health care after independence
  - 1980s introduction of user fees ("cash and carry")
  - User fees became catastrophic and very unpopular
  - Facility-based and NGOs/donor-financed CBHI schemes
    - 2002: 140 schemes
    - Covered only 1-2% of the total population
    - Government participated in some CBHI experimentation
  - Nkoranza Scheme at St. Theresa's Hospital was the first, in 2000: 30% of district population covered
  - The opposition party, New Patriotic Party (NPP) campaigned on abolition of user fee and won the election in 2000
  - 2000-2003:
    - The new government started working on its promise
    - Technical, policy and legislative processes undertaken

Ghana (cont.)

Post-2003

- NHIS bill outlining broad framework, authorizing payroll deductions and VAT to fund insurance
- "Big-bang" approach (merging the formal and informal sectors)
- CBHI models and experiences used for operationalization of national insurance

Progress to-date:

- One-third of Ghanaians covered in NHIS
- CBHI schemes established in 110 districts, with their own boards, but boards disbanded in 2008
- Revenue:
  - Premium from members + contribution from pension funds
  - VAT (2.5% from sales of most goods and services, 75% of total revenue)
  - Informal sector only 5% of total revenue

Challenges:

- Initiative was driven by politics, limited room for learning or expert opinion
- Coverage is still very low
- Financial sustainability has become a challenge

Country experience: Senegal

- CBHI schemes started in 1980
- Schemes were small and fragmented
- In 2014, covered only 4%
- Health insurance became major political issue in the 2012 election
- President Macky Sall committed to scale-up CBHI in three phases

Demonstration Phase (2012-14):

- To determine benefit packages, provider payment system and local and national subsidies)
- Covered 14 Administrative Departments, one department per region

Senegal (cont.)

Expansion Phase (2015-2017)

- Geographic coverage: 1 scheme per county; 1 network by department
- Subsidy for the poor and vulnerable

Consolidation Phase (2018-2022)

- Focus on increasing coverage with a target of 90%

Progress

- Starting in 2012, CBHI piloted in 3 departments
- In 2014, expanded to 11 additional departments
- 2013 and 2014, networks of CBHI launched in 4 departments
- September 2013, Senegal launched Universal Health Coverage (UHC) and CBHI prioritized as vehicle towards UHC

Summary 1: Strengths of CBHI schemes

- Revenue collection:
  - Shift from point of service/out-of-pocket payment
  - Flexibility to set contributions and collection time
  - Revenue generation from informal sector
- Risk pooling:
  - Pooling resources from members, high outreach penetration
  - Transfer from the rich to the poor, healthy to sick
- Benefit packages and purchasing:
  - Collective decision about who is covered
  - Define packages and balance with revenue
  - Collective bargaining with providers (price, quality of care)
  - Developing negotiation and relation management through time
- Management:
  - Capacity and access to reach the community
  - Social influence on behavior of members and providers
  - External support for capacity building
  - Community participation in decision making process

Summary 2: Weaknesses

- Revenue collection:
  - If community is poor, limited resources
  - Not always accessible for the poorest
- Risk pooling:
  - Usually similar small groups joining schemes
  - Limited transfer, from rich to poor or from healthy to sick
  - Financial difficulties, partly due to absence of re-insurance
- Purchasing
  - Limited or restricted benefit packages
  - Providers may have monopoly and bargaining power
- Management:
  - High administration and operation cost
  - Poor or limited management capacity
  - Potential mismanagement of funds
- Earlier CBHI schemes were community initiated:
  - Limited support from government, NGOs, providers and donors
  - In many cases absence of legal and regulatory frameworks

Lessons from country experiences

- CBHI is a potential pathway to UHC
- CBHI requires strong government support
- Schemes need to be designed as part of the broader health financing system
- Country context matters
- CBHI coverage is a process:
  - requires time, resources
- Technical capacity and resources are critical

USAID
FROM THE AMERICAN PEOPLE

Health Finance & Governance
Expanding Access. Improving Health.

Thank you

www.hfgproject.org

Abt Associates Inc.
In collaboration with:
Broad Branch Associates | Development Alternatives Inc. (DAI) | Futures Institute | Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D) | RTI International | Training Resources Group, Inc. (TRG)





Institutionalizing Community Health Conference

27-30 March 2017 | Johannesburg, South Africa


#HealthForAll

ichc2017.org