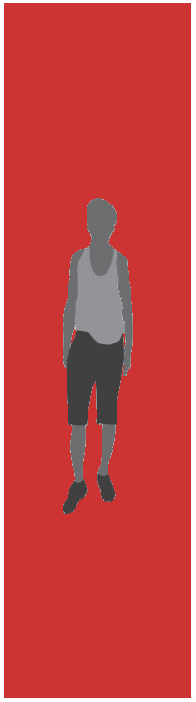

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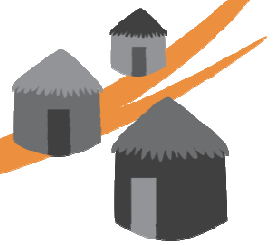

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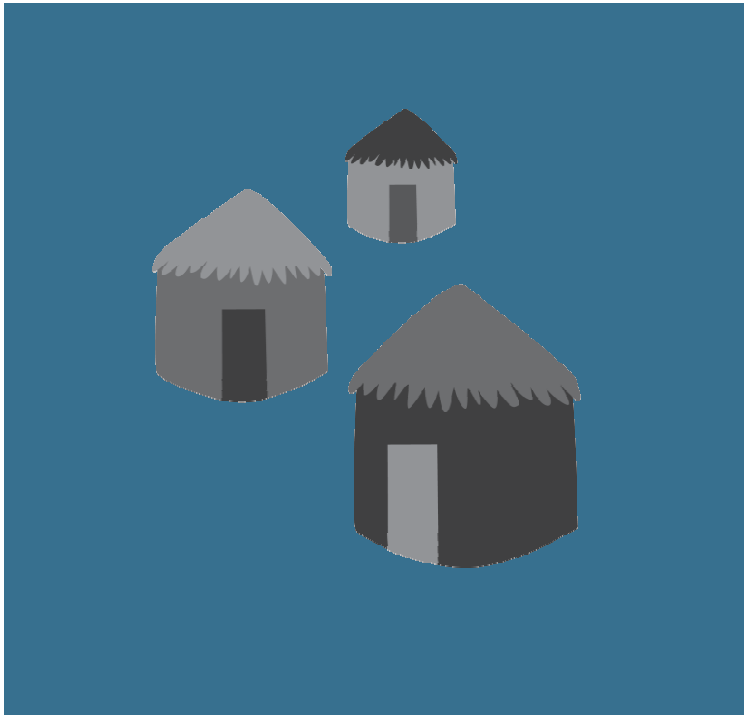

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Overview of Community Based Health Insurance Lessons

Presented at the Institutionalizing Community Health Conference

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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)

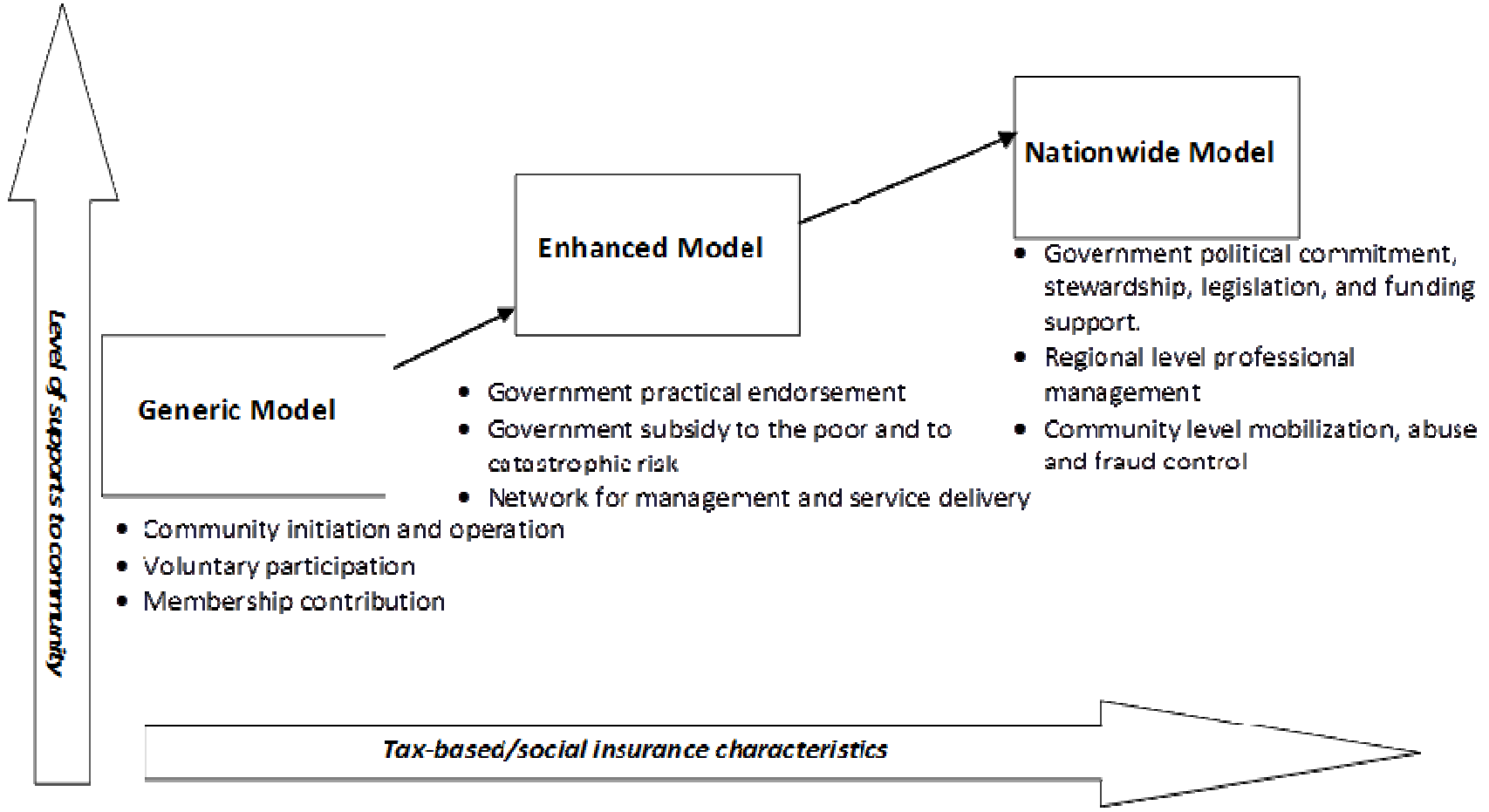
Presentation Outline

- 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

Thank you

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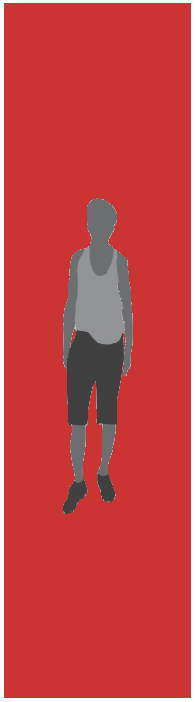

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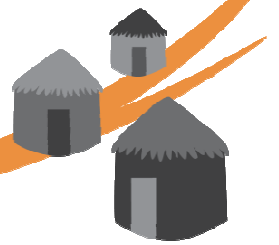

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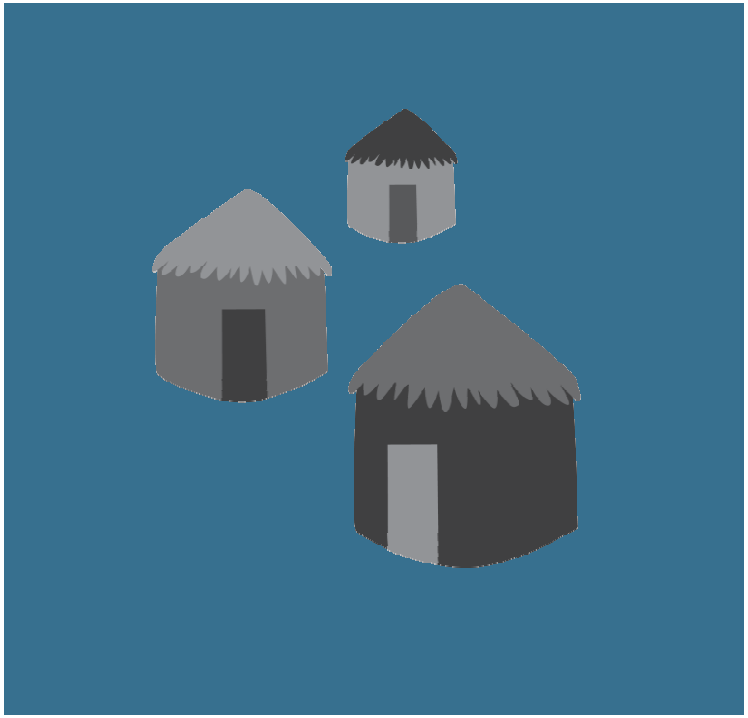

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