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Editorial

Bridging community-based health insurance and social protection for health care – a step in the direction of universal coverage?

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Access to affordable and effective health care is a major problem in low and middle income countries (LMIC) and out-of-pocket expenditure for health care a major cause of impoverishment (Meessen *et al.* 2003; Frenk *et al.* 2006; McIntyre *et al.* 2006; Van Doorslaer *et al.* 2006). One way to facilitate access and overcome catastrophic expenditure is through a health insurance mechanism, whereby risks are shared and financial inputs pooled by way of contributions from salaries or taxation (Carrin *et al.* 2005). In European history, social health insurance (SHI) initially covered salaried workers and their families. The self-employed, unemployed and destitute were only covered at a later stage (Bärnighausen & Sauerborn 2002). In LMIC today, the majority of people are either self-employed or work in the informal sector, which makes expansion of formal health insurance, if any, much more difficult. Taxation systems are generally insufficiently developed and do not allow for adequate revenue collection to ensure universal coverage (Carrin *et al.* 2005).

One response to the difficulty of providing insurance coverage for people in the informal sector is the development of community-based health insurance (CBHI). Such an arrangement implies that the community plays an important role in mobilizing, pooling, allocating, managing and/or supervising health-care resources (Jakab & Krishnan 2001). The subsequent financial power of the group may provide its administrators with a leverage to obtain better-quality services and have more accountable health-care providers (Atim 1999; Jakab & Krishnan 2001; van Ginneken 2002; Carrin *et al.* 2005). CBHI schemes attempt to tap willingness and ability to pay for health care and try to build local risk-sharing arrangements based on solidarity which requires time to mature. In practice, however, most CBHI schemes are small. A review of 258 CBHI schemes found that 50% had less than 500 members [International Labour Organisation (ILO) 2002], which undermines the CBHI's potential (Criel & Waelkens 2003; Carrin *et al.* 2005).

Small-scheme federations or networks can be established to increase membership and improve financial leverage of CBHI (Waelkens & Criel 2004). Support organizations can be set up to provide management assistance at the outset; scheme management can be subcontracted to an umbrella organization or schemes may even merge (Carrin *et al.* 2005). Alternatively, a scheme with a larger membership may be started (Carrin *et al.* 2005), although this may only be possible if premiums are subsidized. In this respect, Bennett (2004) suggests that government subsidies to schemes should target the poor, more specifically those unable to pay a premium, to enable equitable access to health services. The situation of CBHI in sub-Saharan Africa leads to a similar analysis (Ndiaye *et al.* 2007): CBHI is not an option for the poorest, and someone else therefore needs to pay the insurance premium for them – in full or in part. Hence, the need for subsidies to cover the poorest households – while at the same time exercising great caution not to undermine and jeopardize local solidarity dynamics and willingness to pay by other than the poorest households.

Rationale for bridging CBHI and social protection programmes (SPP) for health care

The World Bank defines SPP as public interventions that: (i) assist households and communities to better manage

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risks; and (ii) provide support to the critical poor (Holzmann & Jorgensen 2000). Several such schemes aim at enabling access to health services by the poor by reducing barriers to the uptake of existing services or providing incentives for their uptake. In Latin America, conditional cash transfers are common whereby poor households are provided with cash if they adhere to selective services, such as preventive health services and/or school attendance (Morris *et al.* 2004). In Asia and Africa, vouchers are used to promote the uptake of services by the poor (Palmer *et al.* 2004; Borghi *et al.* 2006) such that they can enjoy free or subsidized defined services at selected providers. In some Southeast Asian countries, health equity funds – i.e. a single-purpose social assistance set up, whereby a third party pays health-care providers for services rendered to eligible poor, exempted from paying user fees – are in use (Hardeman *et al.* 2004; Jacobs & Price 2006; Noirhomme *et al.* 2007). Also in Africa, a variety of community safety nets – in addition to or in absence from public interventions – exist (Foster 2007).

In the new strategy, we propose that SPP (and community safety nets) would financially support – fully or partially – the insurance premiums for the CBHI scheme for those households that experience major problems in paying these contributions. Such a policy may lead to synergetic effects boosting the coverage of social protection for health care. The SPP buys premiums with external funds for pre-identified households, while the CBHI pays providers for delivering the *same* services in the *same* facilities to all insured, i.e. those who were able to pay the premium themselves and those for whom the SPP has paid the premium, totally or partly. But we should not downplay the fact that problems in ability to pay the premiums are not the only reason explaining limited population coverage in CBHI schemes: research in Guinea-Conakry in West Africa clearly indicated that poor quality of care in the contracted health services and lack of trust in the management of the schemes are also important barriers to enrollment (Criel & Waelkens 2003). The poorest also face a variety of other forms of exclusion than in the domain of health care only. Bridging CBHI and SPP therefore does not imply that the need for multi-purpose social assistance, for other problems than health care, or even for health care in case the protection offered by existing CBHI schemes would be insufficient, could become superfluous. Rather, a more intense collaboration with the social sector should be pursued so that the other needs of the poorest can be effectively addressed.

We believe that a merger scenario has important intrinsic merits: it counters the fragmentation of funds and contributes to larger pooling arrangements. Purchasing CBHI premiums for the poorest may appear to be a less efficient option than a policy of direct reimbursement of providers on a per case basis. Our hypothesis is that bridging CBHI and SPP can lead to economies of scale and to a reduction of the high administrative overheads that both CBHI and SPP experience. Last but not least, bridging SPP and CBHI could increase the purchasing power on the demand side possibly leading to improvements in the quality of health care. This in turn may attract more (non-poor) people able to afford the premium, resulting in a virtuous cycle.

Perverse financial cross-subsidy from the poorest to the less poor? The case of Cambodia

The health-seeking behaviour by CBHI and SPP beneficiaries [health equity fund (HEF) members] in Cambodia indicates that the outpatient consultation and hospitalization rates are lower in the HEF member population: 0.65 consultations per capita per annum at the first line and 32.5 admissions per 1000 at hospital level *vs.* 2.97 and 70, respectively among those insured (Jacobs and van Pelt, unpublished data). In this situation, there is an obvious risk of cross-subsidy from the SPP to the CBHI fund when premiums cost the same and cover similar benefits.

We believe that this analysis of undesirable cross-subsidy needs to be mitigated in light of the following two considerations. First, implementing different premium levels could very well be considered, similar to the experience with the Bwamanda scheme in the Democratic Republic of Congo in the 1980s (Criel & Kegels 1997). For a same package of benefits, the premium for households able to pay would be higher than the subsidized premiums for the destitute – in analogy to the principle of income-related contributions, such as in European SHI. This would reverse the direction of cross-subsidy. Having different levels of premiums for the non-poor and for the destitute introduces a degree of vertical equity (i.e. income solidarity) in the financing arrangement next to the existing horizontal equity (i.e. risk-solidarity), which should be safeguarded. Ideally, there should also be a provision to shoulder indirect costs for the poor as these have been found to be a major impediment to seeking timely and appropriate care, even when health care is provided for free (Jacobs *et al.* 2007).

The cross-subsidy in the case of a merger scenario is not one from poor to less poor, but from an international fund to a local autochthonous CBHI fund. If the case, one may well argue that the cross-subsidy is not at all undesirable, but on the contrary, an efficient, well-targeted investment of donor funding, with a clear and sustainable objective. Indeed, it is not realistic, nor desirable for that matter, to expect the international community to

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indefinitely go on funding SPP: at some stage, the political process should promote and eventually even force better-off households to cross-subsidize health care for their poorer compatriots (Criel 2006), in analogy of the mandatory character of most European SHI systems.

Conclusion

The potential kick-start to CBHI schemes by linking them to SPP during a sufficiently long period could enable the schemes to mature financially and managerially. In the long term, local and/or national solidarity arrangements – which need time to develop and grow – can enable fair cross-subsidies. Such solidarity mechanisms are socially and politically more acceptable and sustainable in the case of one single fund rather than different funds catering for different population groups. The non-poor – i.e. the most important group in terms of social and political power and influence – will be more positive towards cross-subsidy if they themselves benefit from the CBHI scheme when in need. Separate funds may pave the way to the doom scenario, whereby CBHI would only cover non-poor and offer them care in specific contracted facilities, leaving SPP to cover the poorest households through health care in the public sector. This scenario would not only put further stigma on the poor and reinforce social inequalities, but also create a perverse incentive to structurally underfinance the public sector, as politically powerful population groups may see no relevance in increasing its funding.

Our hypothesis is that an articulation between CBHI and SPP, along the lines described in this paper, could contribute to improve administrative efficiency, to strengthen the purchasing power of demand-side organizations (in the present case, the combination CBHI–SPP), to avoid unnecessary and stigmatizing fragmentation of funds, and to eventually scale up the coverage of social protection for health care. We therefore plead for careful piloting of local initiatives linking CBHI and SPP. The proof of the pudding is in the eating: the processes followed and the results obtained will need to be carefully monitored and the *do's* and *don'ts* progressively identified.

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