CBHI: An evolutionary approach to achieving universal coverage in Low-income Countries?

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Universal coverage of health care

- **Universal coverage (UC)** is defined as **access** to key promotive, preventive, curative and rehabilitative **health interventions for all** at an **affordable cost**.

- It implies **financial risk protection** with appropriate health financing mechanisms

Selected countries with UC

General tax		General tax + vuluntary		Payroll tax + genera tax	
Country	Year of UC	Country	Year of UC	Country	Year of UC
Norway	1912	New Zealand	1938	Germany	1941
Japan	1938	Netherlands	1966	Belgium	1945
United Kingdom	1948	Denmark	1973	Austria	1967
Kuwait	1950	France	1974	Luxembourg	1973
Sweden	1955	Australia	1975	Greece	1983
Bahrain	1957	Ireland	1977	South Korea	1988
Brunei	1958	Hong Kong	1993	Switzerland	1994
Canada	1966	Singapore	1993	United States	2014
United Arab Emirates	1971	Israel	1995	Thailand	
Finland	1972			Philippines	
Slovenia	1972			Korea	
Italy	1978			Taiwan	
Portugal	1979			Chile	
Cyprus	1980			CostaRica	
Spain	1986			Mexico	
Iceland	1990			Colombia	

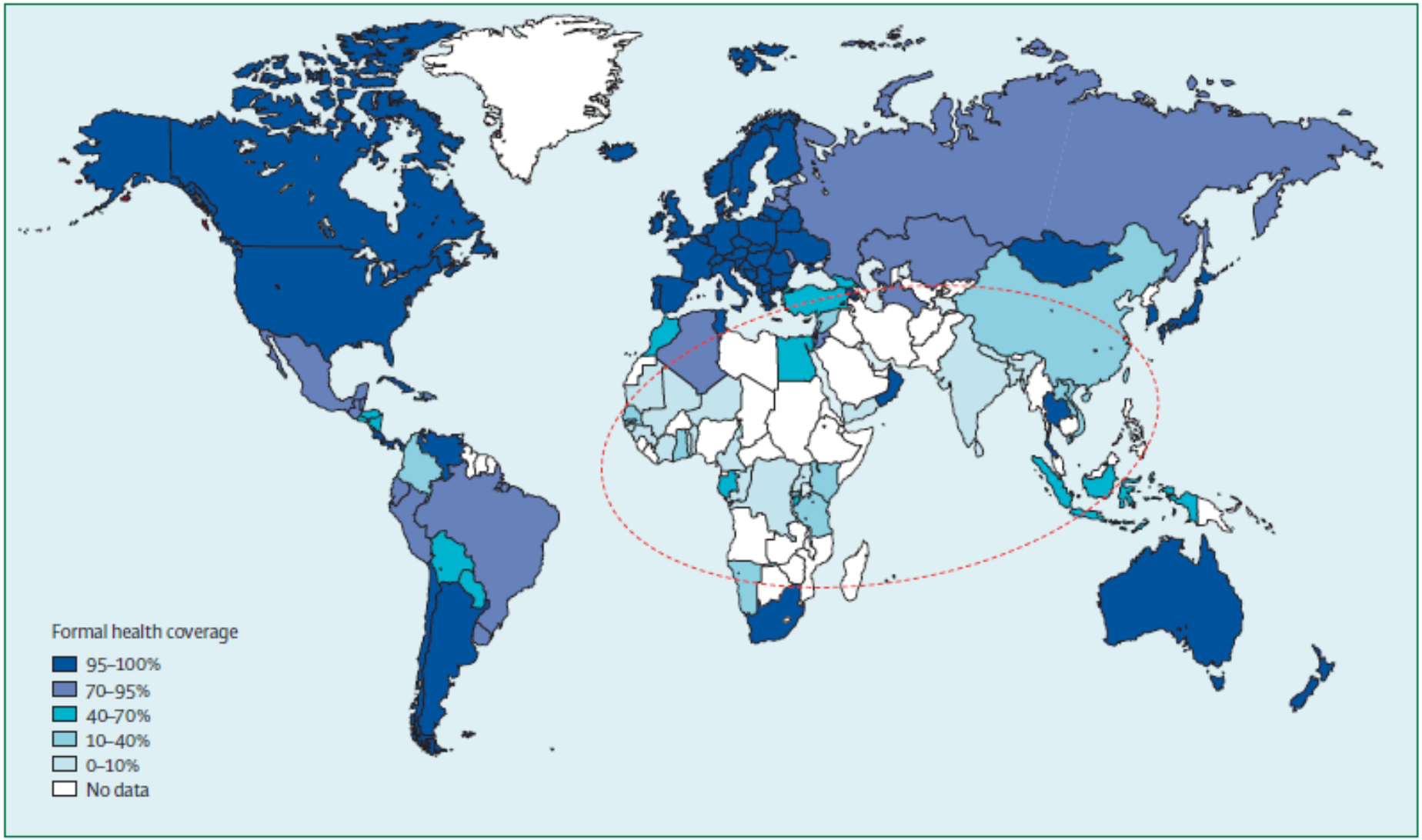


Figure: **Extent of universal coverage worldwide**

The encircled region has the poorest rate of health coverage in the world. International Labor Organization defined coverage as the population formally covered by social health protection (eg, under legislation, without reference being made to effective access to health services, quality of services, or other dimensions of coverage), explaining the depiction of the USA and South Africa. Source: data compiled by the International Labor Organization, 2008, from multiple sources; mapping by the Results for Development Institute (R4D).

Community-based health insurance:

- Applying the **principles of health insurance** at the **community level** for **social protection purpose**.
- 19th Century: developed in Germany, Japan, UK
- 20th Century: Introduced to low-income countries to provide **financial risk protection** to the people **in the informal sector**
- More than 30 years experience gradually reveals a potential **pathway of CBHI towards UC** in low-income countries

Objective of this presentation

- Discuss the possibility of using CBHI to achieve UC based on existing evidence by **extending tax-based/social insurance characteristics into CBHI scheme.**

- Share a 3-step evolution process:
  - **Generic model**
  - **Enhanced model**
  - **Nationwide model**

Table 1. The key characteristics of a **generic model** of CBHI

Community supports	**Community itself**, defined by geographic, professional, or ethnic characteristics		
Health Financing functions	Revenue collection	Participation	**Voluntary**
		Source of revenue	**Membership prepayment**
	Risk pooling	Risk pooling	Start within one community **(small size)**
		Fund management	**Managed by community** committee or local health provider
	Service purchasing	Service coverage	Outpatient, inpatient, or both at local level
		Purchase mechanism	FFS, Capitation
Country cases	Philippines, China, Uganda, Kenya, Tanzania, and etc.		

Table 2a, Promises and challenges in a **generic model** of CBHI

Criteria	Promises	Challenges
Effectiveness		
Financial risk protection	Increased awareness and reduced OOP	Limited with high OOP
Healthcare utilization	Increased health service utilization	limited due to limited small benefit package
Resource mobilization and cost recovery	Improved cost-recovery and resource mobilization	Limited only from membership contribution
Efficiency		
Scheme management	Created experience in risk pooling management	Lack of professional management
Healthcare delivery	Limits abuse and fraud through community participation mechanism	Weak cost control over healthcare provider

Table 2b, Promises and challenges in a **generic model** of CBHI

Criteria	Promises	Challenges
Equity		
Enrollment	Making it available to the people who are in informal sector	Failed to reach poorest of the poor
Benefit	Pro-poor by targeting informal and rural populations	Pro-rich due to high co-payment
Quality		
Scheme management	Community governance	Lack of professional management
Service delivery	Pooling will empower consumers	Lack of control on healthcare quality
Sustainability		
Political	Grass roots community involvement	Limited government support
Technical	Technical assistance for sustainable design	Low participation rate, adverse selection, small risk pooling, limited benefits, and poor scheme management

Table 3. The key characteristics of a **enhanced model** of CBHI

Community supports	At multi-community/ regional level with **local government political endorsement**		
Health Financing functions	Revenue collection	Participation	**Semi-voluntary based,** Government subsidy to the poor
		Source of revenue	**Government subsidy** (for the poor, or for catastrophic, or re-insurance)
	Risk pooling	Risk pooling	Cross-subsidy among the network of communities
		Fund management	**Managed by community with network of professional TAs**
	Service purchasing	Service coverage	Strengthening the links with provider network
		Purchase mechanism	Capitation, case-based payment
Country cases	Rwanda, Uganda, Mali, Senegal etc.		

Table 4a, Promises and challenges in a **enhanced model** of CBHI

Criteria	Promises	Challenges
Effectiveness		
Financial risk protection	Increased by introducing re-insurance through network	Limited protection with high OOP
Healthcare utilization	Improved through government subsidy	Constrained by small benefit package
Resource mobilization and cost recovery	Cross subsidy among communities	Limited only from membership contribution
Efficiency		
Scheme management	Increased through professional network support	Week professional management
Healthcare delivery	Improved through provider payment mechanisms	Depends on complexity of provider payment mechanism

Table 4b, Promises and challenges in a **enhanced model** of CBHI

Criteria	Promises	Challenges
Equity		
Enrollment	Improved by government subsidy to the poor	Not equal across schemes
Benefit	Improved by government subsidy to the poor	
Quality		
Scheme management	Improved by professional network support	Depends on network management capacity
Service delivery	improved by provider payment mechanisms	Complexity of provider payment mechanism
Sustainability		
Political	Increased by regional political/ technical support	Not able to scale up at the national level
Technical	Improving by network support	Small risk pooling, adverse selection, and low benefits

Table 5. The key characteristics of a **nationwide model** of CBHI

Community supports	**Political commitment and stewardship at national level with legislation backup**		
Health Financing functions	Revenue collection	Participation	**Semi-compulsory, incentivized,** Majority targeted population
		Source of revenue	**Government subsidy (administration and premium)**
	Risk pooling	Risk pooling	Cross-subsidy among communities with Risk-equalization mechanism
		Fund management	**Professional management** with **community participatory roles**
	Service purchasing	Service coverage	Standardized comprehensive benefit package
		Purchase mechanism	Capitation, case-based payment. Global budget, and PBP
Country cases	Rwanda, Ghana, China, India, etc.		

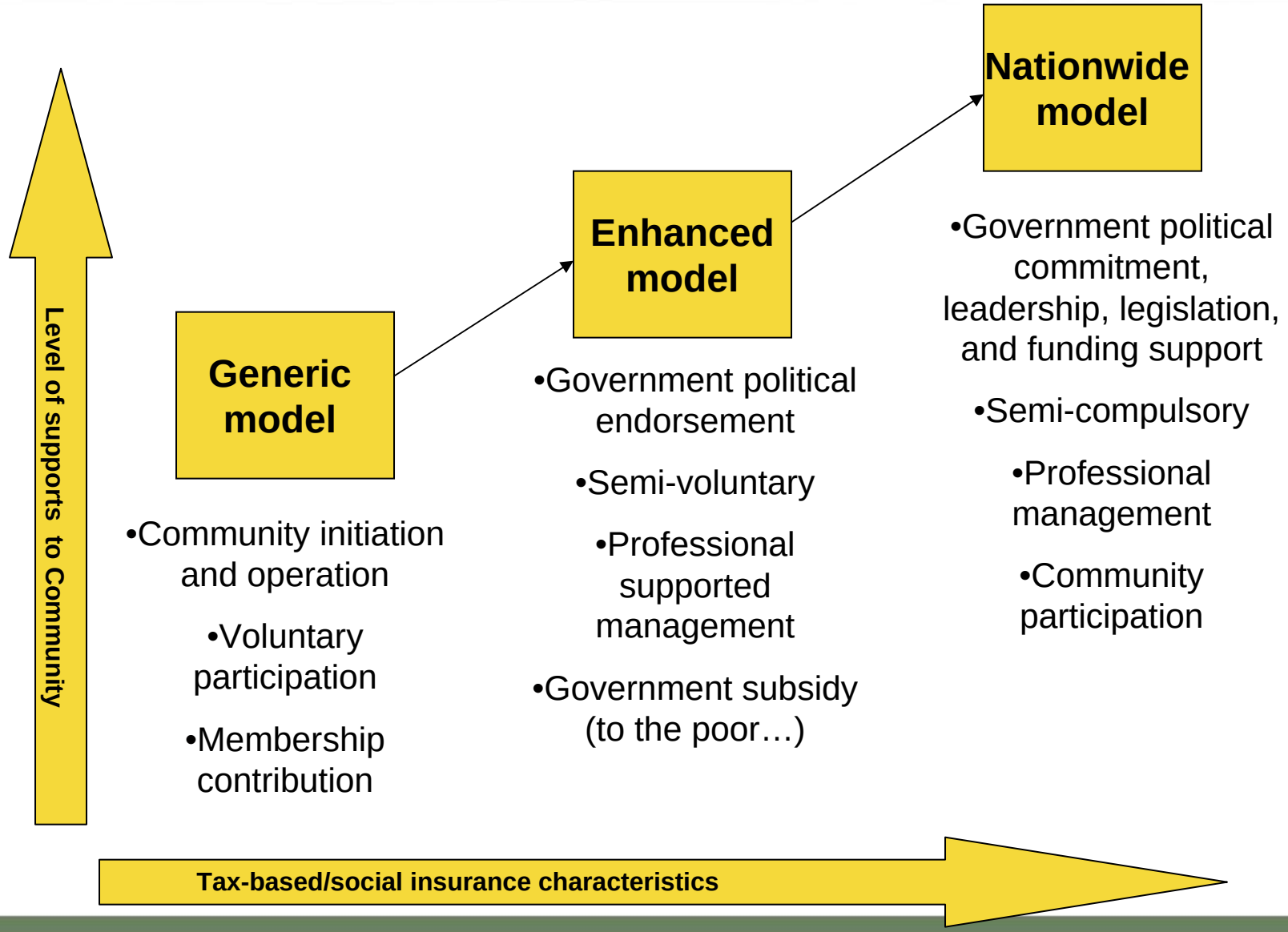
Table 6a, Promises in **a nationwide model** of CBHI

Criteria	Promises
Effectiveness	
Financial risk protection	**Broader benefit package and government subsidy of premiums reduces OOP**
Healthcare utilization	Increased significantly
Resource mobilization and cost recovery	Increased with significant government subsidies to the poor, benefit package, and scheme management
Efficiency	
Scheme management	**Improved by introducing professional management at regional level, with strong community support**
Healthcare delivery	**Improved by introducing provider payment mechanism and continue community oversight to limit abuse and fraud**

Table 6b, Promises in a **nationwide model** of CBHI

Criteria	Promises
Equity	
Enrollment	Improved by government subsidy to the poor
Benefit	**Improved by government subsidy to the poor, and risk equalization mechanism**
Quality	
Scheme management	Improved by professional management
Service delivery	Improved by introducing provider payment mechanism and service guideline
Sustainability	
Political	**National scale-up possible with government stewardship, financial, and legislation support**
Technical	**Improved with introduction of national technical guideline and technical support**

Figure 1. Three-step evolution process using CBHI to achieve Universal Coverage



Thank you

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