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COMMUNITY HEALTH INSURANCE AND UNIVERSAL COVERAGE

WHAT IS COMMUNITY HEALTH INSURANCE (CHI)?

Several forms of community-based financing mechanisms exist in the world, particularly in low- and middle-income countries. They are primarily based on the concepts of insurance, credit or saving and advocate or bring in solidarity at the community level. These mechanisms are largely community initiated, owned and operated.

National health policy makers – particularly in some low- and middle-income countries – advocate community-based mechanisms, specifically Community Health Insurance (CHI), as a way to enhance health care access and to protect individuals from financial risks of illness. Articulating CHI with the national strategies for attaining universal coverage and finding the adequate role and scope for CHI in the general health financing spectrum are the main question policy makers need to think about.

WHY CHI MATTERS?

Community health insurance is part of the health systems financing landscape in low- and middle-income countries since over two decades. Widespread throughout Africa and Asia, CHI presents a heterogeneous and variable picture in terms of contributing to health systems financing and financial protection. Given its potential and ability to reach out to a section of disadvantaged households, CHI could be used as an additional mechanism for financing health.

HOW DOES CHI CONTRIBUTE TO THE ACHIEVEMENT OF UNIVERSAL COVERAGE?

CHI's contribution is relevant to all three dimensions of universal coverage: (i) population coverage, (ii) service coverage, (iii) direct cost coverage.

In terms of population coverage, CHI seeks to extend financial risk protection to those who are not covered by any formal mechanisms. Although the poorest of the poor are usually excluded unless an effective mechanism for subsidizing the contribution payments are in place - which is the case for example in Rwanda and in the Indian *Karuna* Trust scheme, where donor funding is used for subsidizing premium payments for those who do not have the capacity to pay.

On the service side CHI schemes can cover primary care, referral care, or both. Generally the schemes focus on first-line healthcare services and are too small to function as risk pools that would provide coverage for expensive interventions such as surgery.

There is much variation between the different CHI schemes on their ability to cover direct costs. This is partly to do with the way the schemes are designed and partly with the level of direct payments required by the health service providers. For

example in Mali studies have shown that in some contexts and under some schemes direct costs for the CHI members are lower than for the non-members, while in other contexts the members actually have higher levels of direct payments than the non-members.

In practice, with the notable exceptions of Ghana and Rwanda, CHI has rarely achieved more than marginal population coverage (coverage at national level rarely exceeds a few percent of the population) and has had only a marginal impact on accessibility or affordability of health services from the national level perspective. However, they do introduce prepayment and pooling mechanisms at the community level and can engender the solidarity needed to build a wider movement towards universal coverage.

WHAT THE POLICY MAKERS NEED TO THINK ABOUT?

No blueprints are available to integrate CHI in national strategies. Since the size, spread, organization and relative strength of CHI differ across countries, it is necessary to fit it appropriately in the national health financing system. One frequent approach is that of a fragmented strategy, whereby CHI coexists with and hopefully complements other financing modalities, as in Senegal, Mali, and India. Less frequently, CHI becomes a model for a nationwide comprehensive strategy, as in Ghana and Rwanda. In any case, a systemic approach is needed.

Financial risk protection is possible through CHI only when service provision is regulated and controlled for induced demand. The difficulties of China's New Cooperative Medical System to translate population coverage into financial coverage make a case for improved regulation at the supply-side of care.

For CHI to extend to larger populations, and particularly the poorest, subsidies are a sine qua non. Domestic cross-subsidising is one possibility, as put in practice within Ghana's National Health Insurance Scheme framework. Donor subsidies are another way forward, as witnessed by Rwanda's channelling of Global Fund resources through CHI. In both cases political will and strong commitment toward solidarity are needed, at domestic and international level.

For CHI to maximise its risk pooling potential, schemes can join forces, as has been shown in Mali and is in progress in several African countries. Another way forward is making affiliation mandatory, as applied by Ghana and Rwanda. Both decisions rely on attitudes towards solidarity. Failing to join forces – as experienced in Senegal – raises a question mark over the feasibility of voluntary solidarity. Yet legal enforcement of affiliation is not sufficient to enrol the informal sector, or to guarantee effective access.

For CHI or any other social health protection arrangement to guarantee equitable access, there is need for empowerment of the most vulnerable groups and individuals. Evidence today – from women in *Nongon* and *Ahmedabad* to poor city dwellers in *Nouackchott* and *Pune* – strongly suggests that CHI can have a positive transformative impact. The empowering potential of CHI is still rarely studied. If confirmed, it would enable decision makers to consider CHI not only as a financing device, but also as a social investment.

Further reading:

Soors W, Devadasan N, Durairaj V and Criel B (2010) *Community health insurance and universal coverage: multiple paths, many rivers to cross* [Background paper for the 2010 World Health Report].