



Community-based health insurance: how to promote effective and equitable coverage?

In low- and middle-income countries, the majority of healthcare expenditures come from out-of-pocket payments. In India, as much as 70% of healthcare is financed privately, with over 60% coming from out-of-pocket expenditure. This places the highest burden on the sickest and poorest segments of the population, and can cause financial disaster or prevent people from seeking medical care.

The World Health Organization, among other international bodies, has called for universal health coverage. However, no matter the coverage commitment, governments struggle to subsidise healthcare for the poorest community members. One approach to reaching them has been community-based health insurance (CBHI) schemes.

What is community-based health insurance?

CBHI schemes are local mutual aid schemes that put in place arrangements for mobilising, pooling, allocating and managing (or supervising) members' resources for accessing healthcare services. Annual premiums are typically in the range of US\$1–5 for individuals or US\$10–40 for households. In a very small number of cases, the poorest individuals and households are highly subsidised or completely exempt from paying the premiums. Almost all schemes cover hospitalisation, but only a few of them cover outpatient or maternity care. As with the National Health Service in the UK or private health insurers in the US, these schemes share the financial risk of needing medical treatment among all of their members.

Main Findings

- Socio-economic status, trust in the scheme, and the quality of the healthcare service are the major factors influencing enrolment.
- The presence of elderly individuals in the household, distance to healthcare facilities, and high one-off annual payments are the main barriers to joining a scheme.
- Stringent financial requirements prevent the participation of the poorest community members.
- Dissatisfaction with the insurance benefits and a poor understanding of CBHI are the main barriers to membership renewal.

Systematic review of evidence about CBHI schemes

A recent 3ie-funded systematic review has synthesised the available evidence on the factors affecting voluntary uptake of CBHI schemes and membership renewal in 20 low- and middle-income countries. Overall, the evidence suggests that additional government support can help to increase trust in the schemes and reduce barriers to joining and renewal. The evidence suggests that there is potential for CBHI schemes to be effective in improving poor members' access to health coverage.

This review specifically considers schemes where membership is voluntary and all – or at least most – of the members have to pay contributions in order to take part. So far, most CBHI schemes have remained small and have low enrolment rates. For CBHI schemes to become sustainable and effective social protection mechanisms, they will need to move from niche programmes to large-scale ones by enlisting and retaining more members. For example, Ghana and Nigeria are in the process of integrating CBHI schemes within their

national health insurance programmes in order to achieve universal health coverage.

Demand factors affecting enrolment

The strongest factor affecting uptake of CBHI is the socio-economic status of the household, with relatively well-off families being more likely to enrol. This type of programme is least effective at reaching the poorest community members, as financial constraints are a major barrier to joining.

A range of other factors also affect enrolment. They include social determinants of inequality, such as the marital status of heads of household, age, sex, prevalence of chronic illness in the household and education. The presence of elderly individuals in the household appears to be a barrier to enrolment in all regions. However, the reasons are unclear, since this was not mentioned as a factor in any qualitative study. Insurance literacy also affects enrolment. Finally, larger households are more likely to enrol in Sub-Saharan Africa but are less likely to do so in Asia. While female household heads are more likely to enrol than

their male counterparts, they are also more likely to drop out. This is particularly true in Asia, where the biggest determinant of renewal is the sex of the enrollee. The education level of the household head also has an effect. Better-educated individuals are more likely to renew their membership. Dissatisfaction with the insurance benefits and poor understanding of CBHI are the main barriers to renewal.

Supply factors affecting enrolment

Trust in the scheme's management is a significant enabler of enrolment. Good-quality healthcare services and a desirable benefits package also affect enrolment in CBHI schemes and membership renewal. Benefits, such as maternity insurance and coverage for pharmaceutical expenses, are particularly desirable. The distance to healthcare facilities is also an obstacle to enrolment. The majority of studies indicated that concern exists over the lack of appropriate legislative back-up from the government.

Finally, the poorest community members face barriers to joining, as they find the timing and mode of





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payments difficult. Many households find it hard to pay the annual fee all at once and would prefer options for payment in kind.

Implications for policy

Evidence suggests that governments can play a crucial role in developing and expanding CBHI schemes in low- and middle-income countries by creating an enabling environment through the development of government-mandated guidelines for schemes that are compatible with health and social security policies. Another area the evidence supports is for governments to focus on increasing insurance literacy through information campaigns and by regulating providers' quality of care. The provision of subsidies for poor and vulnerable community members would also increase the inclusiveness of such schemes.

Implications for programming

Organisations supporting and implementing CBHI schemes can enhance scheme management with these improvements:

- Increase knowledge of schemes among communities;

- Base provider choice on community members' preferences;
- Involve communities in scheme management;
- Educate consumers on solidarity and insurance principles;
- Provide dispute resolution systems for members; and
- Conduct outreach to poor and vulnerable community members.

Benefits packages can be made more inclusive and attractive with these improvements:

- Extend coverage to include maternity care, ambulatory care, out-patient care, and transportation;
- Increase community involvement in benefits package design;
- Provide incentives (e.g. discounts) for large families to enrol;
- Provide flexible timing and payment modalities for premiums; and

- Integrate schemes with existing savings or credit facilities, initiating income generation schemes.

Implications for research

The authors identified large information gaps concerning factors that could influence enrolment in CBHI schemes and membership renewal. Further research is needed that would increase our understanding of the mechanisms affecting uptake of such schemes. It should include the effect of the range of services, proportion of total healthcare expenditure in a community or household, and the catchment population CBHI schemes cover; comparative analyses of different models (e.g. hospital, mutual aid, linked to microcredit); sustainability analyses; and impact of interventions (e.g. insurance awareness tools, flexible payment modalities, financial and non-financial incentives to health workers).



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What is a systematic review?

3ie-funded systematic reviews use rigorous and transparent methods to identify, appraise, and synthesise all of the qualifying studies and reviews addressing a specific review question. Review authors search for published and unpublished research and use a theory-based approach to determine what evidence may be generalised and what is more context specific. Where possible, cost-effectiveness analysis is done. The result is an unbiased assessment of what works, for whom, why and at what cost.

About the systematic review

This brief is based on *Factors affecting uptake of voluntary and community-based health insurance schemes in low- and middle-income countries*, [3ie Systematic Review 27](#), by Pradeep Panda, Iddo H Dror, Tracey Perez Koehlmoos, SA Shahed Hossain, Denny John, Jahangir AM Khan and David M Dror. It synthesises evidence from 54 studies (36 quantitative, 12 qualitative, and 6 mixed-method studies), covering 20 countries, mainly in Africa, South Asia and South East Asia, to understand the factors affecting uptake of CBHI schemes. Most studies reported on schemes in rural settings and in low-income countries, with only few lower-middle income countries and only very few upper-middle income countries.

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