



Primer for Policymakers

Approaches to Scaling up Community-Based Health Financing Schemes

In many low-income countries, a large share of the population faces financial barriers to accessing health services. This has a negative effect on the use – or timely use – of services. Local civic, political, and religious leaders have begun to address these barriers within their communities. One grassroots response that is increasingly common, particularly in sub-Saharan Africa, is the development of community-based health financing (CBHF) schemes.¹ Dynamic CBHF growth has piqued the interest of governments in the region, which are caught between the opposing pressures of tight public health care budgets and the population's limited ability to pay for health care. As ministries of health consider options to improve the financial accessibility of health services while not reducing health sector revenues, the expansion, or “scale-up” of CBHF schemes is increasingly popular as a policy strategy.

What are CBHF schemes?

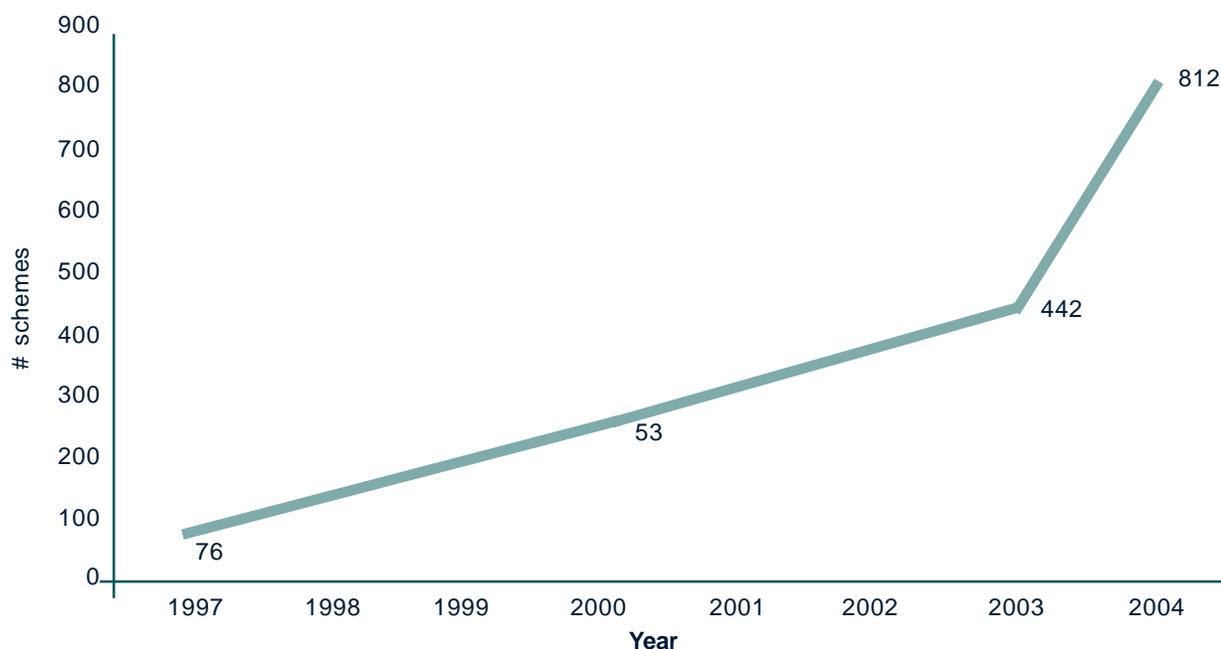
CBHF schemes are a form of insurance: they allow members to pay small premiums on a regular basis to offset the risk of needing to pay sometimes large health care fees upon falling sick. However, unlike other insurance schemes, they are typically based on concepts of mutual aid and social solidarity and are always not-for-profit (Bennett et al. 2004). A small number of such schemes have been in existence for a long time, but as their numbers have grown dramatically during the past five to ten years, they have garnered increasing interest at the community, country, and global level (see Figure 1).²

While the effectiveness of CBHF schemes at protecting the poor in a sustainable manner has been questioned (Ekman 2004), recent studies demonstrate positive trends not only in protecting the

¹ This primer focuses on sub-Saharan Africa, as there appears to be a particular interest in scaling up CBHF schemes in this region, but draws upon lessons from elsewhere as appropriate.

² Data from the 2003 inventory of The Concertation (www.concertation.org) from 11 countries (Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal, Chad and Togo, with data from Rwanda (Butera forthcoming) added.

Figure 1: Growth in CBHF schemes in West and Central Africa



poor, but also in reducing financial barriers to care and improving the use of priority health services (Schneider et al. 2001, Sulzbach et al. 2005, Franco et al. 2006, Diop et al. forthcoming). As a result, national and international stakeholders see them as an option for extending insurance coverage in low-income countries, particularly among rural and informal sectors of society.

What do we mean by “scale-up”?

Until recently, the development of CBHF schemes has not been systematic: individual communities and organizations initiated schemes alone or with a development partner,³ and governments have had little strategic or leadership role.⁴ During this fairly long period of “experimentation,” many lessons have been learned about how to set up and operate CBHF schemes, as

well as about common pitfalls.⁵ A major lesson is the importance of developing an enabling environment for CBHF – components of which include adequate local technical assistance; partnerships with local government, organizations, and financial institutions; and consensus on a national strategic plan for the development of CBHF schemes. With the rise in the number of schemes and the concurrent increase in interest by governments and the international community in harnessing their potential, recent efforts have focused on rendering CBHF more systematic and on scaling up CBHF schemes to cover a larger share of the population. This new phase in CBHF development aims to **maximize the coverage of rural and informal sector populations by CBHF schemes** within a given country. As the focus is no longer specifically local, but rather national, this enterprise develops into a political as well as technical one. The role of government and its development partners is crucial, and must be coordinated and strategic. It should be noted that it is unlikely that a fully scaled-up CBHF program would

³ International assistance agencies such as the International Labor Office (ILO), U.S. Agency for International Development (USAID), French, Belgian, and Swiss Cooperation, and Danida as well as local and international NGOs such as Save the Children and Catholic Relief Services have provided technical support for the start-up and operation of schemes.

⁴ In the last year or two, Benin, Ghana, Rwanda, and Senegal have adopted government policies (strategies, laws, etc.) addressing CBHF development.

⁵ Extensive documentation exists on these subjects, most of which is available through the website of The Concertation (www.concertation.org).

cover the entire population, but rather the usually large share of households that are employed in rural agriculture or the informal sector that otherwise would not benefit from health insurance.⁶ Thus, CBHF should be seen as a complement to other financing, risk-sharing, and pro-access instruments, such as user charges, health insurance schemes for the formal sector, and targeted subsidies.

Why is scaling up important?

A widely held goal of the health sector is to ensure that the entire population has access to quality health care. In many developing countries, however, the majority of the population works outside of the formal sector and is difficult to reach with formal health insurance mechanisms. This population can be temporarily or partially excluded from health care when user charges⁷ must be paid because of irregular or seasonal revenues that do not always provide households with the cash needed to seek care when illness occurs. Moreover, there is a need to protect such households from catastrophic health expenditures, hence the need for some form of health insurance.

During the late 1980s, there was significant interest in social health insurance (SHI) schemes in sub-Saharan Africa as a way to provide access to health care for all. Analysis at the time and since, however, suggested that such schemes were unlikely to be successful (Vogel 1990a, Vogel 1990b, Normand and Weber 1994, Carrin 2003). Enrollment in SHI was likely to be focused among the more affluent segments of society who had formal sector employment (a minority of the population), which

could increase inequities in access to care. Administrative costs associated with such schemes were likely to be high compared to the benefits afforded and the population covered. Moreover, it was feared that SHI risked promoting inefficiencies in the health system if it were not designed well and managed properly. Finally, obstacles to the design and implementation of SHI are present in most sub-Saharan African countries, among them weak organizational and managerial capacity at the national level, and infrastructure problems that impede the collection of premiums, the payment of reimbursements, and the monitoring of health and financial information (Carrin 2003).

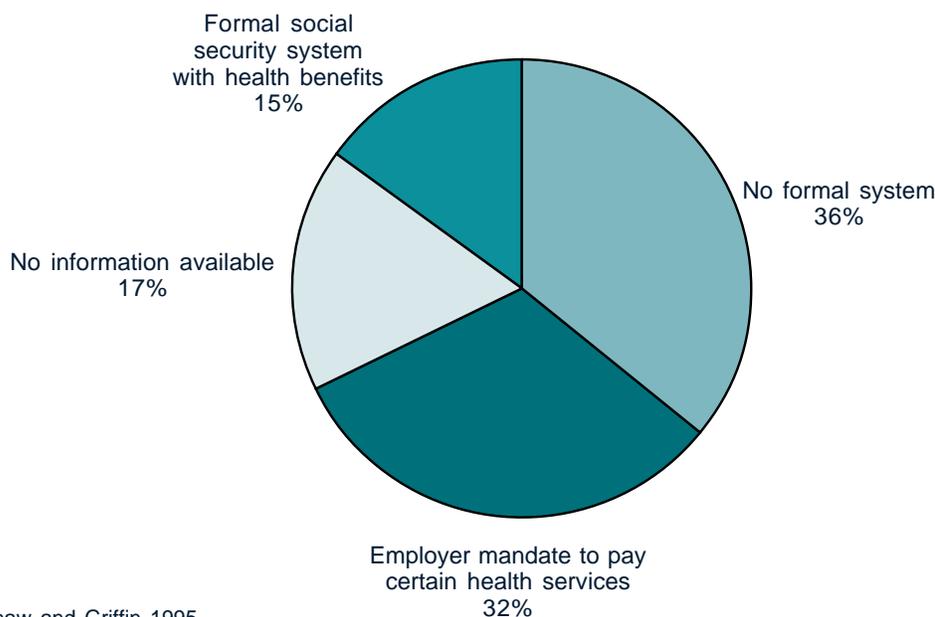
Even when SHI is an important part of a policy aiming for universal coverage, it is not a short-term fix. In Kenya, national policymakers are actively pursuing the transformation of its National Hospital Insurance Fund, currently covering 10 million people, into a Social Health Insurance Fund that would cover the entire population of approximately 30 million. Donors and stakeholders in Kenya have cautioned that the transition period for systematic enrollment of the poor and informal sectors is at least 15 years, and particular attention must be paid to ensuring that the poor have effective access to preventive services during this transition. International experience with implementing SHI confirms that such a transition to universal coverage takes more than a decade (Carrin 2006).

A 1991 survey of 47 African countries found the situation regarding health insurance as illustrated in Figure 2. The sub-Saharan countries that have some form of health insurance in place (social, private, employer-based) typically have very low population coverage, less than 10 percent in most cases (Shaw and Griffin 1995, Bailey 2004). Consequently, a growing number of countries are interested in combining different options for health insurance to cover as much of their population as possible (Waelkens et al. 2005). Most recently, in 2003, Ghana launched a National Health Insurance Act, an ambitious plan to cover its population with district-based health insurance schemes. Various models of community-based health insurance seem to be one promising, and increasingly popular option, especially in the short-term.

⁶ In Rwanda, by 2006, about half of the population has joined a scheme. However, this is an exception; there is not another country where scheme membership approaches 50 percent, though the share covered continues to grow virtually everywhere.

⁷ Some countries have abolished user charges for government-provided services. This eliminates most of the financial barrier to these services (though the patient's cost of transportation to the provider and, often, the separate purchase of drugs can also represent financial barriers). However, abolishing user charges deprives the government system of revenues that, though a small proportion of total costs, often fill important gaps that otherwise compromise quality. Further, many people use or would prefer to use private commercial or not-for-profit providers that must charge fees. Lastly, abolishing user charges is a form of untargeted subsidy policy, where all, regardless of ability to pay, receive the subsidy from government and health sector funds.

Figure 2. Health Insurance in African Countries



Source: Shaw and Griffin 1995

How is scale-up done?

To date, there is little experience scaling up CBHF schemes in sub-Saharan Africa; the few schemes that have attempted scale-up are at early stages of the process. Consequently, there is no roadmap to success, and governments have approached scale-up in different ways. Nevertheless, it has become clear that scale-up has two interlinked aspects – political and technical.

Political aspects of scaling up CBHF

Scale-up of CBHF is first and foremost a political enterprise because it inevitably necessitates some level of political leadership. The scale-up process varies, however, according to the type(s) of CBHF schemes that already exist, the policy context, the interactions of different actors (central government, local government, civil society, socioprofessional organizations, community-based organizations), and how intervention strategies are used to create a supportive environment for scale-up.

The features of CBHF schemes that already exist in a country tend to influence the health insurance model that is being promoted for national scale-up. Experience indicates, however, that the **acceptability** and

replicability of scheme features – that is, how the features fit the political, administrative, and organizational context of the country as a whole – matter. For example, the provider–community partnership that underlies the Rwanda CBHF model applies nationwide. Rwanda’s essentially homogeneous model differs greatly from the diverse faith-, socioprofessional organization-, or ethnicity-based CBHF schemes that were emerging in Ghana before the enactment of the National Health Insurance Act in 2003, and the socioprofessional organization-based *mutuelles* (mutual health organizations) that were established before the enactment of legislation in Mali.

The Rwanda CBHF model was designed with the intention of providing an experiential base for eventual scale-up throughout the country. Because scale-up was intended from the start, nationwide acceptability and replicability were key criteria for the organizational features of the “pilot” schemes. To ensure acceptability, schemes were designed using an interactive approach that involved local actors (through local workshops) and central actors (through national workshops); final design features reflected a consensus of these actors. To ensure replicability, the schemes were built on local

organizational relationships that exist in all Rwandan communities. The “adaptation” phase that followed the pilot phase elaborated further the roles to be played by local actors (cells, sectors, administrative districts) in the context of the country’s administrative decentralization. Proposed local innovations for improving scheme performance were judged on the basis on their replicability: if Rwanda had not had a wide network of community banks (*banques populaires*), with at least one community bank in every commune, the community bank–CBHF partnership that started in Bungwe District would not have been adopted as an organizational feature. (Box 3 in the next section describes this community bank–CBHF partnership feature.)

The situation in Rwandan contrasts with that of Ghana prior to 2003, where schemes emerged as isolated community initiatives in diverse religious and ethnic contexts that were not easily replicated or universally acceptable and, hence, did not provide a model that the central government could implement as national policy.

To ensure acceptability and replicability, designers of scheme scale-up are adopting and reorganizing aspects of schemes in ways that harmonize with existing institutional relationships. Reorganization may be **partial** or more **fundamental**.

Partial reorganization is seen in Rwanda, Benin, and Senegal. In these countries, selected organizational features of existing CBHF schemes were modified to promote the viability of scale-up. For example, to build optimal risk pools, scheme promoters are aligning the boundaries of target membership populations with the boundaries of local government units or sub-units. In addition, networks of CBHF schemes (called federations or unions) are being promoted to support schemes in terms of risk pooling, social intermediation, and other functions.

Ghana’s reorganization was more fundamental. With the Health Insurance Act of 2003, Ghana moved from schemes based on religious, professional, or ethnic groupings to a national program of schemes based on

the country’s administrative districts, and with significant changes in ownership, organization and management, benefit packages, contribution policies, and linkages with formal health financing institutions.

Technical aspects of scaling-up CBHF

Because the development of government policy regarding CBHF scale-up is relatively recent, and implementation of technical strategies will take time, there has been little evaluation of the process. In the absence of an empirical information base from which to analyze the effectiveness of different technical strategies, this section describes some of the strategies that countries have adopted and consider some advantages and disadvantages of various approaches.

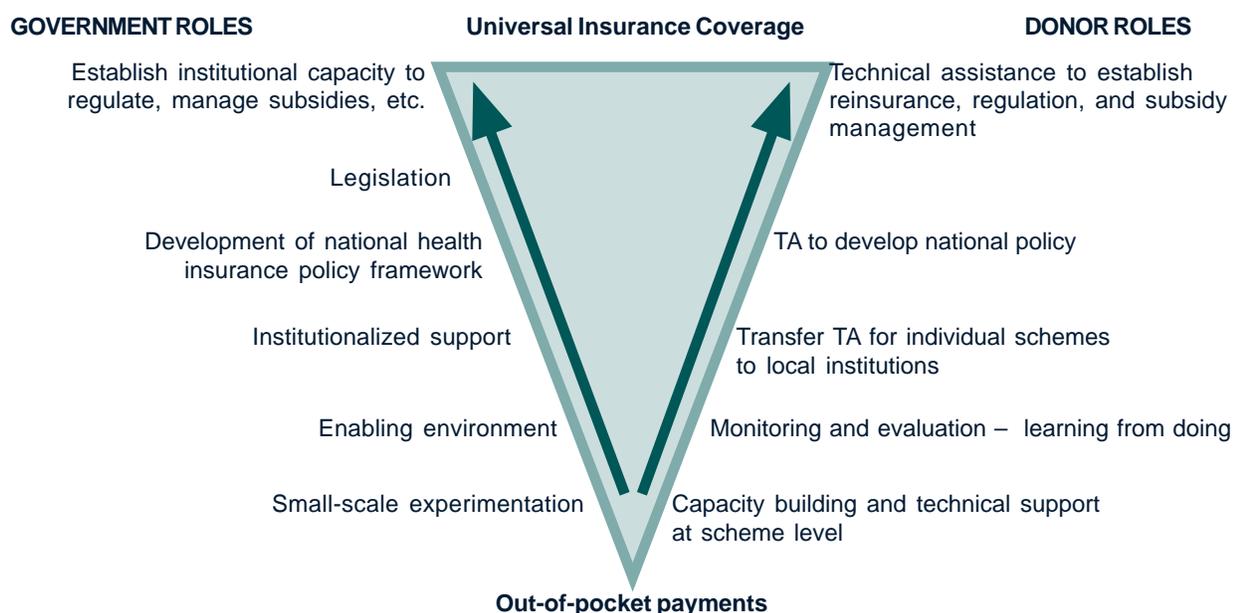
Steps in the scale-up process

While the transition from small-scale CBHF schemes to more comprehensive coverage will differ in different countries, a generic transition process, with steps for governments and donors to take, can be described. (Figure 3 illustrates this process.)

The first step for the government is the **creation of an enabling environment for CBHF**. This involves encouraging coordination and networking among CBHF schemes and their promoters, evaluating and documenting experiences to identify best practices and problems, promoting information-sharing and exchanges of experiences, building technical and policy capacity on CBHF, and encouraging local partnerships. Simultaneously, donors can play an important role by supporting evaluations that provide information on how the target population perceives the schemes and how well the schemes are working, supporting study tours that enable policymakers and implementers to learn from experience elsewhere, and providing policymakers with tools, briefs, and other materials on evidence-based decision making and advocacy.

The next step for government is typically the **institutionalization** of technical capacity to support CBHF scale-up. This may involve establishing specific government units that develop and disseminate tools and guides and otherwise support CBHF. The step also

Figure 3: From Small-scale CBHF Schemes to Universal Coverage



Adapted from Arhin-Tenkorang (2001)

comprises **using a pilot phase to prepare for national scale-up, and launching networks of CBHF schemes**. Rwanda used a pilot phase to plan, demonstrate, evaluate, modify, and strengthen CBHF schemes and networks, as well as to build capacity and consensus to roll out CBHF nationwide. Benin and Rwanda have encouraged CBHF development by initiating multiple schemes simultaneously and creating networks of schemes to build the requisite capacity and cover geographic areas in an efficient manner. Donors can provide technical assistance during this step and the following one.

Once countries have established some degree of institutional capacity in CBHF and of experience in scheme implementation, it is appropriate to begin developing a supportive **policy framework** for CBHF schemes. Senegal, Benin, and Rwanda have used the process of writing a **national strategic plan** for CBHF development to build consensus and to provide a roadmap for coordinated, systematic scale-up.

Legislation can be a step in the process of scale-up. Often legislation is used to mandate participation in a scheme, and it may include regulatory elements, such

as fixing scheme reserve and premium levels, and benefit packages. Legislation need not immediately follow upon the development of the policy and planning documents discussed in the previous paragraph. Donors can and should promote dialogue among stakeholders to decide the appropriate timing of legislation.⁸ Also, once the government has decided that legislation will expedite rather than hinder scale-up, it may need assistance from development partners in drafting and implementing the legislation. Countries such as Ghana and Tanzania attempted to scale up using legislative instruments. In both countries, enrollment remains relatively limited. After three years of implementing the Community Health Fund in one pilot district in Tanzania, the average membership rate in 2001 was 5 percent of the population (Chee et al. 2002). As of early 2006, Ghana's enrollment rate (excluding populations exempt from paying premiums) in district-based insurance schemes also was approximately 5 percent (Rajkotia 2006).

⁸ Legislation too early in the CBHF development process (e.g., before the phase of experimentation and lesson learning is complete) could unnecessarily cut off some options and codify suboptimal approaches.

As a final step, countries need to formulate an overall vision for health financing that recognizes the limits of CBHF and pairs it with complementary strategies such as performance-based contracting with providers, SHI for formal sector populations, targeted subsidies, and no-charge preventive services. Donors can play a particularly important role in facilitating the development and articulation of a comprehensive and equitable health financing policy. (This primer on CBHF does not attempt to address comprehensive health financing approaches.)

Intervention mechanisms for the scale-up process

No country has scaled up CBHF schemes using a single intervention strategy. Typically, scale-up demands a package of several intervention mechanisms – legislation, system development, financing, partnership building, etc. and patterns of interaction among actors at different levels. Similarly, no country has replicated the identical scale-up package of interventions of another country. Differences lie in the mix of interventions, the sequencing of interventions, and the respective roles of central and local actors.

Five mechanisms for inclusion in intervention packages are discussed below. Packages can be classified as having a **directive approach** or an **enabling approach**.

Under the directive approach, the package of scale-up interventions provides existing and/or new organizations at the central and local levels with the legal capacity to act on behalf of well-defined target populations. Legitimacy provided by law and the state apparatus is the key ingredient and the first step toward scale-up. Other modes of interventions follow from the law: financing mechanisms, marketing and sensitization, systems development, and training and other capacity-strengthening interventions. Because central actors play a key role in the design of health insurance schemes, the decision-space left for local actors tends to be narrow and community participation recedes as a key feature. Ghana's National Health Insurance Act of 2003 provides an example of the directive approach.

Under the enabling approach, the package of scale-up interventions creates a learning environment where capacity is built through a scheme's own experiences and those of its peer schemes, as well as trial-and-error processes. The formation of local networks (federations and unions) is promoted so that: (i) peer-based learning and the exchange of information services are closer to CBHF schemes and communities, and (ii) CBHF schemes can pool their resources to build their own support systems and defend their shared interests. There is no need to enact specific legislation for CBHF, because the existing framework that governs associative organizations provides a legal base for CBHF. Debates about legislative intervention are oriented toward providing legal capacity to CBHF schemes and protection to their members. Because CBHF schemes remain under the ownership of their members, legislative interventions tend to empower citizens and not state or local government agencies: communities and socioprofessional organizations retain responsibility for scheme development. The linkages and relationship between CBHF schemes and formal health financing institutions, however, are still being debated under this approach. Senegal and Benin provide examples of this approach.

The Rwanda experience with the development of CBHF schemes falls between these two approaches. Indeed, its key characteristic is the tension between the legacy of directive state intervention and the empowerment principles that underlie rebuilding efforts and the decentralization and democratization reforms that have taken place since the genocide of 1994. Rwanda's success may be explained by its middle-of-the-road course of action, where the state recognizes its responsibility in the development of CBHF schemes, but actors and promoters of CBHF schemes maintain the balance between a top-down approach of state intervention and a bottom-up approach of rooting schemes in community organizations and initiatives. Under this course of action, the pilot experiment implemented in Rwanda is a model of CBHF design that fits the country's social context as well as the roles of the different actors (central versus local actors, public authorities versus private and community actors) that develop and manage CBHF schemes.

Mechanism 1. Developing a supportive environment for CBHF

Even in countries where CBHF schemes have multiplied on their own, concrete actions to develop a supportive environment for CBHF can go a long way toward creating conditions for broader scale-up. Governments (national and local) can act in this regard in numerous ways. For example, the Ministry of Health can play an advocacy role by having its personnel participate in inaugurating new CBHF schemes and participating in their general assembly meetings; it can make supportive statements in national addresses about CBHF⁹ and the importance of CBHF in poverty reduction. It can take action to build capacity and promote exchange by producing and disseminating management tools to schemes free-of-charge; by organizing study tours among schemes in the country to demonstrate best practices and problems; by holding periodic workshops to share techniques for monitoring and evaluating CBHF schemes; by sponsoring radio spots explaining their benefits; or by producing tools, brochures, etc. for sensitization campaigns.

Similarly, the Ministry of Local Government can advocate for the development and support of CBHF schemes during meetings of mayors and other locally elected officials; encourage districts and towns to mobilize their populations to join a CBHF scheme and to monitor the activities of health centers contracting with schemes or make promoting CBHF schemes a performance evaluation criterion for decentralized government bodies (see Box 1).

Another element of a supportive environment is the availability of technical assistance. Most new CBHF schemes need technical assistance at least during their initial phases. As demand for schemes increases, the need for technical assistance grows, and it becomes essential to establish and institutionalize local capacity to support communities in launching CBHF schemes.

Box 1. The effects of local partnerships on CBHF growth in Rwanda

The involvement of the Ministry of Local Government, community development, and local affairs at the provincial and district level to launch CBHF schemes had a catalytic effect on scheme development in Rwanda. District mayors took responsibility for the mobilization and sensitization of the population to join CBHF schemes. This had an immediate impact, given that the mayors had existing, well-organized channels to deliver important messages, and they had a certain “moral authority” with the target population. Moreover, district authorities were already in regular contact with the population through the exercise of their duties, i.e., through community meetings, promotion activities, and administrative functions. Bringing together community members, health care providers, and districts in setting up schemes makes the schemes more efficient and sustainable. As a result, new schemes today begin with a coverage rate of about 40 percent of their target population (Ndahinyuka 2004).

Such local capacity may be established in nongovernmental bodies (such as the GRAIM [*Groupe de recherche et d’appui aux initiatives mutuelistes*] in Senegal) or as branches of government (such as the regional health insurance offices established in Ghana). Box 2 provides an example from Benin.

Box 2. Building a supportive environment in Benin

In Benin, several “municipal support committees” for CBHF schemes have been created. Their objective is to support the development of CBHF schemes in their municipalities, to provide assistance, and to ensure scheme sustainability. The mayor serves as president of each committee, and members include health providers and leaders of important community organizations and associations. Examples of the support these committees provide are: social mobilization and sensitization activities, appointing an employee of the municipality to provide technical and administrative support to CBHF scheme management, and mediation and problem resolution between schemes and health care providers.

Another way to create a supportive environment is to facilitate synergies between CBHF schemes and other community organizations to enhance sustainability. Mutually reinforcing partnerships can be built between CBHF schemes, and, for example, microfinance

⁹ In Rwanda, President Kagame mentioned CBHF in his annual national development speech.

institutions; Box 3 describes an example from Rwanda. Partnerships with charitable organizations, for example, can both provide effective coverage for target populations while simultaneously enlarging CBHF schemes' risk pools, making them stronger and more sustainable. Often government is particularly well positioned to facilitate such linkages and institutionalize coordination.

Box 3. Promoting synergies in Rwanda

In the Bungwe district, community bank (*banque populaire*) and local government officials devised an innovative scheme to address the financial constraints to CBHF scheme membership. Traditionally, loans were made primarily for agricultural investments – purchasing animals, land, or equipment. In this case, associations of community members received loans to facilitate their annual membership contribution to the CBHF scheme. The mayor himself carried out an information campaign to explain the system to the community, many members of which had previously not joined because of difficulty in generating the money necessary to pay in one installment. The loan requests were guaranteed by district officials, which had the double effect of building confidence at the community bank, and of ensuring that the community associations would regularly repay their loans.

Removing barriers to CBHF development is often an overlooked, yet easy way to create a more supportive environment. As CBHF schemes are a relatively recent phenomenon, they may be subject to constraining regulations or requirements that often are based on external models¹⁰ and out of step with present knowledge and realities. In Mali today, for example, there is consensus among stakeholders that the 10-year-old law concerning CBHF schemes needs updating to reflect experience and to play a more constructive, dynamic role in CBHF development.

¹⁰ CBHF-like schemes have a long history in Europe. It is important to import these models to Africa judiciously, adapting them to local conditions, not adopting them wholesale without prior analysis of the appropriateness of all features.

Mechanism 2. Using a pilot phase to prepare for national scale-up

Perhaps the most successful scale-up of CBHF in sub-Saharan Africa has taken place in Rwanda. A country with little experience of CBHF in the late 1990s, Rwanda opted for a pilot phase to test the effectiveness of CBHF in meeting health sector objectives, and to systematically build the capacity to put in place, operate, and support CBHF schemes following the pilot phase. Rwanda's success indicates that a pilot phase for CBHF can be an effective strategy for scale-up.

A pilot phase intended to prepare for scale-up requires a high level of initiative and commitment from the national level, where there is consensus that CBHF represents an important possible solution to problems of health financing and access to care. Moreover, a pilot phase is a resource-intensive approach that generally requires the financial participation of development partners. A pilot phase, however, is an ideal setting to introduce many of the approaches discussed in this primer, build experience and capacity, and then make any adaptations necessary before rolling out CBHF on a large scale. It can ensure a higher probability of success because major problems can be identified and resolved during the pilot process. As a result, "shortcuts" can be taken when rolling out new CBHF schemes by adapting the pilot scheme model(s) to local conditions and making changes where necessary, for example in the organizational structure, the benefits package, or the modalities of member contributions and registration. The design, experience, and results of the Rwanda experience are well documented,¹¹ and summarized in Box 4.

¹¹ See especially Gamble Kelley et al. (2006) and Schneider et al. (March 2001).

Box 4. The pilot phase in Rwanda – progress towards scale-up

Pilot phase and subsequent adaptation 1999-2004

- ▲ 54 CBHF schemes created in three districts
- ▲ Three federations of CBHF schemes put in place
- ▲ Registration of 10% of target population (90,000) during year 1
- ▲ Routine statistical data and household surveys showed clear improvement in members' financial access to health care (they used modern health services four times more than non-members)
- ▲ 18-month pilot phase, followed by 24 months of adaptation
- ▲ National strategic plan put in place
- ▲ Extensive local partnerships developed with community banks, locally elected leaders, etc.

* Butera (2005)

Scale-up 2005-present

- ▲ 224 CBHF schemes in place covering 3,073,508 people* across all districts in Rwanda (2005)
- ▲ Approximately 40% of Rwanda's total population covered
- ▲ In the midst of a national three-year scale-up plan (2005-2007)
- ▲ Legislation on CBHF submitted to Parliament for approval

Mechanism 3. Launching networks of CBHF schemes

Launching a CBHF scheme is a process that requires time and resources (Bennett et al. 2004). Traditionally, CBHF schemes came to life one by one, and the fact that the launch process had to be repeated each time contributed to the slow pace of expansion. Now, experience in several countries (Rwanda, Benin, etc.) that wished to rapidly increase the number of CBHF schemes has proven the benefits of creating multiple schemes simultaneously. The concept is that a number of schemes are launched at the same time, in a single geographic area (such as a municipality or a health district). The start-up process – feasibility studies, training, sensitization of the population, the definition of the schemes' benefits package, amount and frequency of premiums, etc. – is done collectively, thereby creating efficiencies in an otherwise time-consuming and resource-intensive process. Equally important, this joint process tends to build coordination and communication as the CBHF schemes learn from one another, and share

best practices. The mechanism also creates, from the start, the basis for a network/federation of schemes that can enlarge the risk pool and therefore provides financial stability and the potential for covering larger financial risks, such as hospitalization. Such networks of schemes have other benefits, too, such as serving as a substantial negotiating force with partners in the community (like health care providers and locally elected leaders) and assuming certain functions such as promotional activities and monitoring and evaluation that are often beyond the capacity of any one scheme.

In countries that have undergone a process of decentralization, aligning new CBHF schemes with defined decentralized areas means that the basis for scale-up is clear. As a result, the process can move quickly, as it did in Rwanda, where CBHF schemes were rolled out in all districts within five years. Not only does the mechanism accelerate the development of CBHF schemes, it produces schemes that are stronger and more sustainable.

Mechanism 4. Developing a national strategic plan for CBHF

In order to move from a phase of experimentation to a concerted national strategy for eventual scale up, consensus on the strategic plan for the development of CBHF must be reached, and the government must assume an appropriate stewardship role.¹² Developing this national strategic plan ideally is a process that brings together stakeholders (see Box 5) to put in place an institutional framework to support the development of CBHF with specific, strategic objectives and interventions that are directly linked to overall health sector and poverty reduction goals. Its intention is to integrate CBHF as part of a broader health financing strategy, so that a country can build a coherent strategy toward universal coverage. Box 6 describes the results in Senegal.

Box 5. CBHF stakeholders

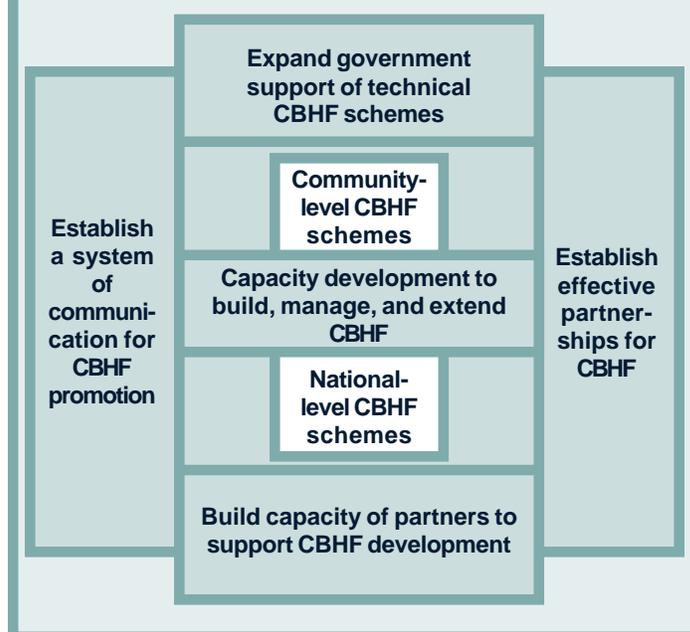
- ▲ CBHF scheme managers
- ▲ Federations of CBHF schemes
- ▲ Health care providers under contract with schemes
- ▲ Promoters and supporters of CBHF schemes (religious organizations, associations, NGOs, development partners)
- ▲ Administrative regions and districts
- ▲ Representatives from the presidency and the prime minister's office
- ▲ Ministries of health, of finance, of social affairs, and of local government, among others

The process of developing a national strategic plan builds the basis for coordination. It usually begins with a situation analysis and an exchange among stakeholders of information and experiences to date with CBHF. This process helps to shape priorities and strategies and eventually, to build consensus and establish a shared vision for CBHF. The shared vision, in turn, facilitates the financing of CBHF by government and other stakeholders. As a result, those providing resources (technical and financial) can better coordinate their efforts, which enables practical and realistic planning

¹² *Appropriate stewardship includes facilitating, guiding, and enabling developments, such as CBHF, toward maximizing their contributions to national health goals and objectives in as "light-handed" a way possible.*

Box 6. National strategic plan for CBHF development in Senegal

The development of the national strategic plan for CBHF in Senegal is part of a wider effort to strengthen the health sector's contribution to poverty reduction strategies; thus the inclusion of CBHF promotion is a priority for the second phase of the National Plan for Social and Health Development and in the new National Poverty Reduction Strategy. It also gives the governmental agency responsible for CBHF (now directly linked to Minister of Health's cabinet) an important advocacy tool for the development of CBHF. From a financial perspective, the plan enabled the government, as well as development partners, to show their commitment to the development of CBHF by pledging more than \$8 million over five years to support the five strategic areas of the plan (depicted below). This budget enabled each region of Senegal to develop an operational plan for the development of CBHF, thus beginning a systematic roll-out.



at the operational level. Establishing a national strategic plan for the development of CBHF is a good precursor to legislation because it provides a forum for analyzing a country's experience and distilling important strengths, weaknesses, and lessons about CBHF before putting in place a formal legal context. The process of developing a strategic plan for the development of CBHF also facilitates a larger discussion of its links to other aspects of health financing and poverty reduction policies, thereby integrating CBHF into a larger policy processes.

Mechanism 5. Scaling up through legislation

Legislation is an obvious instrument for any government wishing to accomplish a policy objective. In the case of CBHF, however, legislation has proved tricky, and has not always had the desired effects. Because government involvement with CBHF in West and Central Africa is so recent, and because the CBHF movement itself is quite young, policymakers are not always equipped with adequate information to craft appropriate legislation. Still, governments are formally seeking to develop specific legislation for CBHF development across West and Central Africa: efforts are underway in Benin, Burkina Faso, Ivory Coast, Guinea, Guinea Bissau, Niger, Senegal, and Togo.¹³ To date, Mali and Ghana have put legislation for CBHF in place, with different results.

Mali was the earliest, and until recently the only, sub-Saharan African country to have a specific law for CBHF schemes. Interestingly, the 1996 Malian legislation was passed before many CBHF schemes existed in Mali and was not intended as a mechanism for scale-up as such. At the time, there were several large, national-level mutuelles (e.g., *Mutuelle des Travailleurs de l'Education et de la Culture*, or MUTEK) but very few community-based schemes. The legislation detailed financial set-up and management practices, outlined the governing texts for CBHF schemes and for federations of schemes, established a process for registration of new schemes, and put the State in a regulatory role. This policy environment, built on urban-based and socioprofessional organizations, was not appropriate for replication on a large scale in a country where the majority of the population is employed in the informal and rural sectors, and it did not support the development and experimentation of other CBHF models. At a workshop held in late 2005, almost ten years after its inception, stakeholders in Mali, including the Ministry of Social Development (with oversight responsibility for CBHF), CBHF schemes themselves,

and their promoters (led by ILO/STEP) agreed that while the legislation was passed with the intention of protecting consumers, its detailed and often onerous nature has hampered CBHF development and needs to be revised to better reflect the realities of CBHF in Mali and facilitate the expansion of CBHF schemes.

Ghana also chose to legislate relatively early in the development of the CBHF movement. In 2002, there were 47 CBHF schemes in Ghana, most of them relatively new or having only a handful of members – with notable, and well-known exceptions such as the Nkoranza scheme (Atim and Sock 2000). The Ghanaian legislation was expedited by an election promise to abolish user fees at public facilities (so-called “cash and carry”). The National Health Insurance Act 650 was passed in 2003, requiring the establishment of district-wide health insurance schemes (DHIS) as part of the new national health insurance scheme (NHIS). At the time the Health Insurance Act was passed, there were at least 160 CBHF schemes in Ghana and their number was increasing rapidly, yet population coverage remained low. The objective of the Act was to assure equitable and universal access for all its residents, replacing fee-for-service with a prepayment mechanism. It placed a 2.5 percent tax on goods to help support the initiative and also re-directed 2.5 percent of formal sector workers’ salaries to the newly formed Health Insurance Council. The Act also provided broad ranging regulatory powers to government – specifically the Health Insurance Council, decreeing a standardized benefit package, and a set premium for all schemes. In the medium term (within the first ten years), the stated objective was to cover at least 50-60 percent of Ghanaians through DHIS. Curiously, the legislation did not build on existing community-based schemes, which were a majority of schemes existing at the time of legislation. Many schemes have since collapsed, as the NHIS set conditions for them that most could not meet, such as payment of a US\$ 1,000 registration fee, as well as a US\$ 615,000 reserve deposit.

¹³ ILO/STEP began an initiative in 2005 to help develop a supportive legislative framework for the development of CBHF in the West African Monetary Union zone (UMEOA).

¹⁴ It is uncertain whether the premium aligns with the cost of the benefits package.

As of early 2006, DHIS were operational in 89 percent of districts with 18 percent of the population registered (however, 70 percent of those registered were exempted populations paying no premium – including the poor, those under 18, and the elderly). Uptake was especially rapid in rural districts, but quite slow in urban areas (2 percent). The target registration rate for 2006 is 45 percent of the population. The benefit package, much more extensive than those of community-based schemes, was set nationally, as were premium rates (72,000 cedis per adult (<US\$ 8); or 144,000 (<US\$ 16) for an entire household) and co-payment rates.¹⁴ This standardization across all districts has caused controversy. In some more affluent districts, communities can afford to pay more than the fixed premiums. Some scheme managers in these areas wish that they could raise premiums, because they are concerned that the fixed premium will not cover the costs of the services specified in the benefit package. Early evidence of dramatic increases in utilization among DHIS members gives further credence to this concern. (Sulzbach et al. 2005). Elsewhere, for example in poorer northern areas, the price of the benefit package appears beyond the reach of some households and some schemes have flouted the law by setting lower premiums to ensure that they achieve a reasonable level of membership. Of course, these schemes also might have difficulty in meeting the cost of the benefits covered.

An early evaluation of the effects of the Health Insurance Act indicates that among never-enrolled and formerly enrolled households, premium rates are cited as a significant reason for lack of membership, suggesting that poorer households are less likely to join the DHIS. However, the same study explains that large families would benefit from the DHIS structure, as the maximum household premium is 144,000 cedis and the benefits package covered is extensive (Sulzbach et al. 2005).

While it is too early to draw conclusions about the legislation's effect on scale-up, important lessons can be drawn from the Ghana experience about managing the process of implementing legislation for CBHF.¹⁵ One major lesson is the importance of engaging all stakeholders in the process to build consensus and trust and to maximize information exchange so that existing CBHF experience is taken into account. Because of the political nature and the pressured timetable for legislation in Ghana (due to approaching elections), the process was criticized as being exclusive and highly politicized. A clear institutional framework did not exist. As a result, many primary stakeholders were not “on-board” at the time of the legislation, creating avoidable difficulties for the subsequent roll-out.

A second major lesson is the importance of a realistic timetable that focuses on creating well-structured national and local institutions for insurance (such as the National Health Insurance Council, National Health Insurance Fund, and the District Health Insurance Committee), building the essential technical and financial capacity within these new structures, and working out common implementation glitches before full roll-out. Early evidence from implementation experience in Ghana shows several common problems of adverse selection, slow claims management, and drug stockouts (Sulzbach et al. 2005, Rajkotia 2006). While many such issues may be easily resolved, not investing adequate time at the start can mean implementation delays later or, worse, replication of avoidable design and implementation flaws.

A third lesson, in contexts where CBHF schemes exist prior to efforts to legislate, is the importance of anticipating a transition. Prior to the National Health Insurance Law, there was an array of different CBHF schemes on the ground. This “experimentation phase” was cut off abruptly by the passage of the law, as most existing schemes soon collapsed. This represents a

¹⁵ *The report, Institutional Aspects of Scaling Up Community-Based Health Insurance: The Case of Ghana (Baffoe-Twum and Apong 2004) provides a detailed look at the Ghana experience of legislating scale up.*

Box 7. The Thai experience with CBHF

Thailand has a longer history of establishment of CBHF-type schemes than the other countries considered here – but one where legislation came after years of experimentation. The Thai Community Health Card Schemes started in the 1970s with a focus on promoting community involvement in primary care, but by 1987 it was clear that communities were more interested in the schemes as a potential risk-pooling tool. As the government had not yet passed legislation regarding the schemes, it was able to dramatically change direction and re-launch the schemes. They were marketed as health insurance mechanisms for those in informal sector employment. In 1994 government agreed to subsidize health cards – matching the premiums paid by households. In 1995 certain restrictions were imposed upon fund management and national-level pooling of risk (2.5 percent of revenues) was initiated. Finally, the 2001 Universal Coverage policy further removed financial barriers to seeking care – although at the same time it effectively closed down the CBHF schemes. A standard 30 baht co-payment was established for all health services, with the majority of health funding coming from tax financing.

missed opportunity for the government in several ways: to evaluate and take lessons from different models of CBHF schemes (something not formally done prior to drawing up and enacting the legislation), and to devise a realistic transition strategy that would capitalize on the positives of the existing community-based schemes (community participation, interest, initiative, and experience) as they were folded into the new DHIS.

Finally, it may be a mistake to design a “one-size-fits-all” national CBHF scheme given important differences (socioeconomic, ethnic, religious) among regions within a single country. In Ghana, where one model is being applied universally, there are some parts of the country wanting to charge lower premiums, while others are willing to pay more. In surrounding countries, there is a panoply of different benefits packages, co-payments, and premiums based on local priorities, economic cycles (such as harvests), and ability to pay.

Given the extension of CBHF in countries like Thailand (see Box 7) and Rwanda where there was no legislation, it is clear that legislation is not essential for scaling up. Indeed, experience in other countries like Mali indicates that premature legislation may impede

scale-up, and certainly does not on its own accomplish scale-up. Legislation is a complex mechanism that requires intensive effort at capacity and consensus building, not to mention unwavering support by the government. Governments need an overarching health financing vision as well as significant capacity and expertise in the area of health insurance to be able both to develop and implement health insurance legislation.

What lessons have been learned about scaling-up CBHF schemes?

The macroeconomic circumstances of most sub-Saharan African countries, and in particular the limited engagement in formal sector employment and limited access to cash on the part of much of the population, mean that for the near future, CBHF is a viable and promising approach to provide insurance coverage for these segments of the population. Expectations about the extent to which CBHF schemes can address health financing problems in sub-Saharan Africa need to be realistic, as even in the countries that have experienced substantial success in scaling up CBHF schemes, the schemes cover at most half the population and account for a fraction of total health expenditure. In the medium and long term, CBHF should be one of a number of components to a broader health financing policy that aspire to universal health care coverage. Today, however, CBHF schemes play an important role in removing financial barriers to health care in the region, especially for rural and informal sector populations where health issues usually are of the greatest importance.

This primer has considered a number of approaches that governments and their development partners are using to scale up CBHF schemes. Some key lessons emerge from this discussion:

- ▲ Scaling up CBHF is an inherently political, as well as technical enterprise.
- ▲ CBHF is an effective strategy to cover a significant portion of the population in countries with large rural and informal sectors relatively quickly when compared to SHI (or as part of a transition to universal coverage through SHI).

- ▲ A supportive environment where partners (local and national government, providers, financial institutions, etc.) are engaged in the development of CBHF is key to successful expansion.
- ▲ When a pilot phase for developing CBHF is combined with political will, it has proven effective at both building requisite capacity and at scaling up CBHF relatively quickly.
- ▲ Developing CBHF by launching networks of CBHF schemes reinforces geographic coverage, coordination, and financial sustainability.
- ▲ The process of developing a strategic plan for CBHF sets a clear institutional framework for scale-up, creates a useful advocacy tool, and adopts mechanisms for the financial and technical coordination of all CBHF partners and promoters. It also puts government in a strategic leadership role and situates CBHF in a larger health and poverty reduction policy context.
- ▲ Legislation is not a necessary prerequisite for scaling up CBHF schemes, although in some contexts it may be a political imperative. It may be desirable to postpone passing legislation until a significant body of experience is accumulated in order to avoid fixing in stone one CBHF strategy. In many sub-Saharan African countries, sufficient legislation exists to serve as the basis for establishing CBHF schemes.

Evolutionary paths to full insurance coverage are likely to differ across countries. CBHF schemes may play an important role, particularly in low-income countries, in extending health insurance to a critical segment of the population. There is much that governments and donors can do to encourage development and scale-up of CBHF. However, all parties should be aware that this is an evolutionary process and thus necessitates sufficient flexibility in policy to learn from experience and adapt strategy in order to achieve the end goal – universal coverage for all.

“Mutuelles de santé mean that poverty is not a barrier to access to health care”

President, rural CBHF scheme, Senegal

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