

**H**elping households manage the risks they face is important in reducing poverty in developing countries. All households face health risks, and when health shocks occur, they have a severe impact on people's livelihoods. High costs of treatment are often exacerbated by reduced income due to ill health. In some cases, people must also sell productive assets to pay for medical care. An estimated 1.3 billion people lack access to effective and affordable healthcare. Publicly funded healthcare, in its current form, is an inadequate mechanism for reaching the poor in many countries, in part because most states have limited health budgets. In two-thirds of all low-income countries, one-third of total health expenditures come directly from patients. Although developing countries bear 93 percent of the world's disease burden, people in most of these countries still have few options for insuring against health risks. The disease burden is highly concentrated in low-income groups, and most households have little disposable income to spend on healthcare coverage. Institutional innovations in recent years have begun to address issues of coping with health risks and financing healthcare.

### Innovations in health insurance

Several developments have helped make private health insurance an increasingly viable option: microfinance institutions (MFIs) have started to expand their financial services to include health and life insurance products; health sector reform and decentralization in many countries have led to policies favorable to private health insurance; and poor people have become more aware of the importance of health security to their economic and social prospects. In spite of the many complicating factors, private insurance companies are beginning to offer innovative solutions for making private health insurance available to the poor.

One innovative model takes advantage of existing MFIs in the low-income market and adds insurance products to their existing credit and savings activities. These insurance products, often called microinsurance, are simple with low benefits and low premiums. In this partner-agent model, the MFI collects information from its clients to create products that best satisfy their clients' needs and then identifies an insurer who can provide these products. The MFIs provide connections to the low-income market, applicable market information on their clients, and a delivery channel for insurance products; the commercial insurers provide expertise and absorb the insurance risk of the products. An estimated 15 million low-income people are currently covered by some insurance product sold through partnerships with MFIs, and this model shows significant potential for expansion.

### Community-based health insurance

Another area of innovation has taken place outside the public sector, and the rest of this brief will look at these community-based models. Community-based health insurance (CBHI) has demonstrated promising results for poverty reduction. A CBHI scheme is essentially any program run by a community-based organization that pools risk to cover healthcare costs. Such schemes are well positioned

to monitor behavior and enforce contracts while at the same time reaching clients overlooked by many formal insurance schemes. CBHI schemes have the potential to solve many of the problems associated with insuring the poor. They reduce adverse selection by grouping people together with varying levels of risk and insuring them as a group. Their lower retail costs (compared with schemes that insure individual members) allow insurance to be provided more cheaply. In addition, community-based organizations are better placed to monitor members effectively.

Most CBHI initiatives have been started by health providers themselves, and in addition to mobilizing resources to address health risks, CBHI may also help improve the quality of healthcare services. These insurance schemes can be an important tool for protecting low-income populations from falling into poverty as a result of their health expenditures, effectively reaching poorer households who would otherwise have no way to cope with this risk. CBHI schemes do have some disadvantages compared with traditional insurance mechanisms, however, including their small size, limited technical and managerial skills, and the quality and accessibility of service providers. Their small risk pools and dependence on subsidies also cause some concern for the sustainability of CBHI schemes. In addition, despite being better positioned to reach poor rural households than most market-based insurance mechanisms, they are still often unable to reach the poorest groups because of the costs of premiums.

### Impact of community-based health insurance schemes

Existing impact evaluations have been limited in scope, and few have addressed the effects of CBHI schemes on their members. In Senegal, household survey data were used to determine the impacts of membership in CBHI schemes on both healthcare use and financial protection. The study found that despite limitations in service provision (only hospitalization was included), the mutual organizations did have some impact on their members. Overall, 151 people out of 2,856 surveyed had been in the hospital in the previous two years, and members were 2 percentage points more likely to go to a hospital. The study also found evidence of improved access to healthcare as well as financial protection. In cases of hospitalization, members paid on average less than half the amount paid by nonmembers, showing that the mutual organizations do provide financial protection against hospitalization risk.

More research is needed, however, on the overall impact of CBHI schemes on poverty. Most CBHI schemes seem to have a pro-poor impact on their members, but only on a limited scale. Approximately 70 percent of households in the area were members of one of these mutual organizations, but not all members of each household were insured. Because of the cost of participation, chronically poor households are generally excluded from these CBHI schemes. To reach the poorest segment of the population, the cost of participation would have to be lowered through public subsidies or some other mechanism.

## Lessons learned

A 2005 review of case studies on community financing schemes in India, Rwanda, Senegal, and Thailand (see "For further reading") draws the following lessons from their successes and failures:

1. The existence of viable healthcare providers is essential for mobilizing demand. Without high-quality services, people were unwilling to pay premiums. As illustrated in the case of Senegal (see Box 1), it is unlikely that the mutual organizations would have achieved the same level of success without the logistical, administrative, and financial support of the participating hospital.
2. Demand for health insurance is another crucial factor. Socioeconomic and cultural characteristics play an important role in whether people decide to purchase health insurance. Existing perceptions of illness and insurance may determine how effective these schemes are. Education might be necessary, especially when starting an insurance scheme in areas where little is known or negative impressions are held regarding healthcare, government provision of services, or insurance in general.
3. Community financing schemes perform better when they are linked to organizations with experience in financial service provision and social protection, such as microfinance institutions. Microfinance institutions offer connections to community members as well as delivery channels for insurance products.
4. Flexibility in payment options is important. In Rwanda, groups set up a system where households used a savings and loan association to save enough money to join a prepayment insurance scheme. Religious and other charitable organizations in both Rwanda and Senegal also made contributions for people who would otherwise be excluded from participation, while other groups established lotteries and started collective activities to earn money to pay for membership fees.
5. People who are struggling daily for survival are unlikely to pay insurance premiums in advance for possible use in the future. In Senegal, the mutual organizations often excluded the poorest households in communities simply because they cannot afford insurance. If most households in an area are too poor to pay premiums or if accessibility to healthcare services in the area is low to begin with, other social protection measures may be more appropriate.

## Conclusion

States can improve social risk management and reduce poverty by promoting institutional innovations like community financing schemes and partner-agent models. Community financing schemes may help overcome some of the challenges facing traditional insurance providers by reducing transaction costs while addressing financing and service provision issues.

## Box 1—Case study in Senegal

The Thies region of Senegal is characterized by a high incidence of poverty, malnutrition, poor health conditions, and health services that excluded much of the population. Households facing illness have often had to sell assets and borrow money to pay for treatment. Since 1990, though, the region has been home to CBHI schemes that involve contracts between a nonprofit healthcare provider, a Catholic-run hospital, and mutual health organizations, which developed out of existing self-help groups in rural areas. These CBHI schemes are community based with voluntary membership, and most cover only hospitalization, leaving high-frequency, low-cost events to be covered by the households. Members purchase a membership card and pay monthly premiums to receive their allotted benefits. Because these groups have contracts with one particular hospital, members receive up to a 50 percent discount for treatment, and the arrangement thus reduces overall healthcare costs.

Capacity building is key. Without the necessary skills and knowledge of insurance concepts among both recipients of healthcare services and those managing these insurance schemes, success is unlikely.

In designing insurance products, it can be helpful to take into account existing risk-sharing arrangements. It would be costly to design a product that would pay out for low-cost, high-frequency events, but in many communities, people manage these occurrences through traditional mechanisms. The CBHI schemes in Senegal, for example, focused insurance efforts solely on hospitalization because the existing informal risk management mechanisms (extended family and other social networks) were already in place to deal with these low-cost occurrences.

Partnering with existing organizations—hospitals and healthcare providers or nonprofits and microfinance institutions providing financial services—is also important. These partnerships provide important connections to the community and can facilitate a process that best meets people's needs while including as many people as possible in coverage.

As policymakers decide how best to use their resources to mitigate healthcare risk, they must consider numerous policy challenges. CBHI schemes can be an important first step in ensuring better access to healthcare for the poor, but to reduce poverty, broader coverage and scaling up are essential. The question is how to scale up while maximizing benefits and overcoming the limitations of CBHI schemes. ■

**For further reading: J. Jütting, *Health Insurance for the Poor in Developing Countries* (Aldershot, UK: Ashgate, 2005).**

**Johannes Jütting** ([johannes.jutting@oecd.org](mailto:johannes.jutting@oecd.org)) is the head of the Poverty Reduction and Social Development unit of the Organization for Economic Cooperation and Development (OECD) Development Centre, Paris.



**International Food Policy Research Institute**

2033 K Street, NW • Washington, DC 20006-1002 • USA

Phone: +1-202-862-5600 • Skype: ifprihomeoffice • Fax: +1-202-467-4439 • Email: [ifpri@cgiar.org](mailto:ifpri@cgiar.org)

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