

Welcome to Session 9



Innovative Health Care Approaches

Organizer: Bryn Sakagawa

Panel: Mark Landry, Dr. Sara Bennett, and
Dr. Pia Schneider

Tuesday, August 24, 2004



Agenda

- Introductions/Overview (USAID)
- Presentations
 - “Improving Health Care Systems Using Geographic Information Systems (GIS)” **Mark Landry**, Abt Associates
 - “Scaling Up Community-Based Health Financing” **Sara Bennett** and **Pia Schneider**, Abt Associates
- Closing Remarks
- Q&As (please hold your questions to the end!)





Scaling Up Community Based Health Financing

Sara Bennett PhD and Pia Schneider PhD,
Abt Associates

USAID

August 24, 2004



The PHR*plus* Project is funded by U.S. Agency for International Development and implemented by: Abt Associates Inc. and partners, Development Associates, Inc.; Emory University Rollins School of Public Health; Philoxenia International Travel, Inc. Program for Appropriate Technology in Health; SAG Corp.; Social Sectors Development Strategies, Inc.; Training Resources Group; Tulane University School of Public Health and Tropical Medicine; University Research Co., LLC.

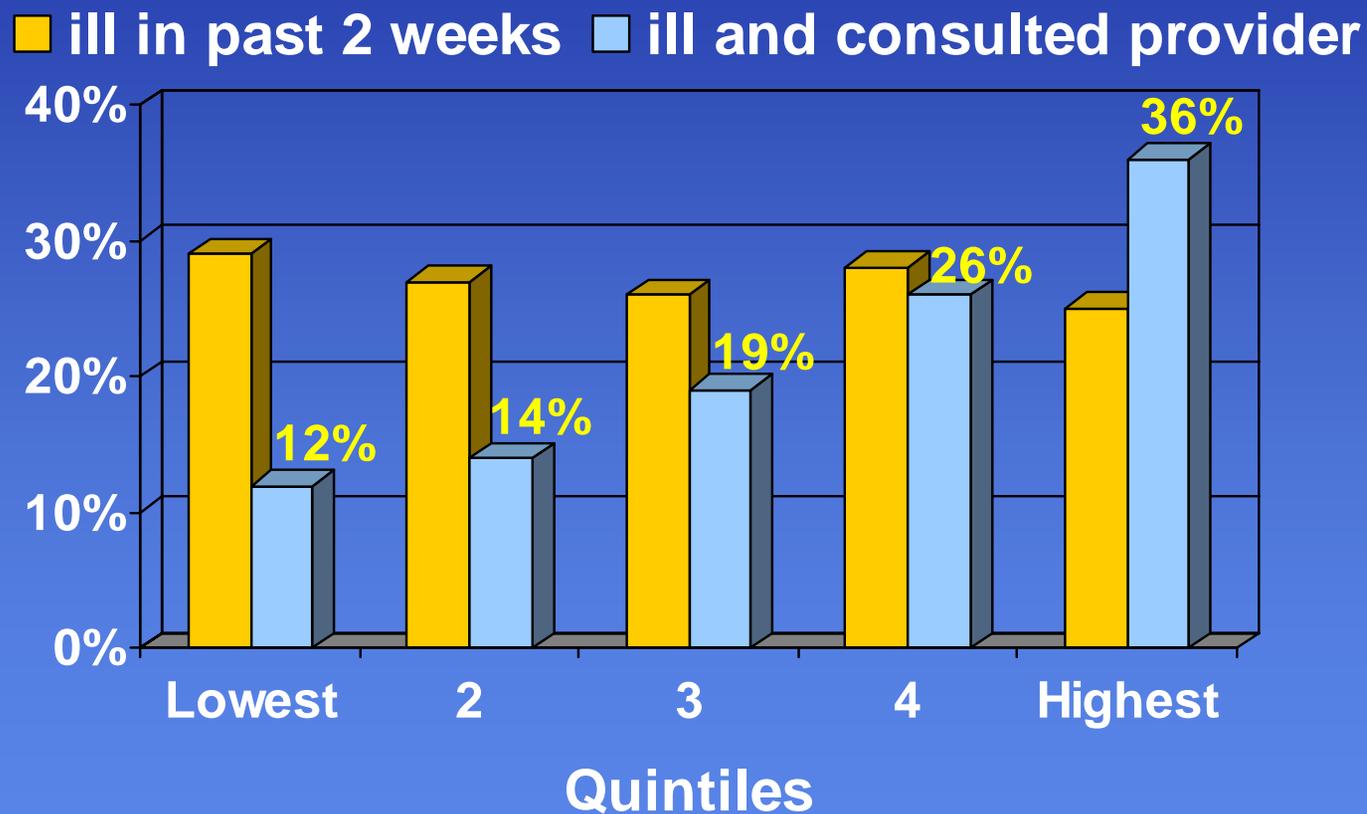


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Outline of Presentation

- ▲ **Why Scale up CBHF/MHO/mutuelles**
- ▲ **Approaches to Scaling up CBHF**
- ▲ **Country Experience**
 - ▲ Ghana
 - ▲ Rwanda
 - ▲ Philippines
- ▲ **Key Issues and Recommendations for Support**

User fees restrict access to care for low-income groups: Rwanda



Source: Household and Living Condition Survey 1999/2001

In response, people start CBHF schemes

Bottom-up approach:

- ▲ Driven by community or health facility
- ▲ Member governance
- ▲ Community participation in definition of benefit package and premium

▲ Preconditions:

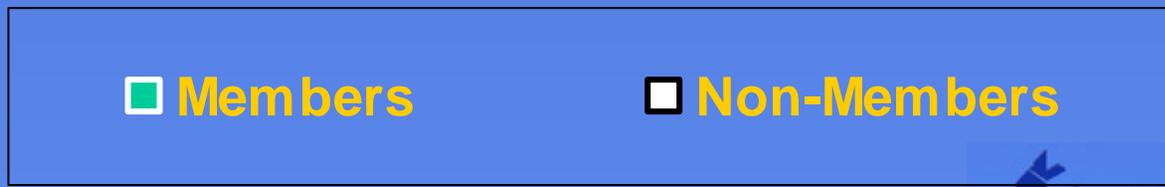
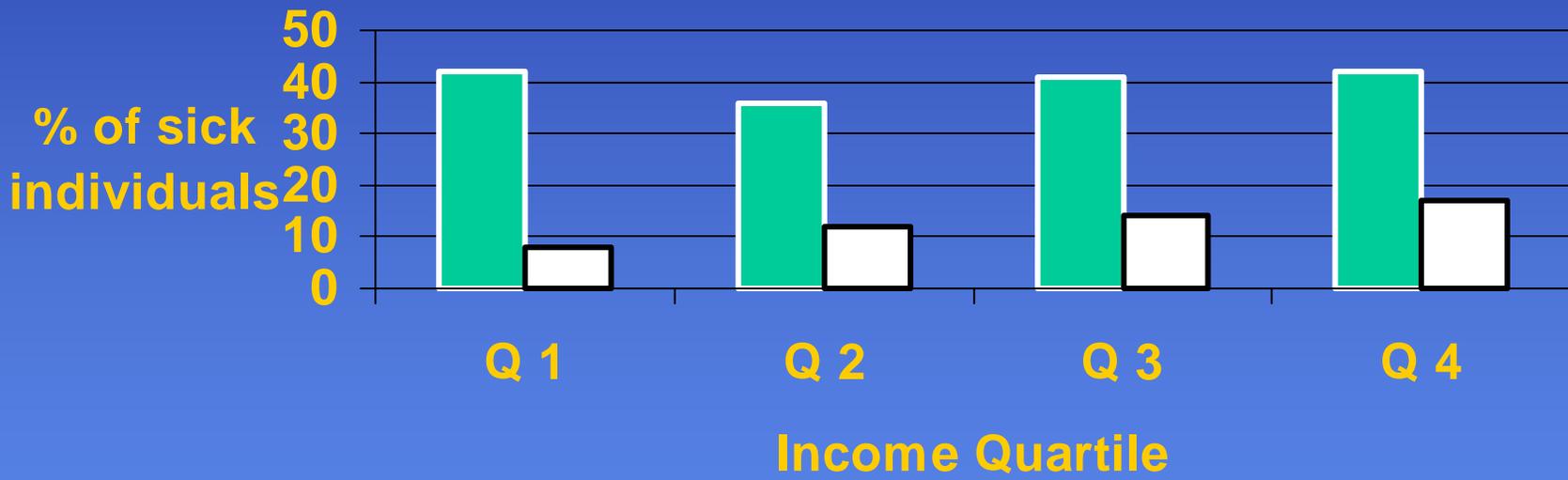
- ▲ Willingness to pay for health care
- ▲ Trust in CBHF scheme
- ▲ Providers offering quality care

▲ Advantages to the population

- ▲ Improved financial access to care when sick
- ▲ Protection against the catastrophic costs of illness
- ▲ Improved ability to plan household expenditures

CBHF Improves Equity in Access to Care in Rwanda

Probability of Service Use in Health Centers



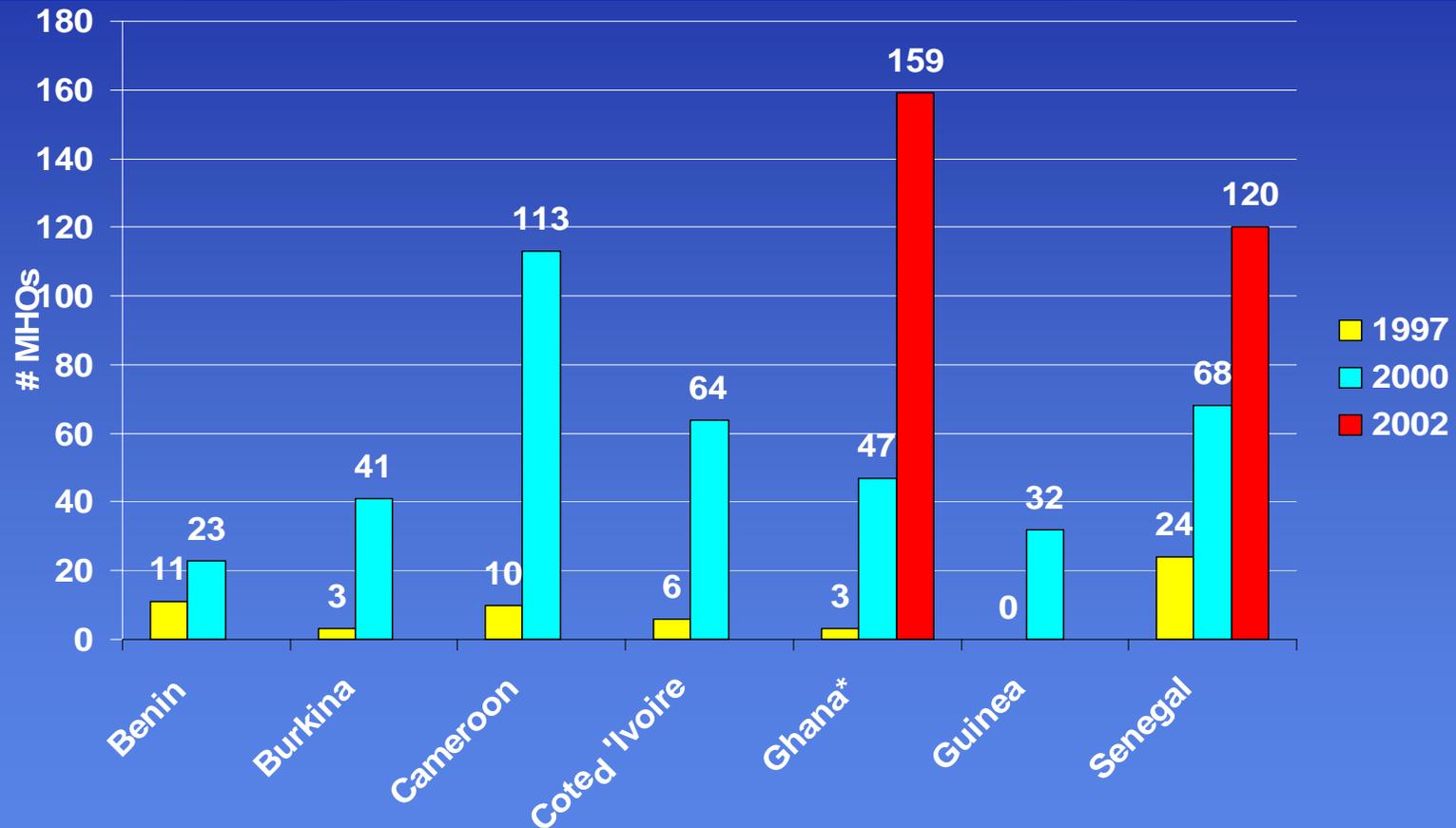
Source: hh-survey 

Also international support for CBHF schemes

“The Commission recommends that out-of-pocket expenditures in poor communities should increasingly be channeled into “community financing” schemes to help cover the costs of community-based health delivery.”

Report of the Commission on Macroeconomics and Health, WHO, 2001.

Leading to a growing number of CBHF schemes



*Ghana data is from '99, '01, '02

But still low membership....

- ▲ Few low income countries have greater than 1% of the population covered by CBHF schemes.

Key challenge – how to scale up such schemes

The process of scaling-up

GOVERNMENT ROLES

Establish institutional capacity to regulate, manage subsidies etc.

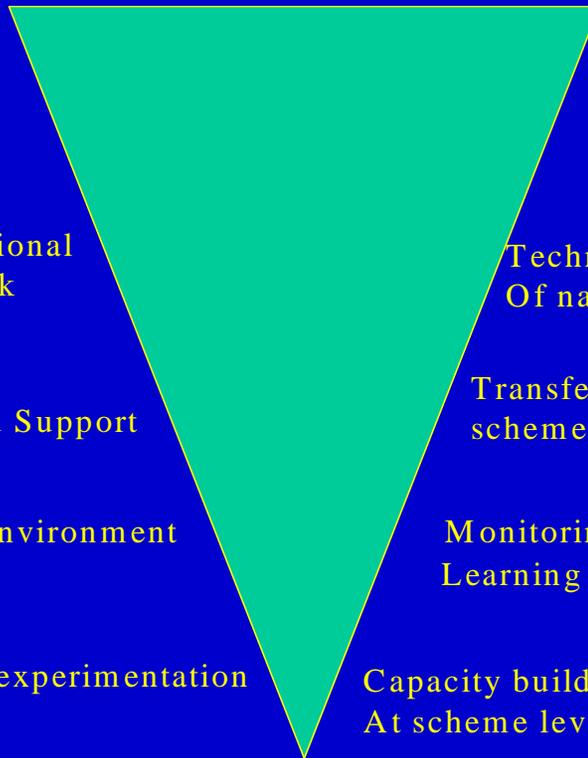
Development of national HI Policy framework

Institutionalized Support

Enabling environment

Small-scale experimentation

Universal Insurance Coverage



DONOR ROLES

TA for establishment of Reinsurance, regulation and Subsidy management.

Technical assistance to development Of national policy

Transfer TA for individual schemes to local institutions

Monitoring & evaluation – Learning from doing

Capacity building & technical support At scheme level

Dominance of out-of-pocket payments

Challenges in Scaling up

- ▲ To ensure equity between schemes, or regions or sub-groups of the population – need to adapt government subsidy patterns
- ▲ Preventing financial instability that may arise due to small scheme size and lack of reinsurance
- ▲ Ensuring that providers are equipped to work with schemes and can manage shifts in forms of payment
- ▲ Preventing the emergence of fraudulent schemes
- ▲ Maintaining the advantages of social solidarity within communities while going to scale

Ghana

The growth of CBHF schemes in Ghana

- ▲ In 2002, 159 schemes, but many still nascent, only about 12 functional & providing benefits
- ▲ Political pressure to drop “cash and carry” led to the National Health Insurance Act, August 2003
- ▲ All districts mandated to establish CBHF schemes by September 2004, and everyone to join.
- ▲ Funded by (i) sales tax, (ii) formal sector worker contributions and (iii) voluntary payments by informal sector workers

Challenges to Implementation

- ▲ Lack of prior local institutional capacity to support nationwide roll out – fraudulent consultants
- ▲ Break neck speed of implementation
- ▲ Lack of clarity about many aspects of implementation and communities concerned that “their” ownership of schemes will be taken away.
- ▲ Act requires accreditation of providers, establishment of reinsurance functions etc. that challenge local capacity
- ▲ Act mandates standardized national benefit package and premiums – that don’t respond to differences between localities

Lessons from Ghana

▲ Institutional Framework

- ▲ Established via Act very early – prematurely?

▲ Organizational Sustainability

- ▲ Scale up places heavy institutional burden –establish local institutional capacity prior to legislating.
- ▲ Importance of ongoing M&E – will the government be sufficiently flexibility to alter course if need be?

▲ Financial Sustainability

- ▲ Substantial government investment to launch schemes distorts incentives
- ▲ Is this level of funding sustainable?

▲ Provider performance

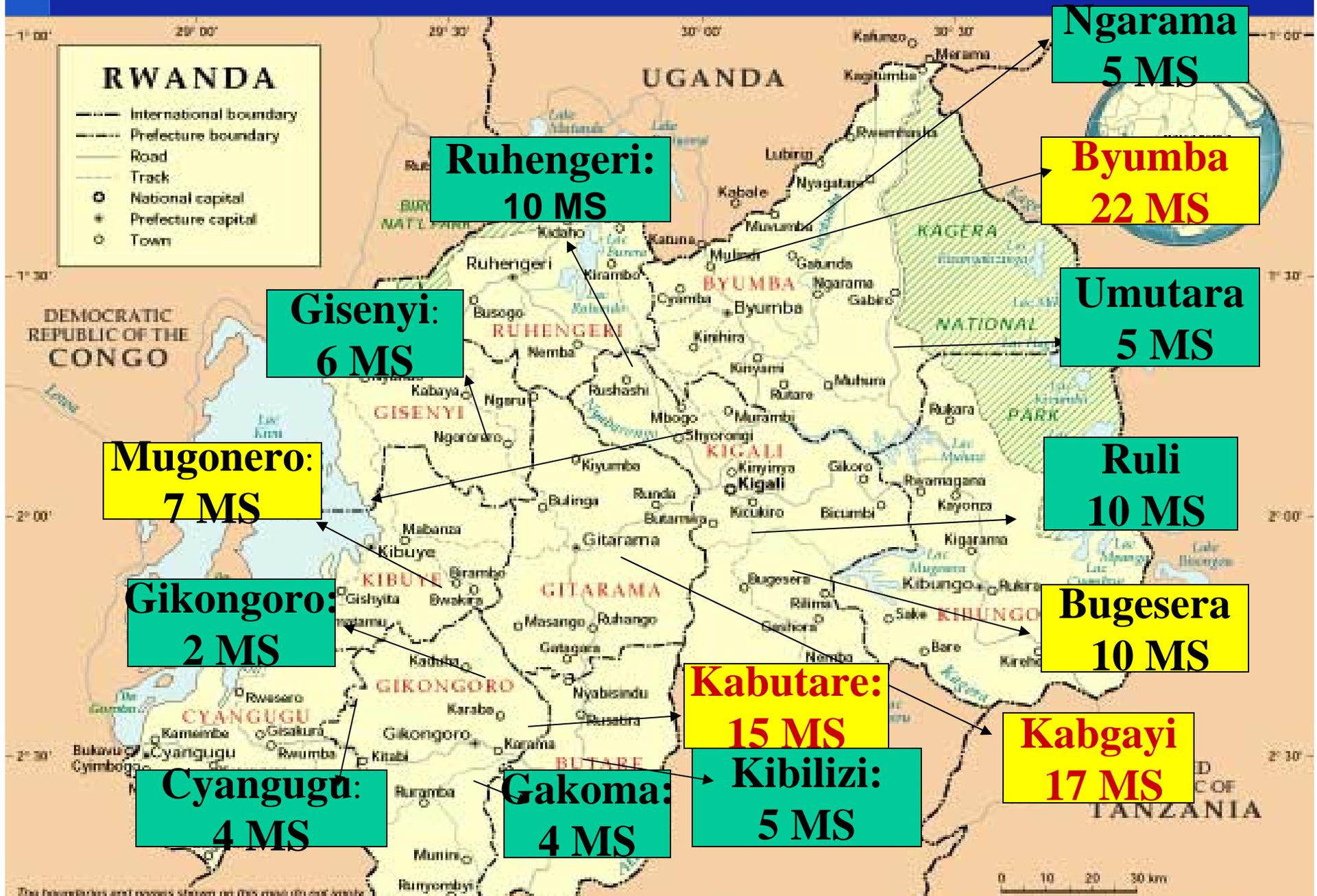
- ▲ Provider concern about prompt payment, and increased demand.

Rwanda

Replication Strategy in Rwanda:

*Findings from CBHI pilot-test
lead MOH to replicate CBHF in
other areas*

SITUATION AS OF MARCH 2004: 122 MHO



Challenges to Implementation

- ▲ Lack of institutional capacity (legal framework, national health strategy)
- ▲ Lack of human capacity among community members to manage CBHF
- ▲ Premium levels too high for poorest
- ▲ Low levels of quality of care affect willingness to insure

Lessons from Rwanda

Support needed when replicating CBHF

- ▲ **Institutional Framework**
 - ▲ Legal framework
 - ▲ National Health Financing Strategy
- ▲ **Organizational Sustainability of CBHF**
 - ▲ Continuous human capacity building
- ▲ **Financial Sustainability of CBHF**
 - ▲ Subsidize premium of poor households
- ▲ **Provider Performance**
 - ▲ M&E and improve quality of care

Philippines

PhilHealth Philippines

- ▲ *Universal Coverage Law*
- ▲ Formal sector workers
- ▲ Poor enroll in PhilHealth Indigent Plan (IP), subsidized by Government
- ▲ Independent workers (e.g. dentists, street vendors) pay same fixed premium per year, independent of income

Results from the Philippines

▲ Formal sector

- ▲ 100% enrolled

▲ Poor households (subsidized)

- ▲ > 100% enrolled following elections
- ▲ Mayor's picture on back of PhilHealth membership card sends confusing message to members

▲ Independent workers

- ▲ Low enrollment rates
- ▲ Unaffordable premium for low-income groups
- ▲ Rich insure in private insurance companies

Support needed when integrating CBHF into national insurance

- ▲ Institutional Framework
- ▲ Organizational Capacity Building of National Health Insurance
- ▲ Financial Sustainability and Equity in Financing
 - ▲ Income dependent premium levels for independent workers (includes dentists and street vendors)
 - ▲ Some solidarity enforcement between rich and poor
- ▲ Provider Performance
 - ▲ M&E and improve quality of care

Conclusions and Remaining questions

- ▲ There is no defined path from individual CBHF schemes to universal coverage – processes are iterative and not always logical
- ▲ The role of government in developing a national health financing policy is critical in scale-up
- ▲ Distinction between replication and integrating into Social health insurance strategy
- ▲ In-country capacity to manage CBHF and scale up is major barrier
 - ▲ Lack of human, organizational, financial capacity
- ▲ What happens to trust in CBHF if scheme governance is moving up?

Recommendations

- ▲ There are TA needs throughout the process of scale-up – these vary according to stage of scale up and local capacity but include:-
 - ▲ Assistance to individual schemes
 - ▲ Assistance with institutionalization of local TA capacity
 - ▲ Assistance with development of financing policy
 - ▲ Assistance with the establishment of legal frameworks, reinsurance functions, subsidy systems, billing systems etc.
 - ▲ M&E and documentation throughout



**Thank You And more on:
www.phrplus.org**



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Come back next week for **Session 10**



Muslim World Outreach and Engaging Muslim Civil Society

Organizer: Ann Phillips
Panel: Krishna Kumar,
Tuesday, August 31, 2004

