

Remind me again: why are we here?

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On pondering the challenges of community-based health insurance, we are reminded of a scene in a movie. The leader of a war, after losing many battles and wasting the lives of thousands of men, asks his lieutenant: "Remind me again: why are we here?" In the midst of all the battles, war itself had become the goal and the ultimate goal of reaching stability and peace had been forgotten. In other words, the means had become the end.

Similarly, in many community-based health insurance schemes, the multitude of logistical demands of initiating, managing and maintaining the schemes seem to overshadow their original purpose – the health and well-being of a specific community and its members. In addition, the implementation of community-based health insurance in low-income countries, especially in sub-Saharan Africa, is too rigid: the designs are often standardized and lack the necessary flexibility to adapt to the local context.

The story of community-based health insurance dates back to the Alma-Ata Conference in 1978, when health ministers made a commitment to reform health systems and extend universal primary health care to poor people. They failed to achieve this due to insufficient resources and lack of political will. Subsequently, the Bamako Initiative of 1987 promoted the introduction of user fees and community involvement (and management) of primary care in Africa to achieve universal coverage.¹ These policies, however, were progressively abandoned because user fees excluded the most vulnerable populations.

Community-based health insurance – voluntary, non-for-profit insurance based on the ethic of mutual aid – emerged as an alternative to user fees.^{2,3} It is primarily intended to bridge the gap in access and social protection between people covered by formal schemes and those who have to pay for care out of their own pocket. The World Bank claims that community-based health financing is effective in protecting many low-income populations against the cost of illness.⁴

After two decades of experience of various models of community-based health insurance, one question that surfaces fre-

quently is whether these schemes remain faithful to the initial goal of serving their communities. The answer to this question will depend on who assesses their performance – those who run the schemes or the beneficiaries? Since these community-initiated and managed schemes are intended to serve the same community, should they not be one and the same? Unfortunately, this is not always the case.

Performance criteria of private, for-profit insurance are at times applied to community-based health insurance schemes, more often than not ignoring crucial differences such as purpose, logic underlying the management of the scheme and the value frame of reference for decisions about its effectiveness and efficiency. Success or failure should be assessed, at least partially, using different tools and outcomes. It is in this light that we should re-examine the concept of adverse selection within the context of community-based health insurance.

The term "adverse selection" is commonly used to describe cases where prospective insurance clients know more about their own health status and risk levels than the insurers. An example of this is a prepayment scheme to which mainly women of reproductive age subscribed to receive future maternity care in a community in the Democratic Republic of the Congo.^{5,6} While controlling for adverse selection may be useful for contributing to financial sustainability, using it as an operational concept to guide decision-making about how to manage the schemes may divert community-based health insurance schemes off their intended course of serving the community in a spirit of solidarity.

For-profit insurance treats adverse selection as an important liability that needs to be minimized, if not eliminated, using the common strategy of excluding or discouraging those with higher health-care risks – and therefore costs – from coverage. Many community-based health insurance schemes have used some of these strategies, such as waiting periods and stipulation of household insurance, to deal with adverse selection. While such strategies may have helped to finance some schemes, they have also contributed to extending the suffer-

ing of sick people and/or to excluding the people most in need from affordable coverage. This is inconsistent with the very purpose and value frame of community-based health insurance, fundamentally rooted in inclusion and financial protection. While schemes must be economically viable and sustainable, a focus on adverse selection deals with the wrong end of the equation. Instead, the emphasis should be on innovative financing mechanisms, such as government subsidized premiums for the poorest as is done in Ghana and Rwanda.⁷ This needs to be done in a cautious way so as not to disrupt local solidarity dynamics.

Health economists should focus on developing a different business model for community-based health insurance to allow these schemes to remain true to their purpose while remaining financially viable and sustainable. Addressing such a challenge is essential for universal health coverage but community welfare and involvement should always be the litmus test for any suggested interventions. Let us never forget why we are here! ■

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