Combining Health Equity Funds and Community Based Health Insurance

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Introduction
During the last decade, various demand-side health financing schemes targeting the poor and the informal sector have been piloted by the Ministry of Health and development partners in Cambodia and in the Lao PDR. Lessons learned from these schemes now inform national policy development and provide an example for other developing countries.

Cambodia is a leader in developing demand-side financing schemes targeting the poor. District-based Health Equity Funds (HEF), now cover 3 million people, comprising about eight of every ten people living below the poverty line. In many districts, voluntary community-based health insurance (CBHI) schemes are implemented alongside HEFs. In Laos, the MOH has implemented a national program to establish district CBHI schemes and more recently supported the introduction of HEFs.

How to combine the different schemes within a broader social health protection or universal coverage arrangement is a topical issue in many developing countries.

Issues in combining demand-side schemes
Fragmentation of financing schemes is typical of the pilot stage in the broader development of social health protection schemes. In the early stages of development, targeting subsidy schemes on the poor has proven to be effective. Overcoming fragmentation and achieving greater uniformity in health financing is, however, desirable, but must be undertaken carefully. An initial step may be to unify demand-side schemes such as HEFs and CBHI, which co-exist in some districts.

The argument for unifying these schemes is to increase efficiencies and the uniform coverage of sometimes overlapping populations who live just below and just above the poverty line. A further argument is to increase the risk pool for prepayment schemes (such as CBHI).

The benefits of linkage can include joint leverage on quality
of health services, common benefit packages, uniform provider payment methods and common administrative procedures, with savings in transaction costs.

Forms of cooperation between demand-side schemes (HEF and CBHI) have been piloted in Cambodia and Laos, including using HEF funds to purchase CBHI premiums for the poor. In principle, cooperation may be implemented at the administrative level, at the financial level, or both. Independent schemes may work together in these ways, or a single organisation could be created to implement both uniformly.

Combining schemes at the administrative level (without sharing finances) presents a range of complicated management issues that require close collaboration and constant contact between the implementers. Transaction costs can be high.

Combining a subsidised scheme (HEF) with a voluntary risk-pooling arrangement (CBHI) raises complex financial questions, related particularly to the cost-effective use of budget or donor funds earmarked to pay the cost of health services provided to the poor. The key issue is the cross-subsidisation that occurs between population groups.

Experience to date indicates that six key variables determine the financial relationship between such HEF and CBHI schemes:

- population coverage
- patient contact rate at health facilities
- voluntary insurance scheme premium rate
- provider payment rate
- cost of medical treatment received
- administrative costs.

Negative cross-subsidisation (from the poor to the non-poor) will occur where HEF population coverage is well above CBHI membership, premium rates for HEF and CBHI voluntary members are equal and the patient contact rate for HEF members is well below CBHI paying members. These conditions are common and need to be carefully managed.

Where the premium rate paid by the HEF is discounted to a level equal to the provider payment made by the insurer to the health facility (for example, through capitation), the potential for subsidising the insurer through the HEF is eliminated. This may also remove the financial incentive for the insurer to continue.

Even so, where the HEF contact rate remains below the CBHI contact rate, it is likely the subsidy will move from the poor who access services to the health service provider. In this case, the subsidy will serve those who utilise services more frequently, that is, the non-poor.

**Recommendations**

In moving to combine different demand-side health financing schemes, health planners must acknowledge the constraints and devise procedures for the application of subsidies – whether to the demand side (HEF beneficiaries) or to the supply-side (to health service providers) – that are transparent and accountable.

Passing funds earmarked for the poor to health service providers as a supply-side subsidy may be justified to encourage an increase in quality that will benefit the poor and the non-poor. If so, the financial flows need to be transparent and performance criteria should be attached to the funding.

From a policy perspective, both the administrative and financial arrangements for the implementation and combination of demand-side financing schemes must be carefully calculated and made completely explicit. This is particularly critical as these developing nations advance uniform universal coverage arrangements.

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