

A Conceptual Framework for Community-Based Health Insurance in Low-Income Countries: Social Capital and Economic Development

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Summary. — The international policy model linking community-based health insurance (CBHI) and universal coverage for health care in low-income countries is implicitly determined by the development of mutual health insurance in 19th century Europe and Japan. The economic and health system frameworks employed in CBHI policy have not sufficiently taken into account contextual considerations. Social capital theories could contribute to understanding why generally CBHI does not achieve significant and sustainable levels of population coverage. A framework of social capital and economic development is used to organize and interpret existing evidence on CBHI. This suggests that solidarity, trust, extra-community networks, vertical civil society links, and state–society relations affect the success of CBHI. Aligning schemes to “social determinants” of CBHI could result in structures that differ from those proposed by current analytic frameworks. © 2007 Elsevier Ltd. All rights reserved.

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1. INTRODUCTION

Community-based health insurance (CBHI) provides financial protection from the cost of seeking health care. It has three main features: prepayment for health services by community members; community control; and voluntary membership (Hsiao, 2001).¹ Major international development agencies construe CBHI as a transitional mechanism to achieving universal coverage for health care in low-income countries (Arhin-Tenkorang, 2001; Davies & Carrin, 2001; Gottret & Schieber, 2006; World Health Organization, 2000, 2005a, 2005b). The current international policy model linking CBHI and universal coverage is implicitly informed by the history of health service financing in Europe and Japan, where CBHI schemes in the 19th century eventually merged to form various types of national health insurance (Criel & Van Dormael, 1999). However, several studies suggest that while there may be lessons to be learnt, emerging in a different socioeconomic

context, under different circumstances, it is not safe to assume that CBHI schemes in their current form will develop into forms of national health financing according to the historical precedent (Barnighausen & Sauerborn, 2002; Carrin & James, 2005; Criel & Van Dormael, 1999; Ogawa, Hasegawa, Carrin, & Kawabata, 2003). Although it is estimated that in West Africa there was more than a twofold increase in the number of CBHI schemes in just three years, from 199 schemes in 2000 to 585 in 2003 (Bennett, Kelley, & Silvers, 2004), this is still a small number of schemes when compared to the situation in Europe.² In the 19th century there were 27,000 friendly societies, which operated much like CBHI schemes, in the United Kingdom alone (Bennett *et al.*, 2004). Also,

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rather than being locally initiated by farmers, associations of industry workers or employers as in Europe and Japan, today's CBHI schemes are mostly the result of top-down interventions led by foreign aid agencies or national governments (Criel & Van Dormael, 1999; Meessen, Criel, & Kegels, 2002). Reviews have concluded that the evidence base on CBHI is limited in scope and quality (Ekman, 2004) and that it is unclear whether CBHI schemes are actually sustainable in the long term (Bennett *et al.*, 2004).

Constraints to increasing CBHI coverage and sustainability have been identified primarily by a body of literature taking an economic or a health system perspective. In agencies such as the World Bank and WHO, analysis of CBHI policy is underpinned by an economic framework, with discussion focusing on features of market transactions such as willingness to pay, information, price, and quality (Dror, 2001; Pauly, 2004; Preker, 2004; Zweifel, 2004). Another related perspective attempts to set financial transactions into the broader institutional context of the health system, analyzing interactions among insureds, insurance schemes, health service providers, and the state. This is described here as a "health system framework" (see, e.g., Bennett, 2004; Bennett *et al.*, 2004; Criel, Atim, Basaza, Blaise, & Waelkens, 2004; ILO, 2002) and it corresponds with the model of health system analysis laid out in the WHO World Health Report 2000 (World Health Organization, 2000). Underpinning both the economic and health system frameworks is the behavioral model of rational utility maximizing *homo economicus*.

This paper argues that the rational individualist model does not permit the systematic incorporation of social context into policy. New, complementary directions in thinking on CBHI policy are needed; particularly an increased focus on values, goals, and power relations, as has been argued in relation to social policy in general (Flyvbjerg, 2001). Specifically, it is proposed that a critical engagement with social capital theories could contribute to our understanding of why most CBHI schemes do not appear on course to develop according to the 19th century precedent, achieving significant levels of population coverage in a sustainable way. It could also help explain the apparently successful implementation of CBHI in certain countries, most notably Rwanda, where coverage of 25.8% of the total population was achieved during 2000–05 (Musango, Butera, Inyarubuga, & Dujardin, 2006).

Social capital has been the subject of spirited academic debate for almost two decades. Since its definition remains under dispute, as a matter of convenience we employ the following as a point of departure for discussion: "the information, trust and norms of reciprocity inhering in one's social network" (Woolcock, 1998, p. 153). Further categories in the social capital taxonomy are considered later in the paper. For at least 10 years empirical studies have suggested that higher levels of social capital are positively correlated with improved development outcomes in areas such as agriculture, water and sanitation, and microcredit in low-income countries (Anderson, Locker, & Nugent, 2002; Brown & Ashman, 1996; Grootaert & Narayan, 2004; Krishna, 2001; Lyon, 2000; Narayan & Pritchett, 1997; Uphoff & Wijayarathna, 2000; van Bastelaer & Leathers, 2006; Weijland, 1999). The World Bank's "Social Capital Initiative" even suggested that social capital could be the "missing link" between natural, physical, and human capital and economic growth and development (Grootaert & van Bastelaer, 2001). Theories of social capital have also been applied widely in public health policy (see Moore, Haines, Hawe, & Shiell, 2006; Shortt, 2004 for a literature review). However, although an important component of social capital, trust, is occasionally discussed in the CBHI literature, CBHI has *not*, for the most part, engaged with social capital theories. In the few cases where social capital theory is considered, it is either mentioned only cursorily or the richness and complexity of the theory is overlooked.

The specific framework of social capital adopted in this paper was developed by Woolcock (Woolcock, 1998, 2001; Woolcock & Narayan, 2006). It brings together several theories of social capital and draws on quantitative and qualitative evidence from field studies. Its particular advantage for our analysis is its focus on community level economic development projects in low-income countries, similar to CBHI.³ It offers CBHI policy a framework that incorporates both economic and social theory by attempting to reconcile debates over whether humans are rational agents or governed by norms and culture. In doing so, the social capital framework can be viewed as an attempt to pragmatically address the need for an alternative, or complement, to income-based and purely economic approaches to development (Bebbington, 2004). By applying this framework to CBHI analysis, this paper aims

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