Trust, Community-Based Health Insurance and Enrollment Rates

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Katia Chen
Ramona Daukste
Ann Przybyl
Nicholas Fechter

Advisor: Thierry Van Bastelaer

Comment [TvB1]: Spelling your client’s name correctly is critical
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Executive summary

The links between poor health and poverty are well understood in the field of international development: poor health can prevent individuals and households from escaping poverty, pull individuals and households back into poverty, and, if pervasive, severely hinder the economic development of a country. Although theoretically several risk mitigation strategies exist—both at the national or local levels—to help the poor cope with health shocks, in practice the majority of the poor around the world have to rely exclusively on their own resources to finance catastrophic medical expenditures, as many governments have failed to establish any formal protection mechanism and social safety nets. The World Health Organization reports that approximately 100 million people “are pushed under the poverty line each year simply because they use health services for which they are forced to pay out of their own pockets” (WHO 40). Without any protection from the government, the poor are forced to search for other financial resilience strategies—that can be classified as behaviors, products, networks, and policies—to address unexpected costs associated with health shocks.

The focus of the research presented in this report is the analysis of community-based health insurance (CBHI) schemes as a tool to increase resilience and reduce vulnerability and risk in the face of health-related financial shocks. Our work is focused on the following elements of the risk resilience strategy framework: first, trust is an aspect of social capital that can be classified within the network strategy; second, CBHI schemes are a type of product for mitigating health financing risks; and finally, the willingness or decision to enroll can be classified as a behavior strategy.

Our research addresses the following hypothesis: the level of enrollment in a CBHI scheme, in both rural and urban environments, is affected by the level of trust present in each setting. Moreover, we expect that trust will manifest itself differently in rural and urban settings, and that communities with higher levels of trust will feature CBHI schemes with higher enrollment rates. To address our research question, we used qualitative data that focused on existing literature on the subject, as well as an analysis of 13 case studies spanning multiple regions throughout the world, in both rural and urban environments.
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Our analysis examined whether, and to what extent, factors of trust impacted CBHI enrollment. Trust is an important factor when considering CBHI enrollment, given the amount of risk that is inherent in the nature of insurance schemes. Our analysis revealed that CBHI enrollment rates are likely affected by three manifestations of trust relationships—trust in others within the community, trust in health providers covered by the scheme, and trust in the CBHI scheme and management team.

Our analysis suggests that communities with higher levels of trust are more open to experiencing change and trying something new together, such as a CBHI scheme. Within areas where traditional risk sharing and risk pooling groups are already present, higher levels of trust and higher CBHI enrollment rates often result. In terms of trust in health providers covered by the CBHI scheme, we find that factors such as the availability, quality, and reliability of health providers are significant determinants of enrollment. The trust relationship between individuals and health providers covered by the CBHI scheme is based largely on experiential knowledge comprised of past and current experiences. Furthermore, our research indicates that the trust in CBHI management and in the scheme itself has a positive impact on enrollment decisions. CBHI schemes that are perceived as fair and transparent are better positioned to create trust relationships with community members.
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Introduction

The links between poor health and poverty are well understood in the field of international development; poor health can prevent individuals and households from escaping poverty, pull individuals and households back into poverty and, if pervasive, severely hinder the economic development of a country. Over the past several decades many internationally financed health programs have been implemented, including—most recently—those related to the United Nations Millennium Development Goals. Despite these efforts, the health gap between developed and developing countries remains unresolved. As indicated by the World Bank, “developing countries account for 84 percent of the global population and 90 percent of the global disease burden, but only 20 percent of global gross domestic product (GDP) and 12 percent of all health spending” (Gottret and Schieber 2). Moreover, the poor in low- and middle-income countries are especially vulnerable when it comes to the availability of health financing options. Fee-for-service and out-of-pocket payments are the predominant forms of health financing available to them. The key health financing options available and their evolution path (Carrin 4) are shown in Figure 1.

Figure 1. Key health financing options at different stages of the evolution towards universal coverage

Currently, the majority of the world’s poor face financial hardships, which can be largely explained by the absence of proper risk management strategies and health
financing tools. As stated by International Labor Organization, in 2008 only 50 countries in the world had attained universal or near-universal health coverage (Ahoobim et al. 1). The failure of governments in developing countries to provide social health insurance, coupled with the limited availability or absence of other health financing options for the poor increase the health financing risks they face.

The majority of the poor around the world have to exclusively rely on their own resources to finance catastrophic medical expenditures, as many governments have failed to establish any formal protection mechanism and social safety nets. The World Health Organization reports that in 2012 that approximately 100 million people “are pushed under the poverty line each year simply because they use health services for which they are forced to pay out of their own pockets” (WHO 40). Moreover, these health-related financial shocks are further exacerbated when the primary income earner in poor households are the ones that require the expensive health care treatments. This situation distorts all income strategies, throwing the family in a vicious cycle of poverty wherein they are not able to cover the expenses of other important items, such as housing, food, clothing, or education.

Furthermore, private health insurance options are usually accessible to the relatively wealthy segments of the population and those with formal employment (Carrin 45). The poor are usually unable to afford the relative high pre-payment costs without government subsidies. In remote areas, especially rural communities, there is limited interest in offering any type of insurance option, due to the dearth of existing health facilities, as well as the high administrative costs associated with creating any formal health financing option. Moreover, even if some type of health financing mechanism is created in these remote communities, it is usually isolated from formal health financing mechanisms and the accompanying networks of health providers, usually suffers from limited management capacity and a small sized risk pool (Preker and Carrin xix).

To acknowledge and mitigate the aforementioned risks, several risk resilience strategies for the poor have been devised, with community-based health insurance (CBHI) schemes promising to be one of the most powerful mechanisms currently utilized in many developing countries. The availability of health financing mechanisms for the
poor is crucial, as these mechanisms represent one of the main determinants of an individual’s access to health services.

**Methodology**

*Health financing risk resilience strategies*

As one of the most vulnerable population groups, the poor are not always able to acquire enough assets requisite for building resilience against unexpected health shocks. Living in highly uncertain environments with limited or no access to possible risk resilience strategies offered by the government or other public actors, the poor can easily be thrown into poverty or further prevented from escaping its grasp. Resilience strategies can play an important role in mitigating these circumstances. Within the context of this research, resilience is defined as the “capacity of people to decrease the impact of events that negatively affect their health, livelihoods, and human development” (van Bastelaer). This capacity can either lower the likelihood and/or lower the consequences of negative events.

Although the poor do, in fact, have coping strategies when shocks arise, the predominant strategies often include increased borrowing, reorganizing the household labor supply (sending children into the workforce), cutting back on education-related expenses, selling non-productive and productive assets, or in the case of health-related income shocks, abstain from seeking health services altogether (Asadul and Pushkar 18). While some low-income households have begun using micro insurance mechanisms or establishing small saving groups, it is hoped the use of more preventative risk mitigation tools, such as CBHI schemes, will prevent individuals and households from employing coping strategies that negatively impact their economic wellbeing. There are four main risk resilience strategies available to the poor in the area of health financing. The framework depicted below in Figure 2 reflects these general areas and illustrates the dependence each of these practices have with each other in creating resilience.
However, to build resilience more than one strategy is usually necessary. The more strategies available to the household, the stronger its ability to lower the risks faced and the more able it is to bolster resilience. For example, the introduction of social health insurance for vulnerable groups, including the poor and/or the disabled, requires a combination of strategies. First, the specific product needs to be defined, in this case the social health insurance for vulnerable groups. Within this strategy the two most important steps include clearly defining the product, as well as articulating a clear management and implementation strategy. Second, clear policies and regulations need to be established, defining the exemption criteria to select the eligible candidates and define the overall administration process to enforce the actual health financing mechanism. Finally, the actual implementation of the product would be highly dependent on the proper communication strategies with the target groups—mainly focusing on the relationship building between the product providers and beneficiaries—as well as their willingness and ability to participate.

Scope of the project

According to the health financing risk resilience strategies framework, our research mainly focused on three elements of the framework: networks, behaviors, and products. We were particularly interested in analyzing how existing networks can impact the adoption of a health financing product as a risk mitigation strategy. Within our
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research we chose to evaluate CBHI schemes, along with whether and how trust affects
the enrollment therein.

As Donfouet and Mahieu argue, “CBHI schemes are an emerging concept for
providing financial protection against the cost of illness and improving access to quality
health services for low-income rural households who are excluded from formal
insurance” [1]. CBHI schemes emerged largely as a response to the absence of
government policies for providing health financing protection for vulnerable groups; as a
result, our research does not cover the policy arena of the risk resilience strategy. Instead,
our work is focused on the following elements of the risk resilience strategy framework:
first, that trust is an aspect of social capital that can be classified within the networks
strategies of the framework; second, that CBHI is a type of product for mitigating health
financing risks and can be classified as such within the framework; and finally, that the
willingness or decision to enroll can be classified as a behavior strategy within the
framework.

The research addresses the following hypothesis: the level of trust present in each
setting affects the level of enrollment in a CBHI scheme, in both rural and urban
environments. Moreover, we expect that trust will manifest itself differently in rural and
urban settings, and that communities with higher levels of trust will have CBHI schemes
with higher enrollment rates. To address our research question, we used qualitative data,
 focusing on the existing literature on the subject, as well as conducting an analysis of 13
case studies in urban and rural environments from regions throughout the world. Figure 3
displays the location of our case studies and whether they represent urban or rural
environments.

Comment [TvB4]: Different reference method?
Figure 3. Case Study Selection

**Limitations**

Although our research provided answers to the questions we were asking, several limitations arose throughout the process. Initially, to better support our qualitative research we wanted to use quantitative data to empirically illustrate how trust affects CBHI enrollment. However, trust is not easily quantified, and the diversity of measurements used to quantify trust allowed for little useful comparison across studies. Additionally, there was little public quantitative data available. Consequently, our research relied mainly on qualitative data and findings included in the selected case studies. Moreover, as CBHI schemes are a relatively new concept, only a limited amount of research and case studies were available. Lastly, although case studies were available from different regions of the world, a direct comparison of the selected case studies proved to be challenging, due to differing contexts and challenges apparent in each community where CBHI schemes have been introduced.

Although we chose enrollment as an indicator of success for CBHI schemes, renewal rates would likely have been a better indicator of the sustainability and long-term success of a CBHI scheme. Renewals indicate a willingness to reinvest in the same scheme. However, due to the very limited amount of research available that focuses on...
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renewals or—even more specifically—to the role of trust in the decision to renew participation in the CBHI scheme, we did not include this variable in our analysis.

When comparing the availability of cases studies in the urban and rural environments; only four out of the 13 case studies reviewed, entirely or partially, focused on urban environments. Moreover, different case studies tended to use different interpretations of the terms ‘urban’ and ‘rural’.

We realize that there are other factors, in addition to trust, which also contribute to the decision to enroll in a CBHI scheme, such as net monthly household income, cost, gender (especially in terms of the head of household), age, education level, number of children in the family, health condition, previous experience with CBHI schemes or other micro-insurance products, and availability of other insurance products. An additional confounding factor affecting enrollment has to do with whether a government sponsored health financing option is available, as it could lower CBHI enrollment rates. Conversely, certain factors could increase CBHI enrollment rates, such as the types of disease and health issues in a particular area, belief that the community will be involved in the design and management of the scheme itself, the local ability and willingness to pay, and the guarantee that health care providers will be easily accessible (Preker and Carrin xix).

Trust as an Indicator of Social Capital

The role of trust in fostering and supporting risk and resilience strategies is interesting for a number of reasons. As one of the premier thinkers on the topic of social capital, Robert Putnam has defined social capital as features of social organization, such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit (67 qtd. in Krishna and Shrader 3). Putnam’s definition of social capital provides ample space for application in the social sciences on the micro, macro, and meso levels of social organization and cooperation. An unfortunate consequence of the ambiguity of social capital has resulted in a wide array of applications for analysis, accompanying definitions and metrics for analysis.

As recently as 1999, the World Bank organized a conference on social capital and its impact on poverty reduction to address the ambiguity of social capital and to
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determine its potential as a development tool. One of the outcomes of this research resulted in an attempt to standardize the definition and method for assessment of social capital across cultures and world regions (Krisha and Shrader 2). Within this framework, authors Krisha and Shrader identified aspects of social organization on both the macro and micro levels, with macro indicators speaking to institutional contexts within which organizations operate and micro indicators speaking to the contribution horizontal organizations and social networks have on the facilitation of social capital (Olson 1982, North 1990 qtd. in Krisha and Shrader 9).

The micro level of analysis was further divided into two types of social capital, cognitive and structural. While the structural elements of social capital represent the organizational compositions and practices through which mutually beneficial collective action is facilitated, cognitive elements are comprised of trust, reciprocity, and solidarity behaviors that speak to values, beliefs, attitudes, and social norms that predispose people towards community cooperation (Krishna and Shrader 5-10). In the application of social capital to risk mitigation strategies, and specifically to micro health insurance products, such as CBHI schemes, the importance of the cognitive element of trust repeatedly emerged as a key determinant for participation in a community finance scheme (Preker and Carrin 126; Tibandebage and Mackintosh 1387; Chernichovsky and Hanson 110).

With trust emerging from the research on CBHI schemes as an important factor contributing to the adoption of and participation in this risk mitigation strategy, we have chosen to steer away from social capital generally and focus on trust as a cognitive element of social capital. In particular, our research was interested in explaining how trust can impact behavioral risk mitigation strategies, such as the decision to enroll in available CBHI schemes.

Our research has shown evidence that trust plays a role in community cooperation. Writing explicitly on the trust and social cohesion in Mali, authors Catherine Reid and Lawrence Salmen reported that, “the most important single factor determining the success of any external intervention was the degree of social cohesion [trust in one another] already existing in a particular community” (19). Many researchers investigating social capital used variations of trust as proxies for cognitive social capital and found trust relationships as vital to many benefits that accrued to both individuals and
Trust, Community-Based Health Insurance, and Enrollment communities (Grootaert and Bastelaer 8-9). Through our research we have collected qualitative and quantitative case studies that explicitly addressed trust’s effect on micro health insurance, while distinguishing between urban and rural communities, as we suspected trust forms and affects communities differently in both settings.

Trust in urban and rural settings

Francis Fukuyama defines trust as an expectation, but it can also be understood as a type of faith in the predictability of behavior that reduces uncertainty (Schneider 1431). Using this operational definition, this research has set out to understand the mechanisms at work that create the foundation of trust, as well as whether and how these mechanisms differ in urban and rural settings.

In our evaluation of trust in urban and rural settings, we made a distinction between the trust that forms among individuals and trust that forms among individuals and organizations. Relationships among individuals, interacting as peers, typically form with less power inequality than the relationships among clients and patrons. As our researched concerned those seeking health care and those in the position to provide health services and/or those providing the financial products requisite for accessing health services, our research investigates the challenges and opportunities in forming and facilitating trust as it relates to these two general circumstances.

Trust among individuals

One method of evaluating trust among individuals in a community is through examining social networks. Research has shown that the poor in both urban and rural settings rely on existing social networks to manage risk, although the formation of these networks and the outcomes they are designed to fulfill can vary greatly (Woolcock qtd. in Fay 224). In rural environments, trust is based primarily on the relationships created by traditional customs, ethnic groups, and common occupations, rather than other social arrangements (Fay 12, 224). Conversely, in urban settings, individuals look to build trust relationships with one another according to the degree of reciprocity and/or mutually beneficial support that can be derived from those relationships, rather than through kinship ties as often found in rural settings (Jellenik qtd. in Fay 224). Generally, urban networks tend to form with greater diversity and are generally larger in size; however
urban networks are usually more susceptible to instability as a result of the transient and impermanent nature of urban dwellers (Jellenik qtd. in Fay 224).

Knowledge of another, facilitated initially among small groups of close proximity, was found to build and strengthen trust between individuals (Carrin et al. 805). According to researchers Andrew Creese and Sara Bennett, “the degree of solidarity and mutual trust is [thought to be] higher in homogeneous, close-knit communities than in scattered and diverse populations comprising people of different ethnic origin, religion and culture” (qtd. in Weismann and Jutting 15). Geographic distance has proven to be an important determinant both in the creation of trust and in determining its reach. This is especially pronounced in rural settings, where it is speculated that distance between groups in villages may disproportionately impede the formation of trust among individuals. Although small groups exist in both urban and rural settings, there is evidence from the literature on health financing that echoes the role of geographic distances as a barrier to the formation of trust among individuals. Such was the case in China’s Rural Cooperative Medical Schemes, where researchers suspected that geographic distance between groups of scheme members may have explained why expanding enrollment and generating larger risk pools proved difficult, given that these were two health product outcomes reliant, at least in part, on trust among individuals in a community (Carrin et al. 806).

Sapag et al. outlined the importance of trust among individuals in an urban community and its impact on health in their study of social capital’s influence on self-reported health in the slums of Santiago, Chile. The authors found that after controlling for common factors affecting quality of health, such as age, gender, education level, and net household income, “trust in neighbors” and “reciprocity within the neighborhood” were modest but significant determinants for whether the poor reported good health in four out of the 10 poorest neighborhoods in the Puente Alto district of Santiago (791). Although this study explicitly set out to examine the role of social capital on reported health, the use of proxies capturing levels of self-reported trust among individuals in their neighborhood clearly demonstrates the significance of trust on a host of factors that, together, inspire an individual to report good health status.
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Trust between individuals and health service providers

Our research has shown that the main challenges associated with the formation and facilitation of trust relationships between individuals and organizations in urban and rural settings are similar to the challenges faced in building trust relationships among individuals, namely the role of geographic proximity and residential transience. For trust to arise there must be consistent and sustained behavior. Transience impedes the formation of trust, as it undermines the time and effort individuals and/or health service providers are able to invest to build the foundation upon which trust can develop. Trust between urban residents and health service providers can be difficult to form due to the high transience of urban dwellers, despite closer proximity to health providers (Tribandebage and Mackintosh). Transience among health providers was also found to be an issue in Dar es Salaam, Tanzania, where private health providers, notably dispensaries, opened and closed regularly in an attempted to remain financially sustainably in a fiercely competitive low-income market (Tribandebage and Mackintosh 1389).

While physical proximity proved a relatively insignificant impediment to the formation of trust between urban residents and health providers, there is evidence that indicates the reverse may be the case in rural settings. In a study of the Vimo Self Employed Women’s Association (SEWA) CBHI scheme in Gujarat, India, non-financial barriers, primarily the distance to health service provider, were found to exclude the poorest of the poor when left unaddressed (Ranson et al. 718; Dror 14). The impact distance had on preventing trust from forming between rural resident and micro health organizations was reported in terms of those excluded, which impacted rural SEWA members disproportionately (Ranson et al. 716).

Community-Based Health Insurance Schemes

CBHI schemes are an emerging and growing tool for providing financial protection against health-related shocks for the poor in rural and urban settings. Hermann Donfouet and Pierre-Alexandre Mahieu defined CBHI schemes as sharing the following characteristics: “voluntary membership, non-profit objective, linked to a health care provider (often a hospital in the area), risk pooling, and relying on an ethic of mutual aid
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and solidarity” (1). It is an instrument that can enable and facilitate access to quality health care and that can reduce the risk of individuals and households being forced into poverty due to high health financing costs.

**Importance of CBHI schemes**

Over the last decades, insurance has been recognized as a financial instrument, which could enable low-income households to better manage financial risks. Low-income households that often lack access to other financial protections or formal insurance can use CBHI schemes as a tool to increase resilience and reduce vulnerability and risk in the face of financial shocks (Preker and Carrin 9). In low and middle-income countries, the majority of the population is self-employed, unemployed, or working in the informal sector, excluding them from coverage of formal insurance schemes. This situation, coupled with the fact that many of these low and middle-income countries lack a strong tax base needed to support a national level social health insurance scheme, leaves poor households exposed to higher health financing risks and forces them to resort to out-of-pocket payments to cover health-related costs (Wang and Pielemeier 320). It is estimated that 30 to 85 percent of total health spending in the poorest countries around the world are out-of-pocket payments. These high out-of-pocket costs represent catastrophic expenses for poor households. CBHI schemes can provide low-income households with a possible solution to high out-of-pocket costs, therefore providing a tool for financial risk mitigation. Moreover, CBHI schemes can provide low-income groups with more bargaining power, allowing them to negotiate for better service quality and products from health care providers (Ginneken 24). Further evidence from a study of informal workers in Tanzania reveals that CBHI schemes can also increase the likelihood of health seeking patterns and usage of health care services (Gottret and Schieber 10).

CBHI schemes sometimes arise as a partnership with local NGO organizations or through sponsorship and subsidies by local or national governments. Cases, where the government helps facilitate CBHI schemes, occur when the government has a general plan for health coverage, though is either unable to reach the farthest and smallest rural areas or is unable to provide full coverage. Under these conditions, the government may partner or sponsor the creation of CBHI schemes in local communities to help manage
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the costs and challenges associated with the health issues in the area. The government support is usually found in the form of government subsidies, which in turn lowers the membership rates for the target population. Examples of this type of scheme and partnership have been observed in rural Thailand and China. In Thailand, the government contributed to half of the membership costs and the other half was covered by the household. In China, the New Rural Co-operative Medical Care System was designed with the subsidy of the government to provide health insurance coverage for smaller rural communities (Wang and Pielemeier 322).

CBHI schemes in rural and urban settings

CBHI schemes are a form of micro health insurance, which has been predominantly seen in rural areas in developing countries. Although predominant in rural areas, CBHI schemes have been successfully implemented in some urban areas as well. The innately different community characteristics and dynamics in rural and urban environments lead to different models and structures of CBHI schemes within each of these settings. Rural and urban CBHI schemes share many similar foundational characteristics, differing mostly in certain areas of the scheme design and the challenges faced within each environment.

In terms of the scheme design, the main observable difference is the ability of rural CBHI schemes to better address the issue of affordability by changing payment forms and schedules. Some CBHI schemes in rural areas collect the scheme contribution in monetary form, as well as accepting payments in the form of crops or other non-monetary means. This is seen predominantly in communities and cultures where bartering and non-monetary exchanges are common (Carrin et al. 803). Altering the form in which individuals can pay for their CBHI membership allows greater flexibility and higher likelihood of on-time payment. A second adaptation that is seen in the rural setting addresses the timing of the contributions. Instead of monthly or quarterly contributions, which is how most CBHI schemes operate in urban settings, some rural CBHI have opted for annual contributions that are timed to coincide with the annual harvest. This change has increased the affordability aspect of CBHI schemes in rural areas where monthly or quarterly payments would not be feasible. The timing to coincide with the time of the
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The harvest of cash crops has proven to be successful in addressing the sustainability of CBHI schemes in rural environments (Carrin et al. 181). Examples of these adaptations in rural settings can be observed in CBHI schemes in rural communities in Bolivia and India. In Bolivia, members were given the option to pay their CBHI scheme contributions in the form of potatoes seeds once a year and in India membership payments were accepted in the form of rice and sorghum that was collected annually during harvest time (Carrin et al. 86).

These types of adaptations and changes in payment forms have not been seen in the same extent in urban environments. In urban environments, some CBHI schemes provide choices between annual contributions or smaller more frequent payment schedules. An example of this type of payment adaptation is seen in Kenya through the Jamii Bora Health Program. This CBHI scheme provides its clients with the option of paying the full premium on an annual basis or through 50 weekly smaller payments (Mwaura 48). This flexibility and adaptation allows CBHI schemes to address the more volatile nature of income in urban settings. There has not been, however, a reported case of CBHI schemes allowing in-kind or non-monetary payment forms in urban environments (Carrin et al. 803). A possible reason for the lack of acceptance of alternative forms of payment in urban settings may be attributed to the high diversity of income generating activities conducted by urban residents. This high diversity would decrease the CBHI scheme’s ability to monetize the received payment forms.

Another area in which CBHI schemes differ between rural and urban environments is in terms of the challenges that the schemes face given the dynamics and characteristics of their settings. In rural environments, the main challenge facing CBHI schemes is rooted in the generally small size of the population within rural communities. CBHI schemes that have attempted to gain establishment in very small rural communities have experienced difficulties in creating affordable programs and providing reliable care for clients (Carrin et al. 807). With a smaller number of people who could possibly afford to pay into the CBHI scheme, the system is faced with the dilemma of becoming less self-sustainable or excluding the poorest of poor by becoming unaffordable for that income group. The constraints in the volume of mobilized resources have an effect on the scope and coverage of the CBHI scheme (Carrin et al. 25). In urban environments, the
main challenge facing CBHI schemes is one relating to enforcement of payments. In general, urban environments possess the characteristics of high mobility and transience, which decreases a CBHI scheme’s ability to enforce payment schedules and continual participation in the scheme (Fay 197). This exposes CBHI schemes in urban areas to increased vulnerability, which puts the scheme’s sustainability at risk.

Discussion and Analysis

Relationships between trust and CBHI enrollment

The success of a CBHI scheme revolves around the existence of social capital in the community (Donfouet and Mahieu 1). Higher levels of trust among CBHI scheme members are important for the functioning of effective risk pooling within a community. Donfouet and Mahieu argue that the greater level of trust and solidarity within a community, the less likely it is that individuals will choose to pursue egoistic behaviors that may compromise the functioning of the CBHI scheme (2). Communities with higher degrees of trust are better able to handle common issues faced by insurance schemes, mainly moral hazard, adverse selection, and fraud. The capacity to deal with these common challenges increases the stability and sustainability of CBHI schemes.

Trust is an important factor when examining levels of CBHI enrollment. One of the main characteristics that CBHI schemes share is voluntary membership. Researchers Sachi Ozawa and Damien Walker argue that enrollment is dependent on elements of trust, given the fact that voluntary membership is a key factor of CBHI schemes (110). If enrollment in CBHI schemes were mandatory in nature, enrollment would be an act of compliance rather than choice. Individuals considering voluntarily enrolling in a CBHI scheme are weighing perceptions and attitudes of trust towards others within their community, the health providers covered by the scheme and the CBHI scheme itself. Furthermore, trust is an important factor given the level of uncertainty regarding the nature of insurance transactions. CBHI schemes, like any other insurance system, rely on the fundamental idea that there are uncertainties regarding future health needs and costs. Enrolling in a CBHI scheme becomes a tool for individuals and households to manage that risk through a series of smaller pre-payments in exchange for the promise of future
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reimbursement by the CBHI scheme once the health need or cost is incurred (Ozawa and Walker 110). In this type of transaction, individuals are trusting that their future health costs will offset the series of smaller pre-payments to the CBHI scheme. Moreover, individuals trust that when the health need finally occurs, the CBHI scheme will reimburse the costs as promised and the health providers covered by the CBHI scheme will provide the products and services needed to address the health issues faced.

Our research indicates that the effects that trust has on CBHI enrollment can be categorized into three distinct levels: trust in others within the community, trust in health providers, and trust in CBHI management and scheme.

Trust in others in the community

Trust in others within the community can have an impact on CBHI enrollment. One way that trust in others affects CBHI enrollment is based on the findings by multiple authors that a community “with high social capital will be more inclined to go through change, therefore more ready to support a new, unknown health policy, such as CBHI” (Donfouet and Mahieu 2). Trust in others within the community is a product of multiple elements. Through an empirical study of households in Cameroon, Alvin Etang examined a number of socio-economic characteristics, including income, years living in the community, age, marital status, years of membership in a Rotating Savings and Credit Association (ROSCA) group, and whether someone has lived in an urban environment, to see if any of those variables had a statistically significant effect on the level of reported trust among community members (14-15). This study concluded that the variable with the most significant positive effect on the reported level of trust in someone was the number of years an individual lived in a community. Additionally, other studies have also shown that communities with higher levels of trust are more likely to assist in the cooperation, aids, and access to health care (Donfouet and Mahieu 3).

CBHI schemes that are created in communities that have other risk sharing community groups are able to leverage the existing trust relationships to assist in the implementation and enrollment into the new CBHI scheme. Individuals living in areas where there are general practices of resource sharing in the community have a higher tendency of enrolling in CBHI schemes (De Allegri et al. 855). These traditional resource
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sharing practices in developing countries many times manifest themselves in informal associations, such as ROSCAs. Other forms of existing risk-sharing institutions and mutual help groups, such as microfinance institutions, can also help facilitate CBHI enrollment. CBHI schemes can be built upon these groups to facilitate creation and legitimization. An example of such a practice would be the successful creation of a CBHI scheme by the Kisiizi Hospital Health Society that was built upon the Engozi societies in Uganda. Engozi societies are traditional burial societies that provide services for burials and transportation of ill members (Wiesmann and Jütting 207-208). In another case, the CBHI scheme called Jamii Bora Health Program was established under the larger microfinance organization Jamii Bora Trust in Kenya. Individuals that were taking microfinance loans from Jamii Bora Trust were also recruited to join the CBHI scheme. This association with the microfinance institution created trust for the CBHI scheme members that a larger organization was overseeing and managing the scheme, leading to higher levels of enrollment rate (Mwaura 46-48).

The implications of the effects of trust in others in the community on CBHI enrollment are expressed differently in rural and urban environments. In urban areas, risk sharing groups are created based upon proximity and expected reciprocity, while in rural environments these groups are based on shared kinship, traditional, and ethnic ties. This difference in the nature of how community risk sharing groups arise can have an effect on CBHI enrollment. In urban environments, where reciprocity and mutually beneficial support is the foundation for participation and formation of risk sharing groups, CBHI enrollment may depend more heavily on being able to convey the perceived and actual benefits to participants. On the other hand, in rural settings where groups arise based on kinship and traditional ties, CBHI enrollment may depend more on a higher degree of group cohesion and agreement in terms of the acceptance and interest in the CBHI scheme. Moreover, enrollment decisions in rural areas may depend on aspects of mutual help and solidarity as expressed by rural members of the Bwamanda CBHI scheme in the former Zaire. Members reported that even if they did not need the health care themselves, they were glad they had done something good for the community by contributing to it and being a member of the scheme (Wiesman and Jutting 207-208).
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Trust in health providers

Trust between potential CBHI members and health providers was found to be a significant contributor to whether individuals decide to enroll in CBHI schemes, and whether they perceived health insurance as a valued investment. If, for example, potential CBHI members perceive a lack of either the availability or the probity of health services, demand for micro health insurance may not materialize, as people demand health insurance as a means to purchase health services (Jutting 285).

An individual’s previous experience with medical facilities and their ability to serve those seeking health care can serve as the basis of trust between those seeking healthcare and health care providers. If an individual seeking health care has a number of experiences with a health provider that has appropriately trained physicians, a consistent supply of necessary medicine, and enough physicians to adequately staff the health facility, this health provider is more likely to build a reputation as a trustworthy and reliable health service provider.

The existence of health facilities in proximity to the community can also facilitate trust and further the enrollment rate in a particular CBHI scheme. An empirical study of participation in rural CBHI schemes introduced by the Rwandan Ministry of Health in 1999 found that while household health and economic indicators did not influence the demand for health insurance, living near health facilities did. Researchers found that individuals living within 30 minutes of health facilities were 296 percent more likely to have participated in the scheme (Preker and Carrin 263-4). Further, researchers speculated that living closer to health facilities facilitated trust building between health seekers and health providers as a function of a greater volume of interactions, more exposure to information campaigns and a better likelihood of personally knowing the management team (Preker and Carrin 264).

Trust between urban residents and health service providers can be difficult to form due to the high transience of urban dwellers and the short duration among health providers serving urban populations, as was previously reported in the Tanzanian case study (Tibandebage and Mackintosh 1392). This lack of trust can negatively affect CBHI enrollment, despite a higher probability of proximity to health services, given the high population density of urban settings (Bitran et al. qtd. in Fay 179). In rural communities,
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It is common to find fewer health service providers within a community. As a result, we find that CBHI enrollment may be more dependent on the proximity one has to health providers and the range of services offered thereby.

**Trust in CBHI scheme and CBHI management team**

The trust that potential CBHI members have in the actual health insurance scheme is a crucial determinant for whether or not community members decide to enroll in the scheme. Researchers Ozawa and Walker reported in their mixed method research case from northwest Cambodia that survey respondents who were newly enrolled or had renewed their membership in the local CBHI scheme expressed higher levels of trust towards the health insurers than those that had never enrolled or had dropped out (2009). Ozawa and Walker also contend that although trust in CBHI insurers was generally prevalent in Cambodian villages, individuals with poor previous experiences with other organizations were less willing to trust CBHI insurers (2009; Schneider 1434).

Given the importance of client trust in the insurer and the CBHI scheme, it is crucial to build an understanding of how to best foster individual and community trust in a CBHI scheme. One way in which trust is fostered relates to the management team and the enabling processes found to repair, create, and develop trust among potential CBHI members. CBHI managers have at their disposal a number of tools that can enhance the likelihood of enrollment among targeted communities. These tools incorporate the stakeholder feedback to determine CBHI scheme benefits package and pre-payment amounts, the accepted payment type and the schedule of payment collections. Research from the International Labour Organization (ILO) covering 258 cases from Africa, Asia, Latin America and the Caribbean, and the South Pacific found that CBHI schemes that incorporated community input, concerning pre-payment amounts and the benefits package, reported higher overall member satisfaction with the scheme and its services (Baeza et al. qtd. in Carrin et al. 803; Aradhna 1661).

There seems to be limitations, however, on whether and to what extent CBHI managers can manipulate pre-payment schedules and the type of pre-payment accepted. These two variables seem to be largely a product of the location of the CBHI scheme, with urban CBHI schemes experimenting more with monthly or quarterly contributions.
and rural CBHI schemes having the ability to explore agricultural and other in-kind contributions (Preker and Carrin; Bennett et al. 1998 and Ron 1999 qtd. in Carrin et al. 803). The inflexibility in urban settings regarding payment type is clearly a limiting factor that can negatively affect enrollment, as affordability is of paramount importance when providing health insurance to the poorest segments in a community. It may be the case that CBHI managers in rural settings are able to build stronger trust relationships with their clients than those in urban settings, as they have more flexibility in providing their members with payment schedules and options that fit more closely with their local economic realities.

In addition to the tools CBHI managers can use to make their product more attractive to the poor, the management team itself must foster a reputation with potential clients as trusted and competent managers with whom community members are willing to invest. The importance of trust between potential CBHI members and CBHI managers is repeated in the literature relating to best practices (Schneider 2005; Carrin et al. 2005; Chernichovsky 2009; Tribadage and Mackintosh 2005). Writing about the potential role of trust and enrollment in CBHI schemes in Rwanda and conducting open-ended focus group surveys in three rural pilot districts, Pia Schneider notes the spontaneous emergence of trust in focus group discussions and specifically describes respondents’ concern with the CBHI managers’ ability to advocate on behalf of their clients with health providers, maintain close contact with the community, learn about people’s problems, and educate individuals about the benefits of micro health insurance scheme (1434).

Though beyond the scope of this paper, there is evidence that the ability of CBHI managers to maintain contact with members could help increase renewal rates (Sinha et al. 661-663). Sinha et al.’s findings were based on a survey conducted in Ahmedabad city in Gujarat, India with over 17,000 women who enrolled in Self Employed Women’s Association (SEWA) in 2004 (657). Renewal rates for SEWA in 2005 were only 37.5 percent. Sinha et al. used a stratified random sample of 110 renewing members and 110 members who had not renewed in 2005 to examine how the samples differed. Surprisingly, the only statistically significant factors differing between those who had renewed and those who had not was whether respondents had “heard of SEWA”, knew
which benefits were provided, and whether they had an account with SEWA’s bank (661). The single largest reason respondents mentioned for not renewing was related to not having been contacted regarding the renewing their membership, which was reported by 57 percent of the 81 responding members who did not renew (661). This evidence shows that CBHI management practices may have an effect on member renewal rates.

Conclusions

Access to affordable health services is a large concern for many poor individuals and households in the developing world. Without formal protection against health-related financial shocks, the poor find themselves more exposed to higher health financing risks, which often forces them to resort to out-of-pocket payments to cover health-related costs. These high out-of-pocket costs often represent catastrophic expenses for poor households, as they consume high proportions of the meager household income available and can potentially lead to the liquidation of productive physical assets. This situation is further exacerbated when the primary income earner of the household requires health services. The lack of appropriate risk resilience strategies, such as proper products, behaviors, networks, and policies, leave poor households exposed to greater financial risk and vulnerability.

Over the last decades, insurance has been recognized as a financial instrument which could enable low-income households to better manage financial risks. As formal or state provided health insurance is more often than not unavailable for certain portions of low-income households and individuals in rural and urban settings, CBHI schemes have become an emerging and growing insurance tool designed to help the poor mitigate health-related financial shocks. Our research has examined whether, and to what extent, factors of trust impact CBHI enrollment. Trust is an important factor when considering CBHI enrollment, given the amount of risk that is inherent in the nature of insurance schemes. This inherent risk is further magnified for low-income individuals and households in the developing world, as they consider whether the insurance scheme is worth investing a portion of their often meager income. Our analysis reveals that CBHI enrollment rates are likely affected by three manifestations of trust relationships: trust in...
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others within the community, trust in health providers covered by the scheme, and trust in the CBHI scheme and management team.

Communities with higher levels of trust are more open to experiencing change and trying something new together, such as a CBHI scheme. Within areas where traditional risk sharing and risk pooling groups are already present, higher levels of trust and higher CBHI enrollment rates often result. Many CBHI schemes rely on these traditional and existing groups to leverage the existing trust relationships for gaining clients. The impact of trust in others on CBHI enrollment is particularly important in areas where CBHI schemes require a high rate of enrollment within the community due to small population sizes. This usually occurs in rural settings, where CBHI schemes face challenges of remaining financially sustainable, while still offering affordable membership prices. Trust and solidarity in these rural communities can facilitate the creation and sustainability of CBHI schemes. In a study in former Zaire, community members reported joining the CBHI scheme, regardless of whether they personally believed they would use the services, as a sign of community participation and mutual solidarity.

In terms of trust in health providers covered by the CBHI scheme, our research indicates that factors such as the availability, quality, and reliability of health providers are significant determinants of enrollment. The trust relationship between individuals and health providers covered by the CBHI scheme is based largely on experiential knowledge, comprised of past and current experiences. Given the experiential nature of this relationship, the existence of health facilities in areas where CBHI schemes are introduced facilitates the development of trust relationships and furthers the enrollment in the particular scheme.

Furthermore, our research indicates that the trust in CBHI management and in the scheme itself has an impact on enrollment decisions. CBHI schemes that are perceived as fair and transparent are better positioned to create trust relationships with community members. Practical ways in which CBHI management teams could foster trust relationships with community members included involving members in determining benefits covered, payment schedules, and the amount of payment fees collected, making themselves easily accessible to answer any questions from members, and providing...
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transparent practices within the management of the scheme and the reimbursement processes.

**Recommendations & Areas for Further Research**

CBHI schemes usually arise in areas where formal or state health insurance is not provided. In many low and middle-income countries, the majority of the population is self-employed, unemployed, or working in the informal sector, excluding them from coverage of formal insurance schemes. These countries also lack the necessary tax base to provide national level social health insurance, therefore CBHI schemes become viable and important tools for mitigating health-related costs for poor individuals and households. Given the potential role that CBHI schemes can play in improving risk resilience and the lessons learned from our research, regarding the impact of trust on CBHI enrollment, we offer the following policy and CBHI management recommendations and suggestions for areas of further study.

*Policy recommendations*

In terms of policy recommendations, governments and policymakers can improve CBHI operations and increase usage rates by providing technical support to CBHI managers, helping legitimate existing schemes, and improving public awareness regarding the concept of insurance. There is evidence that reinsurance of CBHI schemes can strengthen the capacity of these organizations, in addition to providing more stability and greater financial self-sustainability (Dror 675). Reinsurers working with CBHI managers often have an interest in coaching and improving managerial skills and providing technical assistance (Garand and Wipf 3). Policymakers might have a role in providing incentives to formal insurance organizations for reinsurance of CBHI schemes in the form of subsidies or guarantees.

Furthermore, establishing a protocol for CBHI scheme standards and procedures that encourage transparency, on the part of managers, may lend to greater perceived legitimacy for micro insurance groups. The ministries of health in developing countries might provide potential CBHI clients a measure of confidence by legitimizing established CBHI schemes or providing incentives to nascent micro insurance groups to organize and
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operate according to pre-defined industry standards and best practices. It may also prove beneficial for governments to support CBHI schemes by ensuring access to radio and television bandwidth for dissemination of information campaigns regarding the potential benefits and protection that health insurance provides for low-income individuals and households against health-related financials costs.

**CBHI management recommendations**

CBHI schemes in many areas of the developing world are still an emerging and growing concept. Given that insurance, and more specifically CBHI schemes, are new and foreign concepts in many areas, training sessions, workshops, and other public awareness campaigns regarding the benefits of insurance schemes are crucial for the construction of the value proposition of CBHI schemes. Especially in urban environments, where resident transience is greater, CBHI managers ought to focus their resources on providing informational campaigns explaining the benefits of CBHI membership at more frequent intervals. Information campaigns are necessary to build trust in the concept of insurance and the CBHI scheme itself. In rural environments, where trust relationships are based on ethnic, traditional, and family ties and studies have shown that proximity is necessary for those trust relationships to develop, information campaigns in the form of regular community visits and meetings could prove beneficial in increasing CBHI enrollment rates.

When working in rural and urban environments, it is important for CBHI schemes to alter its design and management features to accommodate the unique differences within each setting. In rural communities, where there are typically fewer health service providers and resources available, CBHI managers ought to focus on alleviating the barriers to access to health services for community members living afield and, where possible, negotiating the expansion in the range of services offered by local providers. CBHI managers in rural areas should ensure that the CBHI payment schedules are flexible and appropriate to meet the needs of agricultural workers who may not be able to pay a monthly fee in a non-harvest season. The design and management scheme in urban settings should focus on neighborhoods that are created through some form of similar background, such as ethnic, interest, or occupational ties. Targeting these neighborhoods
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will help offset the risks created by the transient nature of urban environments and allow the leveraging of existing networks of trust among community members.

*Areas for further study*

Further research is necessary to confirm which mechanisms of trust affect the success of CBHI schemes. Studies focusing on renewal rates, as an indicator of success for CBHI schemes, would allow further understanding of the role of trust in the decision-making process and the effectiveness of CBHI schemes to build and maintain trust relationships with its members. Currently, there are few, if any, studies on CBHI schemes that include renewal rates or other data speaking to the longevity of individuals or households in a scheme. Another possible area for further research would be a mixed methods research study incorporating time series data, among urban and rural households across different countries, evaluating their perceptions on participation and renewal in CBHI schemes. This type of study would provide more empirical insight into the significance of trust on the sustainability of micro health insurance. Lastly, our research has identified the impact of trust on CBHI enrollment occurring on three levels: trust among members of a community, trust between members and health providers, or trust between members and CBHI management. It would be helpful for policymakers if further studies identified which, if any, of these three areas has the most significant impact on enrollment, and possibly renewal, rates.

While CBHI schemes are useful tools for managing health-related shocks, it is by no means the ultimate strategy and solution for mitigating risk. In fact, CBHI schemes at times inadvertently exclude the poorest segments within communities. However, under the right circumstances, CBHI schemes can truly be a successful risk resilience product, helping to improve access to health care services for poor individuals and households, as well as decrease their exposure to health-related financial shocks.
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