User Fees or Community Based Health Insurance

Contents

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Program: Basic Needs
Carried out by: Wouter Rijneveld
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1. Introduction

Health projects are part of the Basic Needs program of Woord en Daad. The majority of these projects have a focus on primary health care, but about ten projects involve curative health care. Especially about the latter, Woord en Daad has been discussing the sustainability of financing mechanisms with her partners. In some contexts, notably Colombia, the objective was to have the hospitals incorporated in the Social Health Insurance system of the government, so that costs could be paid from this insurance system. In other contexts, Woord en Daad discussed with partner organisations to start asking user fees (also know as Out Of Pocket money, OOP) in order to cover at least part of the running costs in this way. An average of 50% of the running costs for curative health care was set as a target to be covered by OOP. The vision of asking user fees is not without objections and actual realisation of cost covering differs between countries and partner organisations. One of the points raised in these discussions is that asking user fees may result in declining attendance to hospitals.

The same discussion is going on at the macro level. Some months ago, Worldbank published a more than 300 pages report on Health Financing (Gottret and Schieber, 2006), discussing various models of public health finance.
Social Health Insurance and Community Based Health Insurance are two models that receive much attention as alternative mechanisms for government or donor spending and for user fees.

This study is a brief literature survey of the experiences with Community Based Health Insurance (CBHI). A brief Terms of Reference for this brief research is attached as appendix 1.
The research question defined in this ToR is:

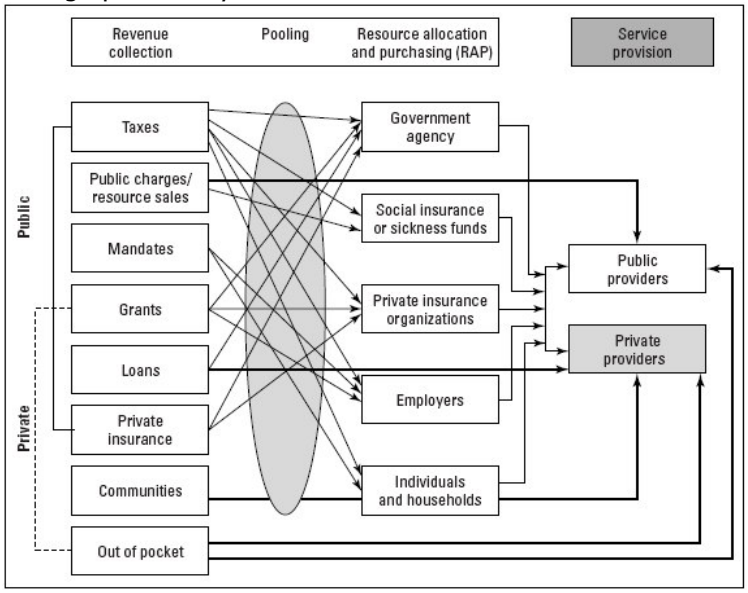
Could CBHI be a possible model for financing health projects of Woord en Daad?

- *What are experiences with CBHI thus far?*
- *What are advantages and disadvantages of CBHI?*
- *What is the effect of CBHI on the impact, outreach and quality of health programs?*
- *What is the effect of CBHI on the sustainability of health programs?*

This means that, since Woord en Daad's health projects are all private health providers, the focus of this survey will be on private health providers and not public health providers, although the role of private health care in relation to the public health system always needs to be considered.
This survey should lead to a recommendation whether or not it seems wise to start a pilot project of CBHI and if yes, under which conditions.

2. Different Health financing mechanisms

Models for health financing can also be seen as risk pooling mechanisms. All have in common that money needs to be raised, needs to be managed in order to pool the risks and needs to be allotted through provider systems. This holds true both at micro and at macro level.



The above figure from Schieber et al. (2006) shows the interactions between the three stages: collection, pooling and allocation.
The main models for health finance are summarized below (mainly taken from Gottret and Schieber, 2006). These models are not exclusive; in most countries a mixture of various models is used.

National Health Service systems

This is the model where the government raises income from taxes (or other sources, such as revenues, external grants), and spends this through a network of public health providers, usually directed by a Ministry of Health. If this model is used with full coverage, citizens are entitled to health care at no further cost. This is the model used in the United Kingdom. Several variations are possible, such as subcontracting of private health providers.
Many developing countries have such a system with only partial coverage (usually only urban areas) and partial access (usually formal workers).

Strengths	Weaknesses
• Comprehensive coverage • High equity • Huge pooling of risk, because of large numbers • Large scope of raising resources: all income sources of the government can be used • Uniform system → potential efficiency	• Unstable funding (depending on national budget discussions) • Often favours the rich, because of unequal access (urban ⇔ rural, informal payments) (richest 20% use 24-48%, poorest 20% use 4-17%). • Potential inefficiency: bureaucracy and monopoly

It is not likely that this type of system will fully succeed in countries where the informal sector is big, governance poor or corruption and bureaucracy high.

Social Health Insurance (SHI)

SHI is also a centralised system for health care. Difference with national health care system is that sources for income are earmarked taxes or contributions and not the general government budget. This usually takes place through payroll taxes for either employee or employer or both. The (former) Dutch Ziekenfonds system is an example of SHI. Sometimes there is one single fund, which provides the highest risk pooling, sometimes there are several funds, usually non-profit, with basic features set by the government. Germany was the first country with the system. 27 of the 60 countries using SHI have reached full coverage, which indicates the difficulty of this. Many donors stimulate countries to set up SHI, but there is no consensus on whether it works fully well in all contexts. Among the countries where Woord en Daad is active, Colombia is implementing the systems since 1993 and the Philippines have recently started setting up SHI. In Colombia, coverage increase from 23 to 62% (48% among the poorest quintile, Escobar, 2005). Income is raised through payroll taxes and from an equity fund (from the general budget). Payment is partly to the demand side (where people can choose to be registered with different insurance schemes), and partly to the supply side: public hospitals, but supply side subsidies will be phased out. Child mortality among insured population fell from 44 to 14 / 1000 births. Universal coverage and financial sustainability remain challenges, and, as Woord en Daad's partner CDA's experience testifies: corruption in the system.

Strengths	Weaknesses
• More income for health care: easy to deduct from payrolls, and more willingness to pay earmarked taxes • Less dependent on budget negotiations • High redistributive dimension (from rich to poor, esp if no income ceilings are used; from young to old; from single to family; from low-risk to high risk) • Usually strong support from population	• Difficult to achieve general coverage, esp. if those to be covered are more than those who contribute (those outside formal system, unemployed, elderly, children) → often exclusion of the poor • Needs strong tax management system • Negative economic impact as labour costs increase • Complex to manage because of many actors • Escalation of costs. If supply side subsidies:

	excessive use; if fee-for-service subsidies: excessive provision. • Weak on preventive care provision

For many countries, it is not likely that SHI will become an instrument for universal coverage and universal access to health care (e.g. Kenya, since 1966, only 7% coverage). Carrin and James (2003) showed that the following factors determine the success of SHI systems: income per capita, well educated work force, low income inequalities and high level of political rights. Not many (if any) of the countries where Woord en Daad is active would seem to qualify for high potential success.

Voluntary or private health insurance

These insurance systems are not based on income from tax and are not income related. Some countries have mandatory private health insurance (e.g. Swiss and Uruguay), in other cases private health insurance is also voluntary health insurance. Often, these systems exist alongside either NHS or SHI. They can function as primary source of coverage of health costs (as in the new system in The Netherlands), as duplicate source (e.g. for elite target groups offering higher quality care), as complementary (when costs are only partially covered by SHI or NHS), or as supplementary source (for services not covered by NHS or SHI).

Strengths	Weaknesses
• Good replacement for OOP payments • May enhance access to advanced services	• Often reach wealthier people only • Risk of selection (c.f. the Dutch regulation of 'compulsory acceptance')

This model seems hardly interesting for the target groups of Woord en Daad in developing countries. Rather for middle or higher income groups.

Community Based Health Insurance (CBHI)

Other names for CBHI are: health insurance for the informal sector, mutual health insurance organizations or micro health insurance schemes. A wide definition would be: not-for-profit prepayment plans for health care, with community control and voluntary membership. CBHI has existed for centuries in many different countries. Often they were a precursor for SHI systems as in Germany. There is a wide variety of forms of CBHI, but further discussion of CBHI is done in the remainder of this report.
The box below defines a number of terms related to CBHI (from Bennett et al., 2004)

Box 1: Glossary of Terms Related to Community-Based Health Financing

CBHF/CBHI
A non-profit type of health insurance for the informal sector, formed on the basis of an ethic of mutual aid and the collective pooling of health risks, in which members generally participate in the management of the scheme.

Co-payment
Out-of-pocket charge paid by an uninsured individual at the time of seeking care.

Cost sharing
Any of several mechanisms whereby costs are shared by more than one payer, such as users, employers, government, insurer. Sometimes the term is used specifically to refer to mechanisms whereby users of government services share costs with government.

Micro-insurance
Voluntary and contributory schemes for the community handling small-scale cash flows to address community risks. May encompass a variety of different types of risks, including the risk of health care expenditures.

Mutuelles de santé/mutual health organizations
Term used within the West Africa region to describe CBHF schemes.

Out-of-pocket spending
Fee paid by the user of health services directly to the provider at the time of service delivery and borne directly by the patient. Fees include cost sharing (and user fees) and informal payments to health care providers.

Payment-in-kind
Payment for health (or other) services that are not in the form of cash but commodities (such as crops) or labor.

Prepayment
Payment made in advance that guarantees eligibility to receive a service when needed, at reduced or zero additional cost. Sometimes this term is used in a manner synonymous to CBHF, but it may also refer to prepayment for an individual or household without risk pooling between households.

Premium
Amount of money paid to an insurer on a regular basis in return for health care coverage for a specified period of time. Also sometimes called "dues" or "contribution."

Reinsurance
Whereby the first (or direct) insurer contracts a second insurer to share in the risks that the direct insurer has assumed on behalf of its members or beneficiaries. It is generally accepted as sound practice to reinsure a scheme against sudden catastrophic or extraordinary liabilities that the scheme may be unable to meet.

Risk pooling
The formation of a group so that individual risks can be shared among many people. Each actor facing possible large losses (such as health expenditures) contributes a small premium payment to a common pool, to be used to compensate whichever of them actually suffers the loss.

User fees/user charges
Out-of-pocket payment made at the time of using health care services.

User fees / OOP

User fees or Out-Of-Pocket payments refers to the money people have to pay for medical services or drugs they obtain. In lower income countries, 85% of the costs for health care is OOP.

Strengths	Weaknesses
• High impetus for quality care • Additional source of funding for health care • Judicious use of health care	• Little equity • No risk pooling – no protection → limiting access to health care for the poor • May lead to poverty

The debate on macro level for or against user fees is going on. Policy makers and organisations as Gordon Brown, Jeffrey Sachs, DfID and Save the Children are against any use of OOP and argue for abolishing. In view of an increasing volume of external aid for health care, various countries have abolished OOP, e.g. South Africa in 1997, Uganda in 2001, Madagascar in 2002 and Zambia January 2006. However, various other scholars (e.g. Leon Bijlmakers, ETC; Alex Preker, Worldbank; David Dror; all during seminar 'Equity in Health', 27-06-06) are very sceptical about abolishing user fees and point to the fact that practice shows that this does not lead to a transfer of resources to the poor (unevenness in access remains, quality and ownership go down, informal fees go up; Drorr: in South Africa, still 85% of the people have to pay for their health care). The question asked by them is: "can the poor afford free health care?"
Most likely, a combination of financing mechanisms will often be needed and no universal overall best solution can be given.

3. The story of CBHI so far

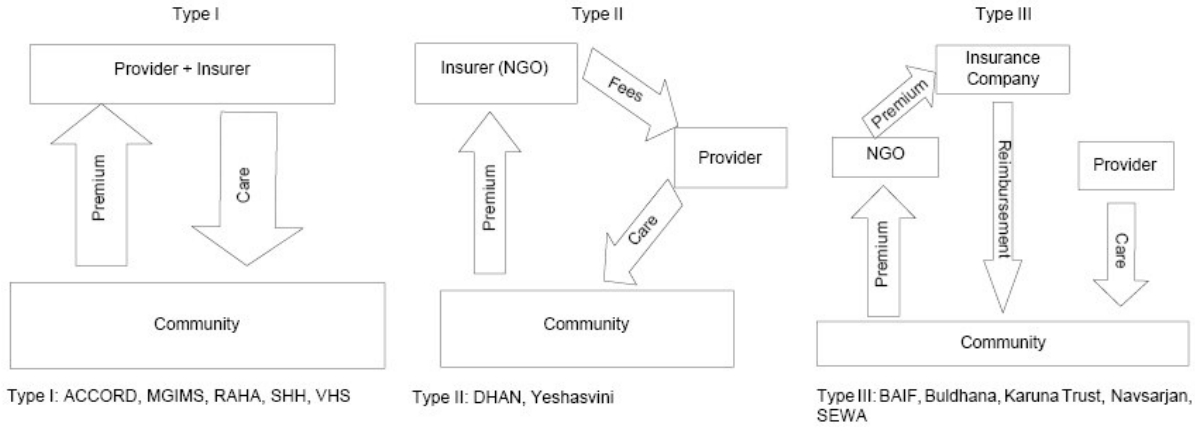
CBHI has existed for centuries in many countries. In many countries with NHS, SHI or universal private coverage, smaller scale CBHI schemes were used as building blocks (e.g. "onderlinge verzekeringsorganisaties" and "friendly societies", 27.000 of these in the UK end of C19. Workers' unions in the time of the industrial revolution often started these.) This also indicates, as Preker et al. (2002) show that low income countries may not be able to leap-frog the developmental process toward general public funding for health. In many countries, there are traditional risk pooling and saving mechanisms that function as a natural setting for CBHI. This is especially the case in Sub Saharan Africa and Asia. In 1997, a survey found 81 documented CBHI schemes, mainly in West Africa and Asia (Bennet et al., 2004). The number of schemes is rapidly growing, among others because a 2001 WHO report from the commission on Macroeconomics and Health advised positively on the use of CBHI. In Ghana they grew from 4 to 159 in two years; in the whole of West Africa from 199 in 2000 to 585 in 2003 (covering 1.5 million people, Bennett et al., 2004), in India: 7.5 million people are covered by 40 schemes, mainly in rural or semi-urban areas and among lower castes, Bangladesh 2.5 million people, Philippines 1.2 million (ILO, 2005, in: Cohen, 2006). In the Philippines, the government is currently (since 2003) involving CBHI schemes to develop the national insurance system, through the PhilHealth Organized Groups Interface.

Three common features of CBHI schemes are (Gottret and Schieber, 2006)

- Affiliation is based on community membership and the community is involved in management of the system. Community is taken in a wide sense: geographic, workers, religious, ethnic, etc. Legal ownership is sometimes with the community (9%), or with central / local government (44%) or with an NGO (25%) or an hospital (11%).
- Beneficiaries are often excluded from other forms of health financing: government systems are inaccessible, SHI is for formal workers, private health care is too expensive.
- Members share common values; often based on traditional methods of solidarity.

Yet there is a wide variety of types. Devadasan et al. (2004) give the following typology:

Figure: Types of Community Health Insurance schemes in India



Type I: ACCORD, MGIMS, RAHA, SHH, VHS

Type II: DHAN, Yeshasvini

Type III: BAIF, Buldhana, Karuna Trust, Navsarjan, SEWA

In the first type, the hospital is also the insurer: provider based insurance. The third type has the biggest potential for risk pooling and scaling up, since the insurance company (in India mainly ICICI Lombard) may be involved with several schemes; however, reimbursement is done after expenses are claimed and lag time for reimbursement is sometimes several months (Ranson, 2002).
Gottret and Schieber (2006: 98ff) give three other typologies of CBHI schemes (such as: based on type of risk covered, based on ownership, or based on sources for income), but the above scheme seems most practical to use.

In Rwanda, people pay user fees to public providers since 1976. In 1999, the government started 54 Micro Health Insurance schemes in three rural districts. People pay RWF 2,500 per year and get free care at health centres, transport to district health centres and some services at district level.

4. Effects of CBHI

On sustainability of health programs

The sustainability of the scheme and the effect of CBHI schemes on the sustainability of health care financing need to be distinguished. In the case of provider-based schemes, the two are almost equal. For the sustainability of the schemes, the design of the schemes, management skills and effective marketing are among the most important factors, while economies of scale may be even more important. This is where the need for reinsurance arises, where CBHI schemes reinsure their funds with bigger scheme-cooperatives, networks or official insurance companies.
5-7% administrative costs is normal for CBHI schemes, but this often involves volunteer labour. This percentage may be lower for bigger schemes and for schemes that grow out of micro credit organisations. Sustainability of schemes is increased by excluding or limiting certain costs or by increasing co-payments. However, this shifts the burden and the risk back to the clients.

In India, provider-based CBHI schemes (mainly with private not-for-profit hospitals) still needed 20-40% external funds from whatever source (Devadasan et al., 2004). Preker et al. (2002) show from a literature survey that CBHI schemes recover 12-51% of health costs.
In Rwanda, members contributed twice as much to the costs of health care as non members (Bennett et al., 2004)

If adverse selection occurs, sustainability decreases. This takes place when people with high risk join the scheme, increase the costs and make lower risk people to leave or not to join the scheme. This is the reason that many CBHI schemes exclude e.g. hiv-aids and TB (e.g. none out of 10 schemes in Senegal included hiv-aids, 6 out of 8 in Ghana did, but only preventive care). However, considerable research is done about pilot projects where hiv-aids is included in CBHI schemes or where these schemes are used as a channel to provide access e.g. to external funds for ARV from the Global Fund. Schemes often apply the 60% rule to avoid adverse selection: 60% of a group or community should be enrolled in the scheme. On the other hand, this rule may be an obstacle for enrolment. Other schemes offer discount to groups that have 60% enrolment.

On impact of health programs

Derrienic et al. (2005) did an assessment of twelve CBHI schemes in Uganda. They found that a significant positive effect of scheme membership on quality of life (actual health situation and ability to cope with health costs). Marketing strategies with the help of membership incentives (subsidies on insecticide treated nets) proved effective. The Mutolere hospital based scheme also includes preventive care in its benefit package, thereby reducing the costs for curative care.

In Rwanda, members of schemes are four times more likely to make use of health care (members: 1.2-1.6 consultations/capita/annum, non-members 0.2-0.3), members consumed fewer drugs per consultation, indicating that health care is sought in an earlier stage. Use of preventive services for women and children increased fourfold compared with non members. Prenatal care was 65% more likely and delivery assistance was twice as likely. Increased social solidarity was another benefit (Bennett et al., 2004). The research by LSHTM found that some insured members still fall below poverty line because of OOP spending for uninsured costs, which indicates that the benefit package may not be sufficiently comprehensive.

In India, officially health care is free for the poor, but in practice people have to pay for drugs and informally also for treatment. More than 40% of hospitalized people borrow money and 24% of hospitalized people fall below poverty line because of the costs involved (2002 Worldbank study by Peters et al., quoted in Devadasan et al, 2004. For Andhra Pradesh, this figure is 22%, Preker et al., 2002). Experience with CBHI shows that people seek earlier treatment when insured and do not wait until sickness becomes an emergency.

CBHI schemes mainly reach the rural middle class (who generally belong to the country's poor). It is harder to reach the poorest section. Targeted subsidies or solidarity funds from local churches are sometimes used successfully to increase the outreach. Payments in kind, or scheduled at harvest time,

or linked to saving schemes are other ways. Preker et al. (2002) also conclude that financial protection does take place, but that the poorest are sometimes excluded.

CBHI schemes also have a potential impact on the quality of health care itself, by providing additional resources and by strengthening accountability. However, this effect is hardly documented, as also Ekman (2004) notes: There is strong evidence that community-based health insurance provides some financial protection by reducing out-of-pocket spending. There is evidence of moderate strength that such schemes improve cost-recovery. There is weak or no evidence that schemes have an effect on the quality of care or the efficiency with which care is produced. In absolute terms, the effects are small and schemes serve only a limited section of the population. The main policy implication of the review is that these types of community financing arrangements are, at best, complementary to other more effective systems of health financing.

However, not everyone agrees about the positive effect of CBHI schemes on health status. A report by ILO and STEP (2002) did a literature survey and concluded (with a lot of caution because of the small quantity of reliable data) that there is no evidence for a positive impact on health status, on utilization of services or on risk protection and that there is no valid evidence either for any other benefit. The main factor responsible for this lack of impact, according to the study, is the small size of the schemes, with 70% under 2000 members. The study sees the main use of CBHI's in its intermediate function to provide access to SHI or NHS systems.

5. Best practices

Cripps et al. (2000) have written a very extensive and practical (222 pp) guide to setting up a CBHI scheme.

The importance of marketing

Marketing CBHI is much tougher than micro credit, especially when medical services are officially free or have formerly been offered for free. Making use of existing networks of grass roots groups, like micro credit groups, self help groups, workers' unions or a system of social workers who know the people helps marketing of CBHI. The twelve schemes researched by Devadasan et al. (2004) all make use of existing community based organisations, or unions, or cooperatives. More comprehensive benefit packages are the most forceful factor for marketing success.
In India, targeted subsidies for the poorest were advocated for. Experience has shown that it is vitally important to make good use of marketing first and financial sustainability of the schemes should not be dependent on subsidized premiums. In Karnataka enrolment went down from 82.000 to 25.000 when people from lower castes were asked to pay the premiums themselves in the fourth year, after having been subsidized for three year (Cohen, 2006).

Participation and ownership

The definition of CBHI already includes the notion of ownership. Especially in terms of defining the conditions, the premiums, the packages of benefit, it is important to listen to the participants' wishes. Among experts there is disagreement as to what the poor want most: protection for emergency situations (surgeries, hospitalisations), or protection and payment for primary health care, drugs or even transportation costs.
Ownership of the schemes also improves efficiency and reduces fraud by increasing social control and accountability. E.g. in a scheme in Uganda, members decided to raise co-payments in order to protect the financial viability of the scheme (Derrienic et al., 2005).
Another aspect of it is influence in management of the fund. Especially with provider-based CBHI, this is an important and more difficult issue.
Also, when there are targeted subsidies, the community should be involved. Criel (seminar 27-06-06) indicated that in this way targeted subsidies for premiums for the poorest of the poor (the destitute, homeless) are easily determined, but difficulties arise when it concerns those just above this level.

Working at understanding insurance concepts

This is related to the point about marketing. In many case studies, lack of understanding is mentioned as a reason for drop outs for the schemes: people do not understand the use of co-payments or expect to have their premiums returned if they do not fall sick.
A pre-assessment of willingness to pay seems to increase this willingness (Preker et al., 2002).

6. Actors

In The Netherlands

- Following, the 27-06-06 seminar, an initiative is started to form a network for exchange and cooperation. Cordaid and Ecorys are leading, ICCO is also involved.
- InterPolis (now part of Achmea) (Toon Bullens) is active in CBHI. Achmea is also planning to set up a foundation.
- Micro Insurance Association Netherlands, MIAN (www.mian.nl). Rabobank Foundation is partner of this association. They support some projects in Sri Lanka, Philippines, India (TN)
- Rabobank Foundation. Frank Bakx indicated that RF has no specific expertise in the field of CBHI, but would be willing to think along and use his network to introduce us to experts.
- Dutch NGO's involved in CBHI's: Cordaid (Mutolere hospital, Uganda), Oxfam Novib (Dhan, India. I.s.m. Mian / Interpolis), ICCO: nog niet.

Other countries:

- Belgium: Masmut (www.masmut.be) is a platform of various actors: research, policy, insurance companies, NGO's in the field of micro and social health insurance.
- Uganda: Uganda Community Based Health Financing Association (UCBHFA), financed by Ministry of Health in Uganda: a network of CBHI schemes.
- India: network of CBHI: (www.comhealthins.org), CHIN (Community Health Insurance Network). The network has 67 members from many different states, but not all are involved in CBHI yet (incl. a hospital from The Leprosy Mission in Uttar Pradesh). Through its website, CHIN offers many overviews of CBHI, case studies, lessons learned and impact analyses. Dr Devadasan is coordinator of this network.
- India: (www.microhealthinsurance-india.org) Consortium of the Federation of Indian Chambers of Commerce and Industry (FICCI), the Erasmus University Rotterdam, The Netherlands, and the University of Cologne, Germany (Dutch profs David Dror and Wijnand van der Ven). Focus on research and training. With a good database of article (abstracts) on the topic. In case we would consider a (pilot-) project in India, it should be worthwhile to contact this consortium. Also in case we would like to do extended research, a student from Erasmus University would seem a good option.
- www.concertation.org. African network for CBHI. French speaking countries. With summaries about health finance, regulation for health insurance, documents and lists of organisations per country. (6 CBHI schemes in Burkina Faso, mainly very small).

7. Conclusions and Recommendations

Strengths of CBHI	Weaknesses of CBHI
• Better access / use to health care • Protection against high costs • Better cost recovery of health care (but not fully) • Increased solidarity • Potential for increased efficiency and effectivity through increased accountability • Useful as intermediate mechanism toward general insurance systems • May serve as effective mechanism for targeted subsidies	• Limited protection • Sustainability of schemes questionable • Often small scale (related to two points above; reinsurance needed) • Exclusion of the poorest • Danger of adverse selection (only high risk members join) • Danger of over-consumption or over-prescription (depending on model used) • Effect on providers of care often limited

1. Insurance business is a very technical area that requires very specific expertise, different from expertise in micro credit.
2. CBHI is not a solution to replace external assistance to health projects. It should rather serve as an additional resource for health finance or a (partial) replacement for OOP spending, to be completed by government spending / external funding / OOP co-payments.

Actions for pilot project

Looking at the complexity of CBHI, the absolute need for participation from the communities involved and the probable need for an extensive feasibility study, the decision to set up a pilot project must be taken by the partner organisation involved after careful discussion.

1. CSS seems the most natural partner to possibly become involved in CBHI. A hospital, a micro credit program and a PHC program are all operating in the Khulna area. CBHI could possible be provider based (the AWM hospital), but could also be linked to the micro credit program. In any case, a sizeable number of potential members could be reached. At the same time, Bangladesh does have experience with CBHI. Rabobank Foundation is going to be involved in the micro credit program of CSS. Frank Bakx indicated that he would be willing to also take CBHI into consideration, but that specific expertise in this field would need to be attracted from elsewhere, possibly through the network of Rabobank Foundation.
   Recommendation: discuss CBHI with CSS during any next visit. Next steps depend on the outcome of such a discussion.
2. Other partners: send this brief survey for information and indicate that Woord en Daad is considering to become active in this area. During working visits to these partners, the topic should be raised. Possible next steps depend on initiative and enthusiasm of partners.
   Partners concerned: AMG India, Word and Deed India, AMG Guatemala, CDA Colombia, AMG Haiti.

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Seminar: *Equity in Health: challenges for social and community insurance schemes*. Held 27-06-06, at Den Haag. Organised by Dutch Ministry of Foreign Affairs and Cordaid Speakers: Leon Bijlmakers, ETC; Alex Preker, Worldbank; Bart Criel, Institute Tropical Medicins Antwerp; Grant Rhodes, Ecorys; Pontius Mayunga, Mutolere Hospital Uganda.

Appendix 1 - Terms of Reference Research

This is the Terms of Reference (TOR) for the following Research

Name of research study	Research on Community Based Health Insurance
W&D Projectnumber	91.92.001
Contact person/programme	Wouter Rijneveld
Partner organization(s) involved	n.v.t.
Contact person(s)	n.v.t.
Other agencies involved	n.v.t.
Contact person/programme	n.v.t.
Leading organization	Woord en Daad
Research carried out by	Wouter Rijneveld
Date of application	01-07-2006

This TOR has been discussed and agreed upon by the parties involved.

1. **Introduction and Context**
   - *See Introduction of the report*

2. **Objectives and expected results of the research**
   - *Objectives:*
     - *Get an overview of experiences with community based health insurance (CBHI) as a mechanism for financing health care.*
     - *Determine whether it is worthwhile to start up a pilot project with CBHI.*
   - *Research question: Could CBHI be a possible model for financing health projects of Woord en Daad?*
     - *What are experiences with CBHI thus far?*
     - *What are advantages and disadvantages of CBHI?*
     - *What is the effect of CBHI on the impact, outreach and quality of health programs?*
     - *What is the effect of CBHI on the sustainability of health programs?*
   - *The conclusion of the brief report (max 10 pp) should be whether and how to set up a pilot project of CBHI.*

3. **Methodology and Approach**
   - *Literature survey*
   - *Seminar on Social and Community Health Insurances, 27-06-2006*

4. **Required expertise**
   - *Internal research*

5. **Roles and responsibilities**
   - *Internal research*

6. **Follow up**
   - *This introductory research will determine whether or not a pilot project will be started. If this will be recommended, this will be further discussed with potential partners.*

7. **Planning and budget**
   - *Research: July – September 2006, so that costs for a pilot project can be included in the yearplan 2007*
   - *Time involvement: 4 days at 9 hours = 45 hours*
   - *Costs: none, except travelling costs to seminar*

8. **Approved by:**

Gorinchem, *date*	*Place*, *date*
On behalf of Woord en Daad	On behalf of *organisation*

Jan Lock, managing director	*Name, function*