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Original Research

Social capital as a key determinant of willingness to join community-based health insurance: a household survey in Nepal

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ABSTRACT

Objectives: Although community-based health insurance (CBHI) schemes have been considered as an intermediate stage to achieve universal health coverage (UHC) in low-resource settings, there is a knowledge gap on ways to make it better.
Study design: More than 4000 Nepalese households were randomly selected and surveyed.
Methods: Logistic and multivariate multinomial regressions were estimated.
Results: Overall, 88% of included household heads were willing to join CBHI, 61% were willing to pay annual premium less than 600 Nepalese rupees (US$5.6) per household, and more than a half (53%) responded that the government should subsidize a significant portion of the premium. Results showed that a higher level of social capital was significantly related with an increase in odds of accepting higher premiums, while individuals' health status and age did not have such associations. Individuals with bonding social capital were more likely to be inclined to join CBHI. Persons who said they can lend money for a living expense (bonding capital) did not want the government to subsidize the scheme, while this negative association would be reversed if persons had both bonding and bridging social capitals.
Conclusion: We found significantly positive relationships between social capital and willingness to join and willingness to pay for CBHI in Nepal. Policymakers, aiming to achieve UHC, should be advised that bonding and bridging social capital have differing relationships with willingness to cooperate the external funding sources.

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Introduction

Although universal health coverage (UHC) has been championed by health policymakers around the world,[1,2] a reality lags far behind ensuring UHC in low- and middle-income countries (LMICs). Given the gap between 'saying and doing', how to achieve UHC should be more emphasized because UHC would end up as a rhetoric without a better strategy and guidance.[3]

Community-based health insurance (CBHI) has been considered as an intermediate stage, ensuring moving away from households' direct payment for healthcare services to forms of prepayment, in transition to UHC.[4] Community is considered important in this strategy because governments are often facing two difficulties: (1) governments in resource-limited settings are not able to fund enough money to cover the people; and (2) collecting premiums/taxes is not easy especially in rural areas where many residents do not have regular earned income sources.[5]

However, there have not been enough lessons from experiences in CBHI. The World Health Organization's (WHO's) global overview of CBHI acknowledged a weak conceptual framework of CBHI's integration in national policy and heterogeneity in organizational designs and performances.[6] The WHO report revealed a low level of coverage, little impacts on out-of-pocket spending, and a weak relationship of CBHI with healthcare quality. In addition, although a systematic review of 36 studies on CBHI schemes suggested CBHI schemes improve access to care and cost-recovery ratio, it was also reported that actual amounts generated by such schemes were limited.[7] In addition, the review found that interventions' impacts on healthcare quality were limited and that schemes failed to cover marginalized groups.

Without clear empirical evidence on its linkage to UHC, CBHI's viability as a promising financing option will soon be in peril. Based on real-world examples that CBHI has not achieved significant population coverage around the world,[8] critics have pointed out that voluntary prepayments cannot be a long-term solution.[9] It is also been of concern that community-based independent schemes would further fragment the national health system.[10]

However, there is a practical reason why CBHI is still considered as a policy option. In extremely poor resource settings, where population suffers low health coverage and weak governance, an urgent need for an instrument of protection from health and financial shocks makes CBHI the only option. Rare but meaningful experiences have showed that persons enrolled in CBHI have higher probability of healthcare utilization with lower expenditures in poor environments.[11] In addition, CBHI was found to strongly relate with household financial protection.[12]

But there is a knowledge gap on ways to make better CBHI schemes to date.[8] For instance, a cluster-randomized rollout in Burkina Faso which offered CBHI to the target population resulted in less than 13% enrollment rate and limited impacts on health.[13] CBHI schemes' voluntary nature is said to be attributed to a part of CBHI's failures. Adverse selection—asymmetric information between buyers and sellers in the market would lead to wrongly set market prices; therefore, premiums would increase continuously—also has gotten attention.[14,15] Such a threat has made policymakers consider popular solutions for the voluntary insurance market: (1) household (not individual) should be a unit of enrollment for better risk pooling; and (2) compulsory waiting period should be set to prevent people from seeking insurance only when they get sick.[16] However, evidence on the effectiveness of these options on CBHI's sustainability is scarce.

CBHI's 'disappointing' performances have been attributed to, according to a literature review, a high level of co-payments, racial/ethnic exclusions, lack of legal framework, insufficient outside subsidy, narrow benefit packages, or poor quality of care.[17] In specific, (perception of) poor quality of care was among the most important factors of dropout from CBHI,[18] although successful CBHI is believed to increase the quality of care by better meeting communities' needs through net revenue generation in theory.[11]

Critics have argued that the importance of dynamics of the community itself has been overlooked.[19,20] A Burkina Faso case well described the need for better understanding the context; adverse selection was not triggered by a launch of a scheme but by a policy addressing inequity; after premium subsidies were provided to poor households, adverse selection was reported to increase.[16]

The Rural Mutual Health Care scheme case in China showed how lack of interpersonal trust contributes to the failure of CBHI.[21] Even though the scheme set household as the enrollment unit—to reduce adverse selection—about a third of enrolled households were in fact found to enroll partially (which was against the rule).

Critics point out that, in many (failed) cases, CBHI schemes were implemented with 'top-down' approaches by governments or foreign institutions, not by active demands of targeted people or communities. These facts were pointed to relate to CBHI's unsustainability and failures.[8,20] Arguing that rational individualist model (economic perspective) failed to incorporate values and power relations in the context of community, Mladovsky and Mossialos stressed the need to bridge the knowledge gap between social capital and CBHI.[20] Their review suggested that intra-community interpersonal ties (solidarity and trust) can increase the probability of CBHI schemes' success and that extra-community networks may reinforce the stability of the schemes.

This study stresses the importance of social capital and its linkage with CBHI's functioning by exploiting a unique household survey data gathered in Nepal. By analyzing the demand for the potential market for CBHI, this study aims to contribute to health policy with empirical evidence on the linkage of individuals' demands with social capital. It is noteworthy that the survey was uniquely aimed to vulnerable population; the nation's gross domestic product (GDP) per capita was just less than $600 in 2010. The survey was conducted only 5 years after the end of a decade-long civil war (1996–2006). Should the results be found to be consistent with social capital's the hypothesized positive associations with individual's demand for CBHI, it will become more evident to pay attention to context-driven CBHI implementation.[20]