

## Editorial: A view from beneath: Community Health Insurance in Africa

Pascal Ndiaye<sup>1</sup>, Werner Soors<sup>2</sup> and Bart Criel<sup>2</sup>

1 *Initiative de Communication pour le Développement Social (ICODES)-Afrique, Dakar, Senegal*

2 *Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium*

### Summary

This paper presents an overview of the development of Community Health Insurance (CHI) in sub-Saharan Africa. In 2003, nearly 600 CHI initiatives were registered in a dozen countries of francophone West Africa alone. At regional level, coordination networks have been created in Africa with the aim to support and monitor the developments of this innovative model of health care financing. At national level, governments are preparing the necessary legal frameworks for CHI implementation. CHI is increasingly seen as a strategy to meet other development goals than only health. It constitutes an interesting model to finance health care, to pool financial resources in a fair way and to empower health care users. The CHI movement however still faces many challenges. The relevance of more professional inputs in the management of CHI and the need for careful subsidy of CHI schemes are increasingly recognized. There is also need to optimize the relationship of CHI with the other actors in the health system and to scale-up CHI so as to gain in effectiveness and efficiency. The boom in the number of schemes in Africa during the last years is an indicator of the increasing attractiveness of the model. In practice however, enrolment rates per scheme remain low or are only slowly increasing. Context-specific research is needed on the reasons that prevent people from enrolling in larger numbers. On that basis, relevant action to be taken locally can be identified.

**keywords** community health insurance, access, financing, user empowerment, sub-Saharan Africa

Access to decent health care is a global problem that is strongly linked with worldwide changes in health care financing. It is a particularly great problem in sub-Saharan Africa, the only region in the world with negative economic growth for decades now. The policy of free care at the point of use, the option taken in most African countries in the early independence days of the 1960s, became unsupported and was gradually abandoned in the deepening economic and financial crisis of the 1970s and 1980s. From 1987 on, the donor-driven Bamako Initiative tried to remedy this, linking up community participation with community financing in health care. User fee policies contributed to increase the level of resources available in health care facilities and led to improvements in the quality of health care delivery in some settings (Levy-Bruhl *et al.* 1997). But user fees also constitute a strong barrier to health care for many African households trapped in poverty and excluded from formal social security systems.

It is in this context that Community Health Insurance (CHI) emerged in the late 1980s and early 1990s (Brouillet *et al.* 1997; Dror & Jacquier 1999). CHI was largely inspired by the continental European experience with Social Health Insurance (Gruat 1990; Normand & Weber 1996;

Criel & Van Dormael 1998). Initiated by private non-for-profit health care providers, for instance church-related organizations in Senegal and Ghana, or non-governmental organizations in the Democratic Republic of Congo, driven by the search of health providers for funds to operate their services, or by a combination of both, the movement was picked up by a growing number of communities and socio-professional groups excluded from formal social security (Criel 1998; Atim 1999). The principles are simple: on a voluntary basis individuals or households join a non-for-profit structure to share the financial risk of individual health care expenditure; together they decide on the services covered and the contribution charged.

Solidarity is by no means a new phenomenon in African culture. Neighbour support has been a long-lasting tradition and has a place in almost any life event of the African household. A wide variety of arrangements of informal risk sharing and coping mechanisms exist, such as rotating savings and credit associations, burial societies and friends-in-need-groups. However, the increasing burden of demographic growth, economic decline and structural adjustment policies, as well as urban migration paired with profound changes in the social fabric of communities

P. Ndiaye *et al.* **A view from beneath**

outweighed the soothing potential of overstretched traditional solidarity mechanisms.

Governments and donors recognized the potential of CHI as a strategy to increase access to health care under adverse conditions. The movement gained strength and in 1998 several African countries, international partners and local actors met in Abidjan, the capital of Ivory Coast. Together they created the coordination network *Concertation entre les acteurs du développement des mutuelles de santé en Afrique*, currently known and referred to as *La Concertation*. The aim of this network was to support and monitor the developments of CHI in sub-Saharan Africa<sup>1</sup>. It is now gradually extending its activities from franco-phone to anglophone Africa and from West to Central Africa. In East Africa a similar, but smaller, network also operates: the Community Health Financing Association for Eastern Africa (CHeFA-EA). It currently offers support to CHI schemes in Kenya, Tanzania and Uganda. Increasingly, contacts are established between these two coordination networks.

### **A takeoff at different speeds**

The boost of CHI in West Africa has led to a fast sixfold overall increase in the period 1997–2003 (*Concertation entre les acteurs de développement des mutuelles de santé en Afrique* 2004). Table 1 provides an overview count of the nearly 600 CHI initiatives registered in francophone West Africa in the period 1997–2003 (Atim 2000; *Concertation entre les acteurs de développement des mutuelles de santé en Afrique* 2000, 2004). The data for 2006 are based on recent estimates provided by key informants in each of the countries concerned. In 2006, the number of functional CHI schemes in the 11 countries surveyed was 626, which is almost double the number of functional schemes in 2003.

Considering the total number of CHIs, forerunner Senegal also appears as a foregoer. Next are Guinea, Burkina Faso and Mali, followed by Benin, Cameroon and the Ivory Coast. The Niger, Chad, Togo and Mauritania modestly close the ranking. A closer look at country level discloses not only different speeds but also particular modalities of implementation.

In Mali the CHI movement benefited since its early stage from the presence of the Technical Union of Community Health Insurance schemes, the *Union Technique de la Mutualité Malienne* (UTM). The federation offers community groups their own CHI tailored to local needs and further serves as an interface between the movement and the government. Initially relying on organized formal

urban workers, the UTM now addresses successfully both the informal sector and the rural communities.

In Senegal CHI went the other way, expanding gradually from rural villages to urban and periurban settings and from the informal to the formal sector. New initiatives keep emerging. Today formal workers are adopting the CHI concept as a welcome complement to poorly performing formal social security arrangements. The Senegalese State supports the CHI concept and provided a legal framework and a strategic plan for CHI development.

Guinea presents another particularity: a research project (the PRIMA project: *Projet de Recherche sur le Partage du Risque Maladie*) set out the stakes back in 1996 (*Le projet PRIMA en Guinée* Conakry 2002). More recently the implementation of MURIGA (*Mutuelles pour les Risques liés à la Grossesse et à l'Accouchement*, i.e. CHI schemes for the management of pregnancy and birth related risks), differing from the classical CHI concept in its more narrow target group, provides a possible entry-point for yet additional risk-sharing among people.

Burkina Faso initially concentrated on the extension of CHI schemes led by health care providers themselves, but today community-run CHI schemes are increasingly common; Benin focuses on the involvement of locally elected leaders. Cameroon, Niger and Mauritania got involved only recently, but can rely on strong social and religious networks. Ivory Coast, Niger, Chad, Togo and Mauritania still lag somewhat behind. However, intense activity from the planners' side possibly indicates a forthcoming CHI boom in these countries.

The case of Ghana in anglophone West Africa is particular because different types of CHI exist for more than 10 years. The initiative for these schemes was taken at local level by hospital managers, district health management teams, unions, civil society organizations and villagers. More recently, the government took the initiative to promote health insurance in the form of district insurance schemes and in 2004 new legislation was introduced that establishes a framework for the implementation of these district schemes.

This inventory commissioned by *La Concertation* did not include Central and Eastern Africa, but CHI is enjoying an increasing interest there. A particular feature of the situation of CHI in that part of the African continent is the fact that governments and health care providers tend to play a more prominent role in the launching and management of CHI (Waelkens & Criel 2004). In Uganda, a dozen of CHI schemes exist and almost all of them were launched and are managed by hospital staff from faith-based health care facilities. In Tanzania, the government has played a major role in launching CHI at district level with support

<sup>1</sup><http://www.concertation.org>

**Table 1** Community Health Insurance schemes in West Africa

	1997	2000	2003				2006	
	Functional schemes	Functional schemes	Functional schemes	Schemes in start-up phase	Schemes in difficulty	Total number of schemes	Total number of beneficiaries	Estimated number of functional schemes
Benin	11	23	42	11	0	53	41 428	120
Burkina Faso	6	26	35	50	4	89	14 873	60
Cameroon	18	20	22	14	2	38	15 947	30
Chad	3	4	7	0	0	7	1775	11
Guinea	6	27	55	44	10	109	84 820	90
Ivory Coast	0	29	36	1	3	40	527 670	47
Mali	7	22	51	16	4	71	469 815	102
Mauritania	0	0	3	4	0	7	13 055	5
Niger	6	12	9	3	1	13	49 868	19
Senegal	19	29	79	48	9	136	308 563	130
Togo	0	7	9	8	0	17	20 011	12
Total	76	199	348	199	33	580	1 547 825	626

from the World Bank. But private not-for-profit, mainly hospital-based, CHI schemes also exist in Tanzania.

### Small but personalized experiences

The majority of African CHI schemes only count a few hundreds of members, 95% of the schemes having <1000 members – households are the usual unit of membership meaning that the number of individual beneficiaries from the schemes is much higher (Table 1). Most of the members keep strongly linked to a well-defined but limited social basis, like a village, a church or a professional group. These features lead to high transaction costs and limit the efficient and sustainable coverage of expensive risks, such as hospital admissions or costly or prolonged drug expenditure. This is one of the reasons why many of the CHI schemes only cover basic primary care and essential generic drugs. Many schemes are managed or co-managed by the members themselves, but the limitations of management by non-professionals are increasingly recognized.

Smallness has more than only disadvantages. Members generally know each other and sometimes play an active role in the management of the scheme. CHI is increasingly seen as a road to meet other development objectives beyond health. The increased social control and transparency observed in the presence of a well-implemented CHI may boost sustainable development and democratization at community level. An expected outcome in health, next to better access to health care, is the possibility to empower users (and potential users) in their interaction with professional health care providers, and thus to weigh on the supply side. There is evidence, albeit still limited and unsystematic, that CHI can lead to a more balanced power

relationship with the health care providers, and thus constitute a leverage to have service packages that are more in line with local needs and to increase quality of care (Criel & Waelkens 2003; Waelkens & Criel 2004). Furthermore, the inventory of *La Concertation* indicates that CHI handles activities additional to health insurance in more than 60% of the West African CHI schemes, especially in Cameroon, Guinea and Burkina Faso. The most frequently associated activities include the provision of micro-credits and of health care services. This relation runs in both directions: 33% of micro-credit organizations report health insurance as an associated activity. Beyond community level, CHI may eventually contribute to poverty reduction (Waelkens *et al.* 2005).

### Increasing national and international interest

At national level several African countries have developed legal frameworks for CHI implementation (Ghana and Senegal), even making membership mandatory (Rwanda and Tanzania). An increasing number of countries plan such legislation as well. At regional level the participation to the bi-annual meeting of the members of the *Concertation (Le Forum de la Concertation)* is an indication of the growing interest in CHI by a variety of stakeholders, as witnessed by the boom in attendances from 80 participants in 2000 till 372 in 2004. Equally remarkable is the widening scope of present actors, including major national and international stakeholders.

Noteworthy for the maturation of the CHI movement is the evolution of the discussion themes at the bi-annual meeting of the members of the *Concertation*. Whereas in 2000 the central focus was still on the design of CHI, the

P. Ndiaye *et al.* **A view from beneath**

attention progressively shifted in the years after to a discussion on managerial tools for an improved performance, and to the study of means to structure the relationships of CHI with the other actors in the system (especially the health care providers) and of strategies to smoothen the integration of CHI in local health systems. The CHI movement not only acquired important managerial skills, it increasingly displays a systemic vision on health care delivery (Ndiaye 2006).

### Challenges and promises

But no balanced opinion on CHI in Africa can bypass the many limitations and challenges the movement still faces. One of the pressing issues is the need to optimize the relationship of CHI with the other actors in the health system, including health committees, service providers, the State and the donor community. CHI schemes are still considered as rivals by health committees, as watchmen by reception staff in health facilities cut off from under-the-counter payments and as untrustworthy payers by service providers. It takes providers time to understand the objectives of CHI and to appreciate their impact on service provision. Where interests meet, a functioning integrated local health system can be achieved with providers enjoying more stable revenues.

Another important challenge for the CHI movement is the need for scaling-up and professionalizing CHI management without losing the advantages of a personalized approach. One possible path to reach this goal is the creation of networks or federations of CHI schemes. This strategy is already carefully considered or applied in several West African countries (Mali, Senegal, Guinea). Networking offers the potential to cover rare but very costly events like hospital admissions. It can also strengthen the financial robustness of CHI, develop managerial capacity and help create a platform for advocacy and lobbying at the national level. The *Union des Mutuelles de Santé de Dakar* (UMSD) in Senegal and the *Union Technique de la Mutualité* (UTM) in Mali are distinctive examples that succeeded in gaining collective strength and professionalism by entrusting managerial and promotional tasks to a shared central structure.

It is important for donors to understand the specificity of CHI and the need for time for it to develop. The implementation of CHI is a complex technical, managerial and social operation. It took European Social Health Insurance systems many decades to develop. Donors can definitely contribute to a harmonious development of CHI by not handling unrealistic (short-term) objectives and time frames, by strengthening local capacity in terms of design and follow-up of CHI schemes and by an intelligent use of

subsidies in order to make CHI more affordable for the poorest in society. We argue for more attention from donors for the social and political dimensions of the African CHI movement, next to its potential to improve people's access to health care.

### More and broader knowledge for action is needed

As we have argued in this paper, CHI constitutes an interesting model to finance health care in sub-Saharan Africa. CHI enables to pool resources in a fair way and thus to share the burden of health care financing among many. It can create a stable resource of income for health care providers. Last but not least, it can constitute an innovative model of organizing and empowering users in their interaction with health care providers. The recent boom in the number of schemes in Africa is an indicator of the increasing attractiveness of the model. In practice however, enrolment rates per scheme remain low or are only slowly increasing. Today we know some of the more important reasons: poor quality of care, limited ability to pay and lack of trust in the schemes' management. Next to these other factors should be considered: the schemes' designs and the extent to which the package of benefits fits people's demands and needs, the information people have on the schemes, the distance from people's homestead to the health facilities where care is delivered, etc. Introducing health insurance in African societies, where households needs are multiple and pressing, and where insurance is altogether a new cultural concept, is a complex undertaking. We need more systematic, multi-country research on the causes that prevent people from enrolling in CHI en masse. Then actions to be taken can be identified – tailored to each setting. Finally, two important lessons are now increasingly clear and should trickle down to the field. First, the need for more professional inputs in the support, management and follow-up of CHI. Secondly, the need for careful subsidies to cover the poorest households – without however undermining and jeopardizing local solidarity dynamics.

### References

- Atim C (1999) Social movements and health insurance: a critical evaluation of voluntary, non-profit insurance schemes with case studies from Ghana and Cameroon. *Social Science and Medicine* 48, 881–896.
- Atim C (2000) *Contribution des mutuelles de santé au financement, à la fourniture et à l'accès aux soins de santé: synthèse des travaux de recherche menés dans neuf pays d'Afrique de l'Ouest et du Centre*. Abt Associates Inc., Bethesda.

P. Ndiaye *et al.* **A view from beneath**

- Brouillet P, Wade M, Kambé M & Ndao M (1997) Emergence des mutuelles de santé en Afrique. *L'enfant en Milieu Tropical* 228, 40–54.
- Criel B & Van Dormael M (1998) Mutual Health organisations in Africa and social health insurance systems: will European history repeat itself? *Tropical Medicine and International Health, Editorial* 4, 155–159.
- Criel B & Waelkens M-P. (2003) Declining subscriptions to the Maliando Mutual Health Organization in Guinea-Conakry (West Africa): what is going wrong? *Social Science and Medicine* 57, 1205–1219.
- Criel B (1998) *District-based health insurance in sub-Saharan Africa. Part 1: from theory to practice. Studies in Health Services Organisation & Policy*, 9. ITG Press, Antwerp, 149 pp.
- Dror DM & Jacquier C. (1999) Micro-insurance: extending health insurance to the excluded. *International Social Security Review* 52, 71–97.
- Gruat JV (1990) Social security schemes in Africa. Current trends and problems. *International Labour Review* 129, 405–421.
- Concertation entre les acteurs de développement des mutuelles de santé en Afrique (2000) *Base de données sur les mutuelles de santé en Afrique. Travaux de recherche dans 11 pays*. Dakar (Senegal) (<http://www.concertation.org>).
- Concertation entre les acteurs de développement des mutuelles de santé en Afrique (2004) *Inventaire des systèmes d'assurance maladie en Afrique: synthèse des travaux de recherche dans 11 pays*. Dakar (Senegal) (<http://www.concertation.org>).
- Le projet PRIMA en Guinée Conakry (2002) *Une expérience d'organisation de mutuelles de santé en Afrique rurale* (eds B Criel, A Barry & F von Roenne). Medicus Mundi Belgium, Brussels.
- Levy-Bruhl D, Soucat A, Osseni R *et al.* (1997) The Bamako Initiative in Benin and Guinea: improving the effectiveness of primary health care. *The International Journal of Health Planning and Management* 12, S49–S79.
- Normand C, Weber A. (1996) *Social Health Insurance. A Guidebook for Planning*. World Health Organization, Geneva.
- Ndiaye P (2006) *Développement des mutuelles de santé en Afrique: une analyse comparative des approches et de leurs impacts*. Centre de Recherches pour le Développement International (CRDI), Ottawa, Research Matters, 35 pp.
- Waelkens M-P, Criel B. (2004) *Les Mutuelles de Santé en Afrique Sub-Saharienne. Etats des Lieux et Réflexions sur un Agenda de Recherche*. Health, Nutrition and Population Discussion Paper World Bank, Washington, USA, 93 pp.
- Waelkens M-P, Soors W, Criel B (2005) *The Role of Social Protection in Reducing Poverty: The Case of Africa*. Extension of Social Security Paper No 22, Geneva, International Labour Organisation, Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Geneva, Switzerland, 46 pp.

**Corresponding Author** Bart Criel, Department of Public Health, Institute of Tropical Medicine, 155 Nationalestraat, B-2000 Antwerp, Belgium. Tel.: +32 3 2476293; Fax: +32 3 2476258; E-mail: [bcriel@itg.be](mailto:bcriel@itg.be)