CBHI in Africa: successes and constraints, challenges ahead

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- Rapid overview of current situation of CBHI in Sub-Saharan Africa
  - CBHI today in SSAfrica
  - Tentative SWOT analysis
- Challenges, recommendations, research priorities

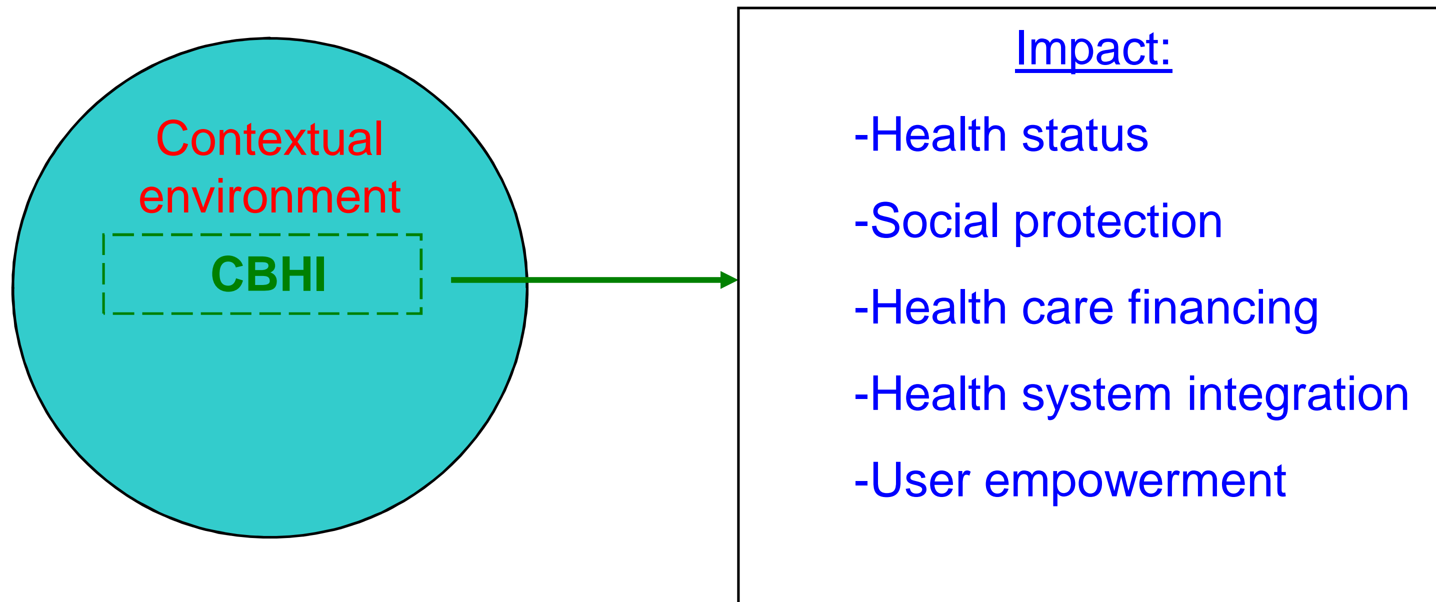
- **Number of schemes: a steady increase**
- Inventory (2003) by the Concertation (www.concertation.org) in 11 francophone West and Central African countries
  - N=622 schemes of which 2/3 functional at time of enquiry
- Inventory Ghana (2004): N=4 in 1998, N=47 in 2000, N=157 in 2004
- Uganda and Kenya (2005): approx. 15 and 30 schemes respectively
- Rwanda and Tanzania: CBHI schemes in half of the districts

CBHI in Africa today (2)

- **Different models**
  - Community-run schemes (the model *Mutuelle de Santé*) mainly in West Africa; mostly management by poorly qualified volunteers
  - Provider-run schemes (MOH or private not-for-profit providers) mainly in East Africa; mostly management by health staff with support from volunteers
  - Mixed models
- **Different legal-institutional frameworks**
  - In some countries legal framework for operation of CBHI: Ghana, Guinée-Conakry, Mali, Rwanda, Senegal, Tanzania
  - In some countries CBHI support cell within MOH or related to MOH: Senegal, Uganda
  - In some countries national programme of promotion of CBHI: DRCongo

- **Size of schemes**
  - Size of most schemes remains small: 90% of CBHI schemes studied in the 2003 inventory by *La Concertation* had less than 1000 members
- **Package of benefits**
  - Variable
  - Most CBHI schemes in West Africa cover first line health care; in East Africa focus is more on hospital care

Under what conditions can CBHI have what kind of impact?



Under what conditions can CBHI have what impact?

- Contextual conditions/factors influencing the development of CBHI
  - Ability to pay: purchasing power
  - Willingness to pay: trust, quality of care
  - Information and education: understanding of insurance, knowledge of scheme’s design
  - Technical support to CBHI in terms of management and monitoring
  - Policy support
  - …

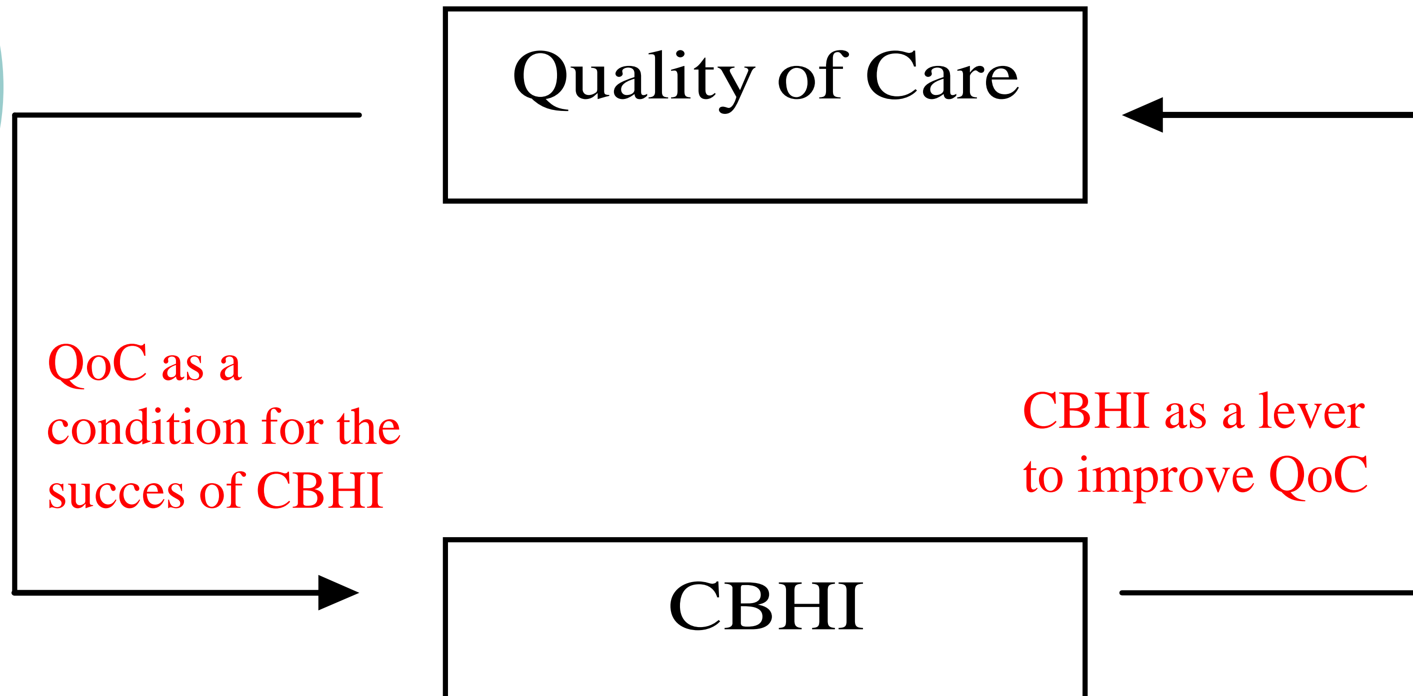
What possible impact of CBHI? (1)

- A **health** dimension
  - path: enable access (utilisation, delays, compliance) to useful health care
- A **social protection** dimension
  - path: protect households ’ income and assets and prevent iatrogenic poverty
- A **financial** dimension
  - path: a stable source of revenue for the providers with less unpaid bills

What possible impact of CBHI? (2)

- A **systems** dimension
  - path: a lever to rationalise the supply side and to promote a more integrated functioning of local health systems
- A **socio-political** dimension
  - path: a counter-power to the health workers leading to more responsive health services and better quality of care

CBHI and quality of care (QoC): two dimensions



Does CBHI work? SWOT-analysis on basis of summary of empirical evidence

- **Strengths of CBHI**
  - Access to health care for insured has improved
  - "Social dynamic"
- **Weaknesses of CBHI**
  - Limited enrolment, small-sized schemes, high transaction costs, problematic financial robustness
  - Till date, hardly an option for the poorest
- **Opportunities for CBHI**
  - Nascent dynamic of federations/unions of CHI schemes (incl. mechanisms of re-insurance)
  - Poverty reduction programmes: source of potential funds to subsidise CBHI?
- **Threats to CBHI**
  - Complexity of CHI underestimated and donors/ development organisations looking for rapid results

Challenges, Recommandations & Research Priorities

- Scaling-up of CBHI
- Management of CBHI
- Support structures for CBHI

- **Increase low enrolment**

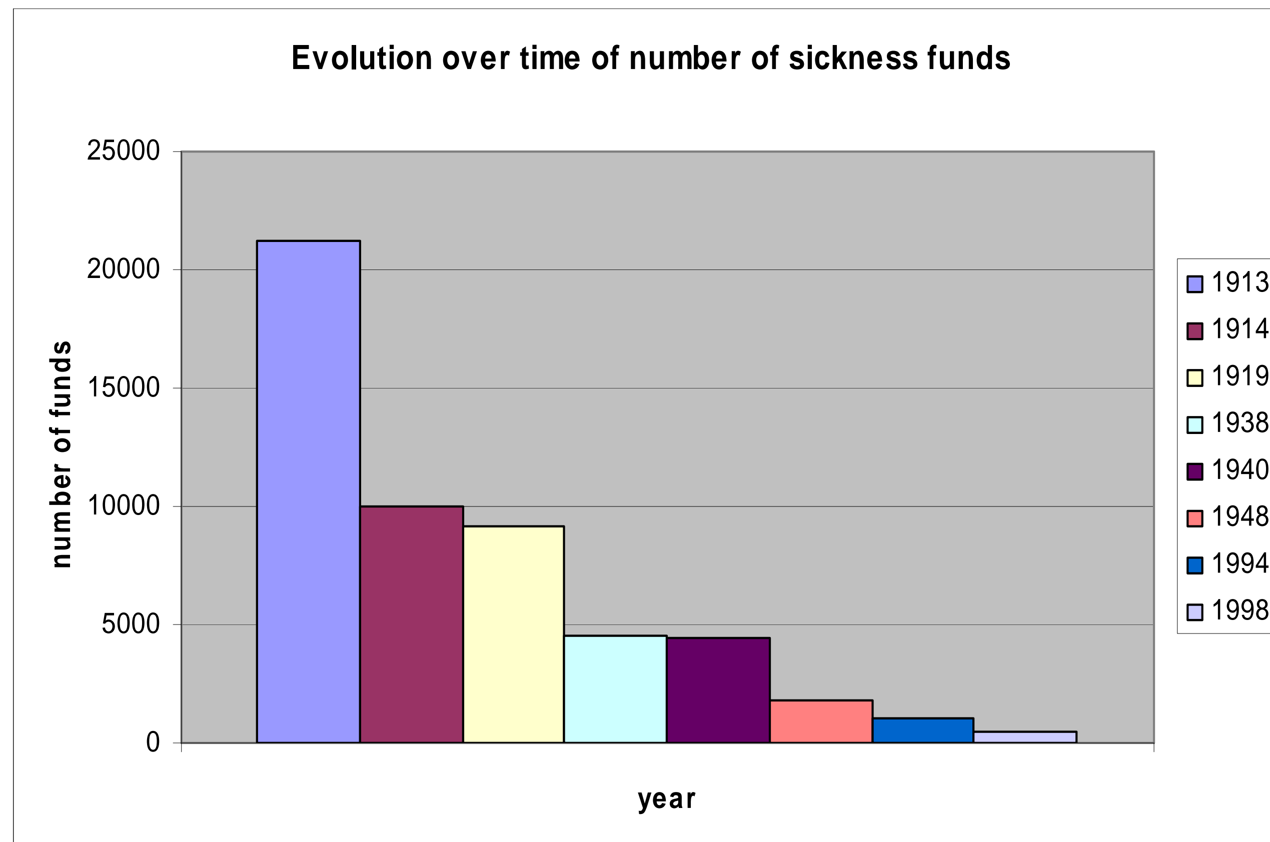
  Enrolment=
  - Function of quality of care
  - *and* F (trust)
  - *and* F (ability to pay)
  - *and* F (design)
  - *and* F (information)
  - *and* …
  - *and* …

Is a matter of local research: context-bound answers

Scaling-up of CBHI (2)

- **Creation of federation of CBHI schemes**
  - Rationale: « Small is not always beautiful »
  - Nouakchott workshop December 2004 organised by ITM and Caritas Mauritania
  - How to steer this process? At what stage of the development of CBHI? What activities for such federations?
  - There are probably lessons to be learned from the Western European experience

The German Social Health Insurance System over time: merging of sickness funds and economies of scale



- **Integration of voluntary health insurance systems and other health care financing arrangements in a perspective of nation-wide (i.e. universal) coverage**
- A variety of scenarios:
  - The Uganda case: no user fees in govt facilities
  - The Kenya experience: Social Health Insurance
  - Legislation for compulsory health insurance: Rwanda, Ghana
  - …

- **Use of subsidies**
  - CBHI and the poorest: exclusion
  - CBHI and the poorest: need for specific arrangements
  - Subsidise their premiums via separate fund? -> **domain of social assistance**
  - Delicate balance to be found: avoid to ‘asphyxiate’ local solidarity dynamics

Targeted subsidies: subsidies for whom?

- Starting from the destitute (“chronic poor”)
  - Economically *and* socially excluded people
  - A small fraction of the population
  - Relatively easy to handle (identification, social acceptability)
- Plus the temporarily excluded…
  - Poor people facing *ad hoc* crisis situation excluding them from health care
  - A large part of the population
  - Much more difficult to handle in terms of identification and overall social acceptability (‘where to stop?’)
  - Much more resources needed
- Both?

- Who decides? What type of cadre?
  - The CBHI management?
  - Health workers?
  - Community representatives?
  - Local politicians?
  - Professional social assistance workers?
- Belgian experience: Public Centres of Social Welfare
  - 1st line: social assistants independent from the service at stake (health care or otherwise)
  - 2nd line: a local political body, democratically controlled, validates decisions made by social assistants

Test modalities of careful subsidy of CBHI in order to include the poor

- Variety of sources of funds potentially available: main challenge however is not availability of money, but rather:
  - The need for trustworthy institutional channels to finance health care for the poor
  - The need for effective, efficient and socially acceptable procedures
- Matter for research: Cordaid-ITM Antwerp-Uganda Martyrs University collaborative research in Uganda (2006-2008)
- As a general rule: develop working relationships between MOH and Ministry of Social Affairs, tear down the walls between the two administrations

Management of CBHI: volunteers or professionals?

- **Management by volunteers versus management by professionals**
  - Volunteers can be asset and indicator of social priority of CBHI, but there are clear limitations
  - The issue is not *or/or* but *and/and*
  - Optimum to be found between the two
  - How to finance the inputs of professionals? External subsidies? On the long term, via economies of scale (CBHI federations)?

- CBHI is complex: social, technical, managerial
- Need for support
  - At onset
  - During operation
- Different types of support
  - ‘Technical’ support: e.g. via provision of relatively standard guidelines ILO/STEP
  - ‘Analytical’ support: e.g. via tailored support to the development of CBHI in a given context
- Examples of regional/national support structures
  - *La Concertation* and their focal points per country
  - Community Health Financing Association for Eastern Africa (CHeFA) and its national branches

Belgian Platform Micro Health Insurance & Mutual Health Organisations : www.masmut.be

Final comment

- CBHI is means to improve access to health care but also a possible strategy to strengthen/ empower the demand-side
- PRIMA research Guineé-Conakry: need for concurrent support to the supply-side: quality of care, human resource management, etc.
- Aim for synergetic effect: demand-side support + supply-side support

  -> **Hypothesis: 1+1=3**