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Community Health Insurance (CHI) in sub-Saharan Africa

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Why Community Health Insurance? And what is it exactly?

Community Health Insurance aims at improving access to health care and reducing vulnerability of population groups that are hitherto excluded from formal systems of social protection in health. The main groups targeted are thus households that get their income in the informal economy, such as home workers and small businesses in urban areas and subsistence farmers in rural areas.

The term Community Health Insurance covers a wide variety of types and arrangements that suite different groups of people best. The five principles generally attributed to Community Health Insurance are the following:

1. Social protection through sharing of health risks: health care needs of members are paid for from a common fund set up with members' regular contributions;
2. A community-based dynamic: organised by and for persons who share common characteristics within a given community: village, enterprise, association, etc.;
3. Participatory decision-making and a management system controlled by the members;
4. Voluntary participation: contrary to formal sector workers, for whom employers have the legal obligation to organise health care protection, the decision to subscribe to Community Health Insurance is taken on a voluntary basis;
5. Not-for-profit character of the schemes.

In practice, however, individual schemes apply these principles to a more or lesser degree. For instance, in some insurance schemes set up by health care providers, participatory decision-making is not really developed. A union may decide that all its affiliated members should subscribe, thus not upholding the principle of voluntary participation. Small informal sector enterprises may decide to pay contributions for their workers, in which case the border between formal and informal insurance becomes blurred. Initiatives taken by formal sector workers who decide to pool their resources to improve their health care coverage are also included, thus widening the public of Community Health Insurance that otherwise is often limited to workers of the informal economy.

In the Anglo-Saxon literature, the label Community Health Insurance is generally used to designate these systems. Less common is the term Mutual Health Organisation, although its French equivalent *Mutuelle de Santé* is widespread in francophone Africa. More recently, under the impetus of the International Labour Organisation, there is increasing use of the term Micro-Insurance.

At present, three approaches dominate the attempts of bringing order in the variety of models that exist. A first approach looks at the identity of the scheme's **ownership** . It may be initiated and run by a health care provider (for example the Ministry of Health that organises Community Health Insurance

at district level; a private provider wanting to improve income flow; a Church-based provider wanting to improve access to its chain of health care structures), by an NGO, a union, by a group of villagers, etc.

A second approach differentiates on basis of the organisational set-up for the scheme's **management** . The scheme can either be managed by the provider, by elected representatives of the members, or the management can be contracted to a third party like a professional insurer body that is accountable to the members and that can very well be in charge of managing more than one scheme.

A third approach classifies models on the nature of the scheme's **membership** . Membership can be defined on geographical basis (people living in the same village or defined by the use of a particular health structure), on ethnic or religious bonds, on membership to another organisation (for example a micro-credit scheme), or on professional occupation. Some schemes do not allow individual subscriptions, but only accept membership of an already organised group such as burial societies, schools or workers of small businesses, in an attempt to avoid adverse selection and to improve the scheme's financial viability.

Current state of affairs of Community Health Insurance in sub-Saharan Africa

A historical snapshot

Some isolated Community Health Insurance initiatives were launched in the 80's and early 90's, often under the lead of expatriate development aid workers familiarised with the history and operation of European Social Health Insurance systems. The example by excellence is the well-documented provider-based Bwamanda district hospital insurance scheme in the Democratic Republic of Congo that started in 1986. This scheme stood model for the Nkoranza district hospital scheme in Ghana that started its operations in 1991. Community-initiated schemes first appeared in West Africa, as early as 1986 with the *Mutuelle Pharmaceutique de Tounouma* in Burkina Faso, and the mutual health organisation of Fandène in Senegal in 1998. There was an increasing interest from development agencies, NGOs and research institutions in the potential of Community Health Insurance to overcome problems in accessing health care. Different models were developed, albeit in a unsystematic way, throughout the West and Central African regions, and later also in eastern Africa.

From the early 90's on, the Community Health Insurance movement in West Africa received increasing external support – often coming from organisations with a strong foothold on the European Social Health Insurance scene. These organisations, like for instance the International Department of the Belgian Christian Mutualities (the largest health care insurer in Belgium), organised training sessions for scheme managers, designed technical manuals and helped to create local support organisations for the development of Community Health Insurance. In Uganda, a series of provider-based models was piloted with the assistance of the British bilateral aid agency. At present, there is huge interest, both nationally and internationally, in Community Health Insurance as an strategy to expand the coverage of social protection in the field of health care. In addition, there is increasing focus on the social and political dimensions of Community Health Insurance as a model that empowers clients and constitutes a lever to improve the quality of care supplied by the contracted health care providers.

The faith in the potential benefits of Community Health Insurance, however, is not (yet) backed up by much solid evidence; but if the exponential growth of the number of new initiatives is an indicator, then the enthusiasm of the population is evidence that should not be discarded. The most recent count of Community Health Insurance schemes in West Africa shows a growth from 76 active schemes in 1997 to 199 in 2000 and 366 in 2003. Next to these there are 220 schemes in the early stages of development.

A catalogue of difficulties and shortcomings

The booming enthusiasm for Community Health Insurance should not divert the attention from the many shortcomings and obstacles that have repeatedly been observed: limited management capacity, certainly when organised on a voluntary basis, lack of trust of potential members, problems in ability to pay, small scale of schemes etc. But above all, there is the poor quality of the health care deterring people to invest scarce household resources in health insurance.

There is currently much controversy among public health specialists whether Community Health Insurance is the way forward or not in the search for more accessible health care services. But the amount of evidence is still scanty. Pros and cons of Community Health Insurance are being commented upon from a range of perspectives: its possible contribution to equity, to health sector financing, to more responsiveness and quality of care from the side of the providers, and last but not least, to more democracy in health. Challenging issues indeed; the bottom line, however, is that our current knowledge still is insufficient to draw any definite conclusions in any of these debates.

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What next?

Given the manifest interest of the population, Community Health Insurance definitely deserves a chance. But how then to contribute to its development? And in which specific domains would donor support be desirable? And what would be avenues for research?

Community Health Insurance is a complex technical, managerial and social arrangement. It should thus be handled with care and must be given the necessary time to develop. Hence the need to resist the search for rapid results and to handle a middle term perspective. Probably the most useful and urgent intervention is to find ways to improve the quality of care in the contracted health services in a sustainable way so that Community Health Insurance becomes a more attractive option to people. There definitely is a place for training in donor support, but training is not enough. Managers also need support structures that can help them in analysing problems and identifying solutions adapted to the specific context.

The limits of voluntary management are more and more obvious. For one, they unavoidably keep the schemes small, since the manager has only part of his time to allocate to voluntary work. But who then will pay for professional management? As long as schemes are small, it is not realistic to count on the members, who often live on less than US$2 a day, to contribute to the payment of professional management. Could paying for running costs – while members' money covers health care expenses – be a way forward? One of the most frequent criticisms of Community Health Insurance is that it excludes the poorest. This fact is of course inherent to the very nature of the system. Yet in various schemes, external donors, such as religious organisations, subsidise the premium of households that they identify as unable to pay. Could such initiatives for inclusion be a solution to reach the poorest – who have never been adequately reached by the health care sector?

The ultimate aim is to integrate the emerging community health initiatives into a national system for social protection in health. One step all countries can take is to prepare the necessary legal context to do so. But this integration will not happen tomorrow. First, existing schemes should succeed to attract a larger proportion of their target population. Once that is achieved, schemes should federate into larger pools. Mechanisms should be developed to promote solidarity and cross-subsidies between richer and poorer schemes. But all these changes should not be pushed through too quickly. Health insurance is not only about introducing a new financial system, but also about important social changes that should be given the time they need. Helping too much, too soon, too fast could contribute to the failing of Community Health Insurance.

Community Health Insurance is booming everywhere in Africa. It is a fascinating movement because Community Health Insurance is about more than only financing health care; it also is about organising and empowering clients in their interaction with health care providers. Our overall knowledge is slowly growing but it nevertheless still remains fragmentary. Hence the need to better document the different models of Community Health Insurance that are being developed in Africa, describe their pro's and con's, explore what works in the field and what doesn't, investigate why it works or why it doesn't work, etc.

The huge problem in accessing basic health care that many African households continue to face and the growing interest of the international community for social protection in health, definitely justify more systematic research in the domain of Community Health Insurance.

Further reading

- Health Financing for Poor People. Resource mobilization and Risk Sharing (Eds. Alexander S. Preker and Guy Carrin), The World Bank, 2004, 446p.
- Maria Pia Waelkens and Bart Criel (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*, March 2004, World Bank, Washington, DC, 99p.