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Health and Population
Social Health Insurance in Developing Countries

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Mutual Health Insurance (MHO) - Five Years Experience in West Africa

Concerns, Controversies and Proposed Solutions

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Health system and health financing reforms in sub-Saharan Africa promoted by international donors since the 1970's have not resolved the problem of reduced access to care. Locally developed self-governing Mutual Health Organisations (MHOs) were seen to have great potential to enhance access to quality health care and contribute to the social and institutional development of society.
Looking at the results of 10 years of MHO development, it seems that the idea is implemented in a community only with great difficulty. The majority of schemes reach only a fraction of the population, and does not solve the problem of access by the poorest segments of the population. The participatory character of MHOs and a management system based on benevolent work are their strength, but at the same time constitute a main weakness. Schemes are often poorly managed (low managerial competence) and poorly designed (poor design features).

The methodologies used for this study are key informant interviews with protagonists of major national and international promoter organisations, who were questioned regarding current prominent problems, controversies and solutions offered in the practical implementation of MHOs.

The paper is structured as follows:

1. Introduction presenting the historical background for health financing and health insurance in developing countries.

2. General approaches identified to illustrate major possible concepts for MHO pro motion.

3. Problems, challenges and controversies that are relevant to understand the major aspects in MHO promotion presented under four main problem areas:

- Institutional weakness
- Problem of moral hazard behaviour
- Low quality of care
- Ineffective support from promoting agencies and government.

4. General key issues for MHO development.

5. Synthesis of the experiences outlining the resulting conclusions and recommendations.

As major results the study reconfirms the recommendations given at the Abidjan platform and explains in detail why the MHO concept is still valid.
The problem of quality of care needs to be addressed by training health care providers to deliver patient-centred care, thereby improving the inter-relational quality of the consultation. Consumer misconception and unrealistic expectations are a major obstacle and lead to mutual lack of understanding between providers and MHO members. Programs of education for curative and preventive health care (medical conferences) can help insurance members better understand the health care offer. Improved collaboration between promoters should avoid unnecessary duplication of interventions in the field. Management tools and training manuals should be shared and made more readily available to existing mutuals. MHOs need to collaborate more effectively with providers so they can both benefit from the synergy created by addressing matters of common interest. Providers need to recognise that their prescribing practices are critical to the success of MHO schemes. The government can support the process by conducting a proactive policy to sensitise health workers about MHOs and to encourage providers to enter into negotiations with MHOs. Providers need autonomy to negotiate suitable local arrangements.
Setting up MHOs is a complex task because local health insurance schemes are situated at the intersections of three complex systems: The Financial, the Social, and the Health Service Delivery System. If an MHO scheme is to succeed, then due account has to be taken of the influence of these three systems.

An alternative strategy for the promotion of MHOs in West-Africa incorporating a more entrepreneurial approach is proposed by the GTZ. The ¨Centre for Health Insurance Competence“ (CHIC) model sets out to address the major problems of managerial weakness and the lack of adequate compromise between the technical requirements and the participation of the community in the setting-up and implementation process.

The guiding idea for the CHIC model is that it is neither per se necessary nor desirable to develop within each MHO a full technical and managerial capacity to run a health insurance scheme in a total autonomous manner. Instead, MHOs may purchase this expertise from a higher level institution (CHIC) which has as its objectives:

- Building a centre of competence for consistent and long term support to a network of MHOs.
- Developing standardized insurance products and administrative procedures suited for local adaptation.
- Providing the organisational and administrative competencies needed to set-up and run MHOs.
- Stimulating entrepreneurial behavior and supporting the gradual assumption of responsibility for an ownership of schemes by local actors.
- Pressing for an efficient implementation of schemes, whilst at the same time respecting the principles and time sequence associated with a bottom-up, individualized community-based approach.
- Setting-up systems to enable the MHO model to be extended and easily adapted to the needs of interested groups.

The conclusion of the paper is that the MHO experience is a necessary step to sensitise the population to the concept of health insurance, to build up the capacity of the state to organize and regulate the sector and improve the general conditions for health care provision. It is argued that a compulsory health insurance system may be introduced in a 10 – 20 year time period, linking the existing formal and informal sector insurance systems when the necessary conditions are in place.

Acronyms and Abbreviations

ADECRI	Association pour le Développement et la Coordination des Relations Internationales
AFD	Agence Française de Développement Française
ANMC	Alliance National Mutuelles Chrétiennes Belge
BI	Bamako Initiative
BIT	Bureau International de Travail
CAMICS	Cellule d'Appui aux Mutuelles de Santé aux IPM et aux Comités de Santé, Senegal
CBHI	Community Based Health Insurance
CEFE	Competency based Economies, Formation of Enterprise
CEPRASS	Centre d'Etude Prospective et Appliquées sur la Politique Sociale et les Systèmes de Securité, Ivory Coast
CIDR	Centre International de Développement et de Recherche, France
CRMST	Coordination Régionale des Mutuelles de Santé de Thiès, Senegal
EED	Evangelischer Entwicklungsdienst, Germany
GNP	Gross National Product
GRAIM	Groupe de Recherche et d'Appui aux Initiatives Mutualistes, Senegal
GS	Garanties de Santé
GTZ	Gesellschaft für Technische Zusammenarbeit mbH, Germany
HC	Health Centre
HCMC	Health Centre Management Comittee
IEC	Information, Education, Communication
ILO	International Labour Organisation
IPM	Institut de Prévoyance Médicale, Senegal
KFW	Kreditanstalt für Wiederaufbau, Germany
LIC	Low Income Countries
MAE	Ministère des Affaires Etrangères, France
MHO	Mutual Health Organisation
MMB	Medicus Mundi Belgium
MoH	Ministry of Health
MSA	Mutualité Sociale Agricole, France
NGO	Non Governmental Organisation
PAMS	Programme d'Appui aux Mutuelles de Santé, Senegal
PHC	Primary Health Care
PHR	Partnership for Health Reform, United States
PRIMA	Projet de Recherche sur le Partage des Risques Maladies, Guinea
PROMUSAF	Programme d'Appui aux Mutuelles de Santé en Afrique, Belgium/Senegal
PRO.NA.PAM	Programme National de Promotion des Mutuelles Privées d'Assurance Maladie
RAGAD	Reseau d'Appui des Groupes d'Action au Développement
STEP	Strategies and Tools against Social Exclusion and Poverty
UTM	Union Technique Malienne
WHO	World Health Organisation
ZEF	Zentrum für Entwicklungsforschung, Germany

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This paper is a result of discussions held with representatives of international promoting organisations from France, Belgium, Germany, the United States, of the UN organisations ILO and WHO, local promoter organisations, and representatives of the government and mutuals in Senegal and Mali.
The paper was commissioned and financed by the GTZ supra-regional project "Elaboration and Introduction of Social Health Insurance Systems in Developing Countries” and the work was conducted between February and September 2001. Interviews were held in March/April in Europe and in May in Senegal and Mali.

Intention of the paper

The authors intend to contribute to the current discussions on MHO promotion by making available the concerns, opinions, controversies and experiences of major protagonists, taking into account experiences from MHO promotion and implementation activities of the last 5 years. The intention of this paper is to benefit from the experiences currently available in order to confirm and/or re-formulate concepts and strategies for MHO promotion.

Methodology: document review and key informant interview

The preparation of the paper started with a review of the existing literature on MHO promotion and the compilation of documentation at the GTZ Project office. Later, relevant documents obtained from interview partners were included.

The interviews were structured by presenting the interviewees with a list of previously prepared questions. Current prominent problems and controversies were discussed, comments on the hypotheses made by the authors were requested, and new topics were explored in the course of the discussions. The emphasis in the key informant interviews was on lessons learned in the practical implementation of MHO projects. Each interviewee was asked for his/her recommendations for others to share. The interviews lasted between one and two hours, were recorded on tape and later transcribed.

Structure of paper

Introductory chapter 1 presents the historical background for health financing and health insurance in developing countries. In chapter 2, five general approaches are identified to illustrate major possible concepts for MHO promotion that are suitable for extending MHOs on a national scale. A sixth approach developed by the GTZ is proposed as an alternative strategy. In chapter 3 the problems, challenges and controversies that are relevant to understand the major aspects in MHO promotion are presented under four main problem areas. The differing solutions proposed by the various actors are discussed and the consensus and/or individual conclusions presented. The key issues for MHO development are defined in chapter 4. In the final 5th chapter a synthesis of previous chapters is presented, outlining the resulting conclusions and recommendations.

It should be noted that the content of the proposed strategies represents the personal opinion of the authors and should be considered as a basis for further adaptation of a possible concept for the promotion of health insurance in Western-Africa by the GTZ.

Authorship of statements

The authorship of statements from interviews can be recognised when a paragraph is initiated by a name (Marcadent -) The content of the total paragraph is attributed to this interviewee. A statement attributed to an interviewee is followed by his name in brackets without indication of a year (Criel). If the idea is taken from an article or other document the author‘s name is followed by the year (Brouillet, 1999).

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1. Health Financing in Sub-Saharan Africa

1.1 Current Health Financing Situation

Reduced access to health care because of financial barriers

The great majority (> 90%) of the population in Low to Middle Income Countries (LMIC) does not benefit from any form of social security. Few people have working contracts or receive salaries. People from the so called informal sector living from an irregular and unstable income have to pay for medical care out of pocket and do not have access to health insurance systems. In case of catastrophic illness or accident, when urgent and specialised treatment in a hospital is required, the admission and treatment fees are beyond the reach of many individual households. In subsistence households, even medical treatment for common illnesses is often unaffordable in certain periods of the year when cash is not available. The process of borrowing money in the extended family or neighbourhood delays treatment and may cause deterioration of the illness or even death. Evidence of this situation are the low utilisation rates of public hospitals and health centers of 0.2 – 0.3 (patient-provider contacts per person/year) (Knippenberg, 1997/MSP, 1997).

The very poor in the population are entirely excluded

Certain segments of the population, exhibit multiple concurrent characteristics (low income level, low level of education and location, low ethnic or professional status) that put them at a disadvantage to society at large, and make them particularly vulnerable to the consequences of illness. Their lack of access to health services is reflected in high morbidity and mortality rate in relation to developed countries: Maternal Mortality Ratio 500 - 880, Infant Mortality Rate 65 - 129 (Peters, 1999). Because of their disempowerment within the system, these excluded groups have given up claiming access to and are under-utilising health services despite their great needs (Dror, 1999).

Limits of family and clan solidarity

Traditional solidarity systems like family and clan solidarity provide a certain amount of security for the poor. But extended family solidarity or borrowing from the neighbourhood have their limits when large expenditures are concerned.

The ability to pay determines access to care

The staff in government health facilities often insists on the official treatment fee to ensure the economic viability of the institution and their salaries. As a consequence, even seriously sick people may be refused treatment.

Under the counter payments

As health workers are generally underpaid and have to struggle for their own survival, they often resort to various coping strategies, for instance by asking for under the counter payments for themselves, which add significantly to health costs (Roenen, 1997/Mc Pake, 1999). The patients attending a rural health centre in Guinea spent 2.2 times as much in illicit payments than for the official treatment fees (Roenne, 2000). These payments constitute a substantial part of the health-practitioners income (Criel, 2000).

The poverty cycle

More serious medical conditions, or a period of prolonged sickness threatening the livelihood can set off a poverty cycle. Property, crops, animals and land may have to be sold at low prices, or a credit at an exorbitant interest rate is taken. Conversely poverty itself induces illness as medical care is out of reach. The World Food Program found in Cambodia that 80% of "hard core" poverty resulted from illness in the family (Weber).

1.2 History of Health Financing

Priority to hospital care and urban population

The health care delivery systems in most sub-Saharan countries since independence have not provided equitable access to comprehensive healthcare. The available resources were put into hospital care and facilities for the urban population. Officially these structures provided care free of charge. In reality patients frequently had to pay for drugs and encourage health staff to deliver services by offering them "under the counter payments".

Primary Health Care policies since 1978 (Alma Ata Conference)

With the introduction of Primary Health Care (PHC) policies in 1978, many African countries embarked on health system improvement activities with the assistance of foreign donors. Networks of rural Health Centres (HC) were constructed and efforts undertaken to organize their effective functioning. A benefit package covering the major diseases and addressing the most important health problems was offered to a larger segment of the urban and rural population. In a second step in the 90's, referral hospitals were rehabilitated and reorganised as necessary backup.

Readjustment policies leading to shortages for health care spending

The introduction of PHC policies coincided with the adoption of economic readjustment policies in the 1980's. Due to economic crises and mismanagement, African governments had to reduce spending for health and social affairs. Less money was available for health. The governments were not able to finance the health system via general taxation. The start-up financing for health system improvement from foreign donors did not achieve significant success.

Promotion of health reform, financing and decentralisation

International agencies like the World Bank, UN agencies and other donors engaged in a policy of promoting health reform, especially in the field of health financing and decentralisation. It was considered vital that the populations participated in paying for health expenses in order to sustain the PHC services.

Bamako Initiative: Cost recovery, community financing, participation

The Bamako Initiative reform (1988) instituted the introduction of user fees in government health facilities, the joint management of the resources generated by health staff and the community, and the decentralization of the health sector.

Improvement of health indicators: EPI/ANC coverage and others

When countries like Guinea and Benin, that were first to implement the BI reforms, were evaluated, clear progress in access to health care and its utilisation was noted, as well an improvement in health indicators. In health centres, between 1998 and 1993, effective coverage under the Expanded Program of Immunisation (EPI) increased from 20 to 66%, and Antenatal Care (ANC) from 12 to 53%. In Benin utilization of the services by the target group decreased initially from 0.3 to 0.25 but later showed an upward trend of 0.34 in 1993 (Knippenberg, 1997).

Exclusion from health care

But despite all efforts, it became apparent that in many African countries at least 5% of the population never had sufficient money to access PHC care (permanent exclusion) whilst some 25 to 35% of the population with unstable incomes had serious problems gathering the money necessary in some periods of the year (temporary exclusion). Hospital care was even less accessible (Rocque, 1995).

Lack of democracy, transparency and low quality of care

Health reforms did not solve the problems of bad governance and the lack of democracy and transparency in the health sector. Despite proclaimed intentions to involve communities in health care planning, health technicians alone continued to set the priorities. Health centre management committees (HCMC) did not sufficiently constitute a counter-weight to health professionals (Criel, 1999). Utilisation rates of health centres continue to decline because of perceived low quality of care.

1.3 Social Health Insurance

Transfer of insurance systems from Western countries?

As a possible solution to these problems, it is tempting to adopt and transfer the health insurance system model that has proved so successful in/from Western countries. But the socio-economic and political context in West Africa is different. Against this background, the European model has to be reduced to its basics i.e.:

- Principles and concepts (namely poverty reduction, equity, solidarity).
- Political procedures that steer the system development.
- Technical design features.

One of the key values of the mutual schemes practised and promoted in Europe is that of solidarity among members. In practice, it means that all members of a solidarity fund provide mutual financial support to those who need it in order to improve basic social and economic indicators. The variety of different solutions found and experiences to be found in Europe at least can be used as a pool of know-how, to help others to develop their own policies. Procedural experiences are as decisive as structural know-how and system techniques (Eisenblaetter et al, 2001).

Different context, scarce economic resources, poorly developed formal labour market

West-African economies suffer from lack of scale due to scarce and inefficient use of economic resources, unfavourable terms of trade for African goods and poor public governance. There is a widespread lack of regular monetary income in these subsistence economies and a poorly developed formal labour market.

Informal sector workers constituting the majority

The large majority of the population works in the non-formal sector, as self-employed, doing petty business as labourers, farmers etc. In many African countries the rural sector alone often employs 80% or more of the population (Marx, 1995).

Weak tax base, low tax compliance

In addition, there is a lack of a robust tax base, low institutional capacity to collect taxes and weak compliance with tax laws. The funding of a health system via general taxation is difficult.

Poor service quality because of deterioration of public services

The under-funding of health services resulted in low public salaries for health personnel, insufficient spending for maintenance, renewal and replenishment of stocks, material and technical equipment. A deterioration of the quality of public health services offered invariably followed.

1.3.1 Formal Sector Insurance

Low coverage of formal sector insurance

Currently the formal sector insurance in sub-Saharan Africa covers only a fraction of the population, usually only civil servants and a few formal sector employees (between less than 1% in Ethiopia, 10% in Senegal, and 11% in Kenya).

Dysfunctional insurances schemes, close to bankruptcy

The existing insurances schemes are often dysfunctional, close to bankruptcy, and plagued by corruption (MAE, 2000). These systems proved incapable to serve as nuclei for the extension of social insurance to the unorganised sector (Ginneken, 1997).

Governments lack managerial capacity and have insufficient credibility

The main reason for this situation is that the administration of a social security system is highly complex. It involves keeping records, ensuring the compliance of employers and employees, and organizing their effective control (Atim, 1998). Governments lack the administrative and management capacity needed to establish and run social security schemes (Juetting, 1999). The average African government often does not have sufficient popular credibility for the organisation and management of a nation-wide social insurance system (Criel, 2000). Insurers and providers need sufficient managerial skills, which are often not available.

Creating greater inequity: Groups with higher incomes capture a greater share of public subsidy

Insuring public and private sector employees has often led to greater inequity. It benefited an already privileged population, increasing their access to both private and public sources of care. In a situation where government health facilities remain heavily subsidised, consumption of their services by the insured implies double subsidy. As a consequence, groups with higher incomes have captured a greater share of public subsidies for health care (Kutzin, 1997).

1.3.2 Compulsory Insurance in Low Income Countries

Compulsory health insurance for low income countries is not recommendable

After examining the possibilities of extending obligatory social security systems in countries of the French Priority zone, a study by the French Ministry of Health (MAE) came to the conclusion that for the category of poor countries (GNP less than 1,000 USD/person) it is not recommended that compulsory health insurance be introduced under the current conditions (MAE, 2000). The main reasons cited in this document were the absence of credibility of social security organisations, the problems with good governance of the central government, and the absence of sanitary structures that could deliver quality health care. For countries with intermediate income, where more favourable conditions are in place, the study saw possibilities for connecting formal and informal sector insurances into a joint compulsory program.

Local health insurance systems-solution for the short and medium term

The MAE study recommended the countries to promote projects that integrate decentralisation, community co-management and risk sharing in their approach.
It also considered local health insurance arrangements "l'assurance sociale de proximité" to have a better chance of achieving the objectives in the short and medium term. The study concluded that at present, social protection systems could play only a complementary role. Local insurance schemes are proposed to provide a suitable alternative for the time being at least until the necessary preconditions for a compulsory health insurance are met.

1.3.3 Traditional Concepts of Solidarity

Solidarity for social and economic risks

Solidarity has always existed in African society (Gueye). A number of relationships and groupings exists, in which the members rely on each other's solidarity or even pool risks among a larger group. These are collective mechanisms designed to face individual risks, often related to life-cycle events such as birth and death, but also illness, and encompass in a wide range of both positive (weddings, baptism, circumcisions) and negative (funeral, illness) events. People come together when members are in financial difficulties, and for social and economic purposes (house construction, to start a business, acquisition of agricultural material, organisation of communal festivities). This contributes to the creation and reinforcement of social networks (Criel, 2000).

Principle of balanced reciprocity

In traditional rural societies, individuals usually expect a return from any contribution they make. The informal risk-pooling arrangements are commonly based on balanced reciprocity, which is the standard for fairness. Any "gift" must be returned at some future time (Platteau, 1997). Insurance is different as it implicates that the members who will benefit within the near future remain unknown at the time of contribution. In consequence the majority of members are paying mainly for their protection without any immediate or visible return.

Reducing anxiety

Criel/ ITG - The concept of balanced reciprocity is not only valid for the traditional rural society. Also in modern insurance systems people expect some return to their investment. Otherwise their willingness to pay contributions is undermined. The return is not per se a material kind. In Western societies people value insurance because it reduces their anxiety.

1.3.4 Provision for Health Risks

Foresight only for social, not for health risks

In African society, provision is made for social risks but hardly ever for health risks. Money is saved to give a dowry when a girl is to be married or food is stored after harvest. It is unusual for people to protect themselves against possible illness that may occur in the future. They will not regularly contribute money for a problem that

is not visible (Villane). People do not put money aside for unforeseen illness, which is often seen as a taboo. Talking about sickness may even attract it (Bationo, 2001). Solidarity exists especially for emergency cases (Koné). But people wait until the illness occurs (Gueye).

People engaged in survival strategies have other priorities

The lack of strategies to cope with health risks can be partially explained by the fact that in a situation when people are engaged in survival strategies, health assurance is not the top priority. Other priorities are more important, such as organising food or school fees for the children. Or people prefer to invest in productive activities. They believe it is better for them to invest the small amount of money at hand in small business activities than to pay the monthly insurance premium, which they perceive will give them only limited benefits (Evrard). With any profits made from business investment, they may be more able to purchase directly quality care from their preferred health care provider (public or private facility), or traditional healer. A proverb from Burkina Faso states, "in an insurance the money sleeps, but in a credit and saving scheme it works for you".

Health insurance is not a traditional African concept

The idea of health insurance is not a traditional African concept, but has been introduced from outside. Mutuals have rarely been created spontaneously by actors from within the informal sector (Galland, 1998). The mutuality dynamic is greatly animated and supported from the exterior (Criel, 2000).

Transform the foresight for social risks into foresight for health

The challenge for promoters of health insurance in sub-Saharan Africa is to transform the foresight for social risks into foresight for health (Koné). Gueye uses the following argumentation to convince community members of the benefits of health insurance: "as much as the night comes after the day, similar the illness follows health. Health and illness come in pairs. Instead of waiting for the problem to happen again, it is better to enlarge the cycle of people, beyond that of friends and family, who can help".

1.3.5 Local Health Insurance Systems

Local health insurance system proposed as solution

Locally developed health insurance systems are often proposed to provide a solution to the specific conditions of the situation of the informal sector workers and their families. These systems have received growing attention from donors and governments since the mid 1990's, that has led to the emergence and rapid growth of health insurance schemes.

Comparable terms:
Mutual Health Organisation, Community Based Health Insurance, Micro-insurance

Comparable terms used for local health insurances are: Mutual Health Organisation (MHO), Community Based Health Insurance (CBHI), and Micro-insurance. The term MHO is widely used in West and Central Africa whereas CBHI more in East Africa. The International Labour Organisation (ILO) calls the concept Micro-insurance. Among the three terms slight variations exist.

The terms generally distinguish between the provider or the community oriented insurance concept. The distinguishing features are mainly in terms of ownership and who took the initiative and financial responsibility for the scheme. Criel (2000) calls these two extremes the mutualistic or participatory model and the provider-driven or technocratic model.

1.3.6 Models of Health Insurance Schemes

Mutualistic or participatory model (MHO or mutual)

Atim defines MHO as a voluntary, non-profit insurance scheme, formed on the basis of an ethic of mutual aid, solidarity and the collective pooling of health risks. Members participate effectively in its management and functioning. These schemes are usually small scale and are targeted for a specific population that is bound through some features of solidarity (Atim, 1998).

Communities organise themselves to establish a health insurance system. In a process of participatory bottom-up planning, priorities are defined and important decisions, such as determining the benefit package, are taken by the communities. The beneficiaries own and manage the system themselves and therefore are the financial risk bearers. A contract is signed between each individual and all the others. They collect the premiums to cover the types of care previously defined and provided by facilities contracted. The insurer and the care provider negotiate the terms of care. Well functioning schemes may play a strong role in defending the interests of households they represent. They can negotiate for better quality, such as better availability of essential drugs, or improved provider behaviour.

Provider-managed model

Provider-managed schemes are often initiated by a hospital that is concerned about securing a stable source of revenue in a context where many patients cannot pay the bills. The health care provider is the insurer and manager of the scheme and is therefore the financial risk bearer. No intermediary structure exists between the payer of the fund and the health care provider. Priorities like defining the benefit package are usually set in a process of top-down planning. The community plays only a negligible part in the process. In some examples a genuine concern to raise peoples access to care can be the driving factor (Bwamanda/Democratic Republic of Congo). The community often perceives this technocratic top-down management approach unfavourably. The non-involvement of the community may lead to a suspicious and distrustful clientele that is likely to show all features of moral hazard behaviour. The little contact with and knowledge of the grassroots membership does not allow for necessary adjustments like taking consumer interests more into account.

An additional aspect of a provider managed health insurance is the intention to raise the hospital revenue. In consequence this may attract patients to prefer hospital services like the outpatient department instead of encouraging them using primary health care services for basic pathologies.

Prepayment model

Another arrangement covering health risks is prepayment. Prepayment schemes are usually organised by health care providers. Risks are not shared with other community members as in insurance schemes. A certain payment is made in advance to a health care provider or health care institution. At every consultation the prepaid amount is gradually debited, according to the consultation fee charged until the total amount is consumed. It allows the purchase of health care at a time when money is available in the household. More expensive events like hospital admissions are difficult to finance with this model.

Linking credit schemes with health insurance

In this arrangement microcredit schemes, which are involved in individual and collective income-generating activities, include an insurance component. In case of more serious illness, the insurance prevents the misuse of the loan for paying health bills, in which case the creditor could not pay back the credit. Examples of such arrangements are the FAARF (Fonds d’Appui aux activités Remuneratrices des Femmes), a WHO project in Burkina Faso and the Grameen Bank in Bangladesh.

1.4 Evaluation of Existing MHOs

Conclusions from literature review

In a synthesis of MHO studies done by Bennet (1998) and Atim (1998) describing experiences in implementing MHO schemes, the following conclusions are drawn (MAE, 2000):

Access	Access to health care for scheme members is good, but in view of the low coverage rate of insurance schemes, this does not have a significant impact in the target population. The majority of schemes achieved less than 10% penetration rate, which leads to technical constraints because only a critical mass of members can assure viable risk pooling.
Efficiency	While MHOs have the potential to influence efficiency in the health sector, the majority of schemes does not use the spectrum of available design tools and mechanisms such as mandatory reference, co-payments, deductibles, ceilings on benefit cover, strict checking of members' identity, or an essential and generic drugs policy (Atim, 1998). Many schemes suffer from poor design. Financial and managerial performance is weak to moderate. A condition of improved efficiency is that free preventive and health promotion services are included (MAE, 2000).
Resource mobilisation	Schemes which take into account consumer concerns and preferences (choice, availability of drugs, transport, hospitalisation etc), conclude contracts with health facilities with a good reputation for quality and synchronise premium collection with income earning periods, can be successful in attracting a sufficient number of members, and ensure they are up to date with their contributions. But often resource mobilisation capacities are modest and limited by the low amount of the insurance premium, low premium and cost recovery, low coverage rates and weak marketing capacity. In feasibility studies people often show interest and willingness to pay defined amounts of premiums, but when it then comes to contribution collection many default or are late with their payments.
Equity	Insurance premiums are flat rate and are not proportional to income, which is very complex to administrate. MHOs are not a solution for the problem of indigence. The majority of schemes had very little ability to protect the poorest parts of the society. MHOs can only channel demand from an existing contributory capacity. Government social assistance programs are required for segments of the population that cannot afford premiums (Galland, 1998/Carrin, 2000).
Democratic governance, Quality of health care	Not many schemes constitute a real counterweight to the health system. Often managers of MHOs lack technical competence and schemes do not function efficiently. Some schemes take up quality issues when negotiating contracts with providers. The study by Atim found that few insurance schemes neither checked provider prescriptions nor monitored the quality of care delivered to their members. For MHO managers, it is difficult to enforce the stipulated quality aspects when providers are not fulfilling their contractual requirements. But schemes may initiate a dialogue between users and providers of health services (Criel, 1999/Huber, 2000).
Sustainability	Atim found that many aspects of MHOs impinge directly or indirectly on their viability as institutions. He concluded that while MHOs possess some managerial and administrative skills, major problems remain in the area of institutional development and the skills required for MHO-specific tasks. These tasks included: setting premium rates, determining benefits packages, marketing and communication, using a Management Information System (MIS), determining the appropriateness of care provided and its pricing, contracting with providers, accounting and bookkeeping, monitoring and evaluation and collecting dues.

Conclusion

Theoretically interesting solution, high potential

Theoretically MHOs seem to be an interesting solution with great potential to enhance access to quality health care, to mobilize funds, improve efficiency in the health sector, encourage dialogue and democratic governance for the health sector and thus contribute to the social and institutional development of society.

Useful concept – but difficult to implement

Looking at the results of about 10 years of MHO development, it seems to be that the communities take up the idea only with great difficulty (Criel). But despite the many problems involved in implementation, the majority of the promoters interviewed are still convinced that the concept is useful and that there is simply no alternative.

Health insurance more equitable than fees for services

Governments are incapable of financing the health system by taxation alone. MHOs can contribute to the correction of some of the negative effects on the accessibility of the health care system caused by the introduction of user fees. Health insurance ensures community participation in health care costs on a more equitable basis than fees for services (de Roodenbeke/MAE).

Greater potential in improving health system performance

But for Bennet (1998), health insurance should not be seen as a source of finance in poor communities, where there is simply not a lot of additional money available. Cost recovery levels will be limited under rural schemes. Bennet argues that well designed schemes have an even greater potential in improving health system performance, particularly quality of care and efficiency, than in raising additional finance.

Insurance as support strategy not as exclusive financing alternative

Insurance schemes should be seen as a supporting strategy, not as an exclusive financing alternative. Like user fees, they should be seen as a means to top-up existing government budgetary financing (Bennet, 1998).

Guides and tools for MHO development

In the last two years several organisations have published a number of interesting guides and information tools for MHO schemes.
GTZ, for example, has developed the software-product InfoSure as instrument for counselling and information of health insurances. InfoSure enables the user to conduct a detailed and well structured analysis of MHO approaches including the institutional frame. Via Internet InfoSure gives access to the case study database. (www.InfoSure.org).
Printed guides and manuals on technical issues are produced mainly by ILO and USAID/PHR plus. The concerted action of different promoters of MHO schemes in Western Africa publishes information of these products (www.concertation.org).

2. The six core MHO Approaches

The authors classified six core MHO approaches:

1. Pilot Project Model
2. Government Agency Model
3. Regional Coordination - Thiès Model
4. Development Agency - UTM Model
5. Provider - Purchaser Co-Development Model

A new approach is currently developed by the GTZ:

6. Entrepreneurial Approach - CHIC Model

The approaches are not mutually exclusive. Some of these models may co-exist in one same context. All six approaches facilitate the extension of the insurance systems on a larger scale. In the text that follows a general description of each approach is presented along with examples and comments.

2.1 Pilot Project Model

2.1.1 Limited Project Commissioned by an External Donor

Scientifically accompanied pilot project by development agency

Development agencies have until recently concentrated their activities in improving health systems by investing in infrastructure, training and management support on the regional and district level. They have become aware of the limitations of simply improving the level of health care on offer. When evaluating the impact of their activities, the extent of the exclusion of large population groups and the perception by the population of low quality of care on offer became apparent. The importance of developing financing mechanisms, which would enable more equitable access to health care structures was recognised. Pilot projects were launched to test models.

The pilot projects are usually very costly, because of their intent to provide a scientifically sound basis for a model that can be generalized on later. Expatriate staff is often needed for the projects and a main feature is a relatively long intensive preparation phase. Comprehensive feasibility studies are conducted. The research process is often well documented and provides much to learn from successes and weaknesses. The theoretical concept provides opportunity for reflection and evaluation.

2.1.2 Examples

a) "PRIMA" Project, Guinea

In 1996, the Rural Health Project (PSR) of the German Agency for Technical Cooperation (GTZ) in collaboration with the Guinean Ministry of Health launched the action research project "Projet de Recherche sur le Partage des Risques maladies: PRIMA" in the Kissidougou district to study the feasibility and potential of local health insurance schemes. The technical research team consisted of an expatriate sociologist as coordinator, a Guinean counterpart, a public health physician, an accountant and 3 animators. The NGO Medicus Mundi Belgium (MMB) ensured technical and scientific follow-up. The concept of a Mutual Health Organisation was

developed and called MUCAS (Mutuelle Communautaire d'Aire de Santé). The objectives of the PRIMA project were to design and test a model of a community-based risk-sharing organisation in order to:

- Reduce the phenomenon of financial exclusion by strengthening the solidarity mechanisms.
- Develop more genuine forms of community participation in the management and supply of district based health services.
- Create a stable source of revenue for health services.
- Create a counter-weight to health service providers and thereby a leverage for higher quality health care.
- Create the basis for sustainable (local and national) capacity for the promotion of community based health insurance schemes (Criel, 1999).

MUCAS (Mutuelle Communautaire d'Aire de Santé) Maliando and Diompilo

Two MUCAS projects started in 1998 and 1999. The Maliando and Diompilo scheme targeted the catchment area of two health centres and covered medical treatment at the primary level, and at the secondary level for specified surgical conditions (i.e. caesarean section, incarcerated hernia) and paediatric inpatient care at two contracted hospitals, including transport fees. Members of the insurance scheme pay an annual premium depending on family size, which provides cover for all episodes of illness experienced by family members and for treatment at the health centre, including drugs. In addition a co-payment has to be paid to reduce abuse (Sylla, 1998).

After two complete years of functioning, the MUCAS "Maliando" experienced difficulties because membership declined. It dropped from 1352 to 1014 members. In the spring of 2000, fewer than 600 people re-enrolled. It required special efforts and pressure from local and health authorities to convince people to renew their memberships or join for the first time. A rebel incursion that has led to much destruction of the health infrastructure and a generally unstable political situation endanger the survival of the health insurance schemes.

b) N'nha project - Ivory Coast

The GTZ supports a health insurance project in Man/Ivory Coast in collaboration with the Ivorian research institution CEPRASS (Centre d'Etudes Prospectives et Appliquées sur les Politiques Sociales et les systèmes de Securité Sociale). CEPRASS acts as local promoter, with a national expert permanently stationed in Man. The project pursued the short term objective of improving financial accessibility to health care and the quality of the medical services for the inhabitants of Man by creating and developing a MHO. The medium and long-term objective was to develop a model for implementation and methodology for the replication and extension of MHOs based on the experiences at Man. Two local counterparts were recruited, from the Man region and have been associated at all stages in the process of implementation, with the objective of training local human resources who can perpetuate the process.

Feasibility study and tools for premium calculation

The project conducted an extensive feasibility study to make a diagnosis of the supply and demand for health care. The financial and actuarial data collected have been used to develop a software product to calculate premiums, taking into account the relevant variables.

Steering Committee "Forum de Man" created from delegates of existing associations

The project encouraged the setting-up and the functioning of the steering committee "Forum de Man" for the introduction of health insurance in the city of Man. Its task was to plan the implementation of the mutuals and then to disband when they were put into place. The sensitisation and social mobilisation process relied on existing associations. The forum consisted only of people who were already community representatives. The principle idea was to have people who already have proven their capacity to interest themselves in a social activity and are legitimate representatives.

2.1.3 Comments

a) PRIMA project - Guinea

Exposing problems of the Guinean health system: Low perceived quality of care, under the counter payments

The achievement of the PRIMA project was to expose the problems of the Guinean health system and bring them to the notice of the Guinean government. In response, The Ministry of Health (MoH) agreed to experiment with new forms of service delivery more acceptable to the population. Prior to the project, the problem of low perceived quality of care by the population, essential drug shortages, frequent under-the-counter payments to health staff and other irregularities and constraints within the Guinean health system were neither recognized nor addressed by the administration.

PRIMA: Research project to develop a model

The PRIMA project with its two MUCAS projects – Maliando and Diompilo – was considered first and foremost a research project by the research team and the scientific advisers of Medicus Mundi Belgium. Their major objective was to generate knowledge and not to generate mutuals. The donor GTZ did not always share this view and expected more concrete results.

Lack of autonomy of the mutualists, low coverage

The evaluation by Hohmann et al. found weaknesses in the managerial capacity of the Maliando and Diompilo health insurance schemes. A major criticism was that the MHO management committee did not receive enough training input to develop more autonomy from the promoting structure, and thus to be able to negotiate on a more equal footing with health care providers. Insurance executives complained that they were not truly made responsible for the management of their mutual.
The project did not achieve significant results in terms of coverage. The question arises whether it is feasible to invest important amounts in a pilot project with the idea that the model coming out of the scientific process can be diffused and extended to other regions. Critics argue that outcome-oriented projects will develop more realistic models. Realistically, each project will have different circumstances to which a methodology needs to be adapted.

The project learned that it is necessary to invest at the same time in quality improvement activities. The existence of insurance alone is not sufficient to exert pressure on providers (Criel).

b) N’nha project – Ivory Coast

Emphasis on socio-professional groups within the N’nha project

Socio-professional groups were considered to be a very strong and credible base for health insurance. The strategy was to contact organized craftsmen (Groupements à Vocation Co-opérative: GVC) via the intermediary of the regional craftsmen chambers (Organisations professionnelles départementales: OPD).
These OPD were considered to be very useful because they had many members, the people were already organized, were accustomed to work together, and had minimal revenue. OPD Members had often expressed dissatisfaction with the services provided and had requested additional services in the areas of education, finance, credit and health. After much lobbying with the regional craftsmen chamber, it was realized that this idea was a failure. There was never sufficient motivation to integrate health insurance into the activities. People were not prepared to manage a service with a non-lucrative objective.

Decision to concentrate in urban areas

During a joint evaluation meeting with PRIMA representatives a strategic decision was taken to abandon a village level project site in order to concentrate instead on an urban setting. PRIMA strongly recommended keeping close contact with the decentralized administrative and sanitary authorities throughout the process. This was necessary to avoid problems of dialogue and institutional cooperation, especially with the central level.

Implementation of the MHOs in Man has been slowed due to a military coup. Even without external factors CEPRASS underestimated the length of time necessary for sensitisation and the setting-up of the health insurance scheme. The mutual health insurance N'nha started operating in September 2001.

Synthesis

In the past, the "Pilot Project Model" achieved a big popularity within the donor community. Other examples belonging to this category are the well known project design of the French organization CIDR, implemented in Benin (commissioned by the Swiss Co-operation), in Guinea (by the EC) and in Tanzania (by the German Protestant Development Service EED).

Generally, all of the pilot projects are confronted with three major threats:

1. They are very expensive in relation to coverage they achieve.
2. They require a long and intensive preparation phase as well as the financial support of the external donor for several years.
3. Their expansion to a bigger regional or national system is uncertain on the basis of the unique and exceptional situation of the pilot circumstances.

2.2 Government Agency Model

2.2.1 Government Agency for the Development of MHOs

Carrin (WHO, 2000) described the model of a government agency. The state actively takes charge of the development of MHOs and creates a special agency to stimulate their creation. The role of this government agency is to provide an enabling environment for MHO promotion and to regulate and monitor the sector. A minimum of statutory regulations is considered necessary to protect members from unsound design of MHO features and fraudulent misuse of insurance contributions by scheme leaders.

Objectives

The government agency has four basic functions to fulfil:

1. Promoting of health insurance.
2. Monitoring and control of MHO activities.
3. Training Activities.
4. Co-Financing health insurance operations (social assistance).

Important aspects of these basic functions are described in detail below:

1. Promoting health insurance

- Inform and sensitise the main stakeholders such as the ministries concerned, regional and local governments, health providers, organisations of civil society and the general population.
- Develop legislation to enable MHOs to acquire legal or corporate status through registration (legal framework).

- Make policy makers aware of the need for decentralisation, to allow autonomy for health facilities in order to make possible contractual relationships.
- Advise the Ministry of Health (MoH) concerning those issues of health service organisation which are crucial for health insurance development: i.e. rational health care, quality of and access to care, proper utilisation of care, cost-containment, etc.
- Inform and train health staff on MHO issues and promote the importance of quality of health care provision.

2. Monitoring and control of MHO activities

- Provide an appropriate monitoring-system for MHO activities which can help schemes to adjust their performance.
- Assist MHOs in establishing a Management Information System (MIS).
- Develop standards for financial management and administration.
- Set-up rules for the accreditation of new schemes.
- Draw up model statutes and regulations in consultation with existing MHOs, which new organizations can adopt or adapt to their own situation.
- Formulate recommendations on the composition of health insurance benefit packages, methods of revenue collection, risk management and the purchase of health services.

3. Training activities

Offering training modules on the introduction and implementation of MHOs i.e.:
- Setting-up of MHO schemes.
- Marketing and administration of membership.
- Participatory methods and improvement of communication skills.
- Management and financial administration.

4. Co-financing health insurance operations (social assistance)

Government can play a substantial role in enabling access of low-income groups to health services via health insurance. At the MHO level, for example, government could subsidize - partially or fully - the health insurance contributions of the poorest. These subsidies would be financed out of general tax revenues. Government could also come to an agreement with donors, allowing them to reallocate part of their funds as subsidies (Carrin, 2000).

2.2.2 Examples

a) Government Support Program for MHOs (PAMS and CAMICS) - Senegal

In 1996 the Senegalese government set up the program PAMS (Programme d'Appui aux Mutuelles de Santé) and in 1998 CAMICS (Cellule d'Appui aux Mutuelles de Santé aux IPM et aux Comités de Santé). These agencies had the task of promoting the development of mutuals in Senegal.

Creation of a multitude of projects without appropriate follow-up

PAMS/CAMICS created a multitude of projects by conducting large-scale training sessions particularly in one region, Kaolack, without appropriate follow up. Today only one of the 14 MHOs is functional. The agency did not sufficiently stimulate demand by conducting well-planned sensitisation activities. As a result, people gained the impression that the government should organize and pay for MHOs instead of themselves assuming responsibility for the process.

Excessive interference of the state, directive attitude

The state created barriers to MHO development by interfering excessively while not providing a legislative and fiscal framework. A specific legislative framework for MHOs has been under study since 1997 and still is not in place. The suspicion was that proper legal status was not given in order to keep direct control over the movement (Letourmy). PAMS/CAMICS adopted a very directive and interventional approach whilst also neglecting available experience in the field (1996–1999).

Attitude of defiance, non-co-operation of MHOs

The existing mutual movement saw the agency's aim as one of trying to control them and they had a negative perception of the PAMS/CAMICS. An attitude of non-acceptance and defiance resulted and mutuals did not cooperate. The role

of legislator and control body was difficult to reconcile with a promotional role. When the new government came to power in 2000, the agencies were obliged to redefine their role, and acknowledge the responsibility of the population for the process. Today they collaborate better with other existing structures.

b) Planning for Universal Health Insurance - Ivory Coast

Vision of universal health insurance coverage

In mid 2001, the current Government of Ivory Coast constituted a national expert-commission and gave them the task of designing a universal health insurance system covering the whole population. This was the first time such a concept had been attempted in West Africa. Only a few months later, on October 9th, 2001, the parliament passed the new health insurance law.

A comprehensive health insurance system is planned that is intended to protect the entire population against risks of illness and motherhood. Overall, it consists of a combination of two different sub-systems, supplemented by a regulatory authority. The Government proposes to entrust the management of these sub-systems to the National Health Insurance Fund (CNAM), and the Agricultural Social Fund (CSA) whilst the National Regulation Authority (NRA) has responsibility for the overall system (see Table 1). Both insurance funds are to be managed under private-sector principles.

Organisation of the planned universal health insurance system/ Ivory Coast

Table 1:

	Subsystem	Proposed management
1	Combined system for salaried workers of the public and private sector and the informal sector	National Health Insurance Fund (CNAM)
2	System for the agricultural sector	Agricultural Social Fund (CSA)
3	Contribution collection, financial administration and allocation of budgets	National Regulation authority

As far as the funding of the new insurance system is concerned, the government has submitted different concepts for the formal, the informal and agricultural economical sector. While the formal sector should achieve contributions by employees and their employers based proportionally upon wages, the proposed source of financing for the informal and agricultural sectors is based on revenues from sales.

Premiums 15% of household income

According to a study by the World Bank in spring 2001, the new insurance system will require a monthly contribution of at least 2 000 F CFA (3 Euro) per person. For the average seven-person-household, that would correspond to approximately 15% of available household income. The budget necessary to set up the insurance structure is estimated at 30 billion F CFA (45.7 million Euro), with an annual turnover of approximately 397 billion F CFA (605 million Euro). The new health insurance funds are expected to become operational in 2003. The insured, assuming that they will be able to afford pay their contributions, will have to wait a further six months, before they will get the right to draw benefits.

The reform will have an enormous impact on the economy and social security policy of the Ivory Coast. The registration and tax systems, the health services and the entire social infrastructure will need to be (re)structured and (re)organized.

Unfortunately, at the present stage the government of the Ivory Coast is not taking sufficient advantage of either the cultural and community participation experiences of the existing mutual organizations or of the financial know-how of the private health insurance market in the country. Both types of health insurance organizations are intended only to play a role in the supplementary insurance market.

The proposed reform programme faces big challenges: Conventions and contracts specifying service levels and quality standards will have to be drawn up and negotiated with all health facilities in the country. Acceptance of the new health insurance system by the recipients will depend on its capacity to adapt to the life and working conditions and mentalities of the different users.

Scepticism of the international community

Despite their scepticism of the scheme, the international community has been asked for support by the government of the Ivory Coast. The scheme does have massive economic and social potential and a positive result would act as a powerful example to neighbouring countries.

c) Equipe Préfectorale Pour la Promotion des Mutuelles (EPPM) - Guinea

District based Health Insurance

The PRIMA project sought to include features of the concept of District Based Health Insurance, an idea originally put forward by Criel (Criel, 1998) and taken up by Dror/Jacquier (1999) from the ILO and Foirry/CREDES (2000). The approach assigns a role in the planning, design and management of local health insurance schemes to the decentralised bodies of the Ministry of health. The advantages of involving public health managers are that, a health insurance system for a whole district can be designed and a better compromise is possible between technical decision-making and community participation.

Creating capacity at the regional and district health administration level

The PRIMA project encouraged the involvement of the regional and district sanitary administrative authorities and providers, and led to the setting-up of a promoter organisation EPPM (Equipe Préfectorale pour la Promotion des Mutuelles de Santé) at these levels. Maintaining a dialogue with the health authorities was considered vital throughout the process in order to avoid problems. The EPPM served as an advisory body to provide medical and managerial inputs in the decision making process. The objective was to involve the EPPM in the major steps of the project and thereby transfer the competencies of the process of MHO promotion and create local sustainable capacity. The long-term objective was that the health administration would integrate the mutual system in their development strategies and annual planning.

2.2.3 Comments

The importance of the role of the government in providing an enabling environment for MHO development is recognized. But the regulating functions and the extent of government involvement in the setting-up process is seriously questioned. Government "support" can be a mixed blessing. It can seriously compromise the autonomy and independence of MHOs.

Excessive state intervention in cooperatives in post-independence Africa

Experience with co-operatives in post-independence Africa showed that governments tried to control the movement by directly interfering in the planning, budgetary and personnel decisions of the cooperatives, without regard for their independent status. This often led to the creation of structures which were neither appropriate nor effective. The experience was that structures like the federations that were put in place by governments and were not developed from base organisations, did not become functional. People cooperated as long as they benefited from allocated funds, but abandoned the program when problems emerged (Marcadent).

Weakness of public administration

In most West-African countries public administration is weak and has difficulty enforcing established regulations. Moreover, in many cases problems with good governance exist. Civil society is often too underdeveloped to act as a counterweight to the bureaucracies.

Dominance of District Health Management Teams

Criel, who has been both partisan and initiator of the idea of District based Health Insurance, is not convinced that it is appropriate for District Health Management Teams (DHMTs) to take the initiative and develop MHOs in their area. He argues that local health insurance will unbalance the power relationship between providers (of which DHMTs are part) and the consumers. It could hardly be expected that

DHMTs would create institutions that challenge their own dominance. The initiative for MHOs should come from other institutions (NGOs, external institutions, associative movements) that can act as a liaison between the community and the health provider.

Impact of EPPM

The EPPM was created as part of the technical District Health Team. In the evaluation of the PRIMA project (Hohmann, 2000) the idea of creating a promoter organisation at the health administration level was considered in a positive light. But the evaluation team argued that the composition of the body was not intended to be representative of the triangular partnership (Insurance scheme – providers – health authority) which characterises a MHO system. The EPPM did not include representatives of mutuals and therefore was not seen to be in a position to defend their interests. The only provider representative was at the same time a member of the district administration, which resulted in a conflict of interest. It was observed that the EPPM members, despite having received considerable training input, lacked dynamism and did not play the role that was expected of them. They did not have personal motivation to dedicate the necessary time and effort to MHO promotional activities. Contact with the mutualists was superficial.

Conclusions

The challenge is to balance the needs of support with the need for autonomy and freedom from state control. A minimum amount of statutory regulation by the state (i.e. insistence upon external audits of MHO accounts) is required to protect members from poorly designed MHO features and fraudulent use of insurance contributions by scheme leaders. But it is necessary to guard against co-option by the governmental bureaucratic apparatus. Governments should not interfere in the day-to-day management of mutuals, but rather only assume a role as prime facilitator with the objective of widening the population's access to health insurance (Carrin, 2000). The role of the government is to provide a facilitating environment for MHO development but not necessarily to be the initiator and operator in the implementation of mutuals (De Roodenbeke).

In 1998 the Abidjan platform recommendations, a consultative meeting of the major MHO promoters, it was clearly stated that MHOs are participatory organisations established on the initiatives of their members and that they should not be created directly by governments or other external bodies. The autonomy, independence and responsibility of MHOs have to be safeguarded (ILO, 1999).

2.3 Regional Coordination - Thiès Model

2.3.1 Regional Coordination of MHOs as Endogenous Support Body

Regional level suited for networking

The regional level is the first level at which networks can be established and local systems strengthened by technical and political measures. The African context provides only a few examples of where the need for regional support was expressed or even self-organized by local insurance schemes. A useful and effective regional structure requires a certain number of comparable insurance schemes that are prepared for closer cooperation. Such association can help insurance systems retain their local character and to be better accepted.

Objectives/activities

The tasks of the regional coordination are:

- Sensitise the population to the idea of health insurance.
- Work with existing groupings that could serve as vectors to sensitise specific population groups.
- Support mutuals in administration and management.
- Set-up new MHOs.

- Develop didactic training material and management tools.
- Reinforce the relationship between health care providers and MHOs.

2.3.2 Examples

a) GRAIM/CRMST/Thiès Region/Senegal – "Endogenous" MHO movement

The most authentic "endogenous" MHO movement in West Africa, without much interference from external donors, developed in the Thiès region in Senegal from 1989 – 1993. The first mutual, functional in 1990, was called Fandène. The experience encouraged the creation of other MHOs in the area, which copied and adapted the set-up process and management procedures.

Innovative institutional setting: Catholic Hospital St. Jean de Dieu

The movement benefited from exceptional circumstances resulting from its relationship with the private non-profit Catholic Hospital St. Jean de Dieu, which offered a reduction of hospital fees of up to 50% for the treatment for MHO members. Therefore the great majority of schemes covered mainly catastrophic risks like hospitalisation. Only recently were schemes encouraged to include primary care in the benefit package (Wade, 2001).

Development of technical support structure and regional coordination

Existing mutuals felt the need to create their own technical support structure. GRAIM (Groupe de Recherche et d'Appui aux Initiatives Mutualistes) was founded in 1994 and later, in 1997 complemented by a regional co-ordination structure (Coordination Régionale des Mutuelles de Santé de Thiès: CRMST). The objectives of both bodies are to support the mutual movement. The CRMST became the federal structure and represents all the mutuals within the Thiès region. It is the communication platform of the representatives of the local mutual schemes and provides help and political support for its members. GRAIM developed into a NGO and specialized as a management support structure. It provides technical and teaching expertise for the creation of new schemes, as well as for improvement of the administrative procedures in the day-to-day management of existing schemes. Because of its NGO status, GRAIM can also offer consultancy work to external donors.

Support to 15 MHO schemes: 25,000 beneficiaries

Since 1997, diverse sources (ENDA-Graf, ANMC/Promusaf, ILO/ACOPAM, PHR, GTZ, etc) have supported this dynamic. In 2000, GRAIM and CRMST supported 15 MHO schemes operating in rural and urban areas of the Thiès region, covering 25,000 beneficiaries (6,200 MHO members) from a target population of 46,000 people. The average size of a mutual scheme is 490 members, the largest MHO has 3,500 members.

b) Co-operation with Local Initiatives: A Belgian Approach to Support Health Insurance Schemes in West Africa (ANMC)

PROMUSAF (Programme d'Appui aux Mutuelles de Santé en Afrique)

Since 1995, the Belgian Health Insurance Fund ANMC together with the Belgian NGO World Solidarity (WSM) developed the support program PROMUSAF (Programme d'Appui aux Mutuelles de Santé en Afrique) for MHO schemes in West Africa.

ANMC making available its expertise

A demand for support existed from organisations in Africa that wanted to establish solidarity mechanisms between members to share the risk of illness. Few structures had the knowledge and the institutional capacities to create an operational health insurance system. ANMC decided to make available its expertise in health insurance management.

In 1996, they developed in cooperation with the ILO the "Practical guide for MHO in Africa", as well as a manual for training of trainers. A continuous training process based upon this manual begun.

PROMUSAF network in Senegal, Burkina Faso and Benin

ANMC identified as a priority the need for an intensive close support on the ground. ANMC recruited coordinators of national programs in Senegal, Burkina Faso and Benin, creating the PROMUSAF network.

Supporting sustainable local initiatives

The priorities of PROMUSAF are directed towards the sustainable development of local initiatives. The strategy consists of providing individualised and close support to local partners in a process of self-promotion. The aim is to accompany the supported structures, leading to true autonomy. Special emphasis is put on capitalizing existing experience through the building of networks and exchange of information at the regional and international level (Evrard, 1998). PROMUSAF develops strategic partnerships with existing organisations in the field (e.g. GRAIM). ANMC seeks to set up practical partnerships between organisations in Belgium and those in the African countries (twinning of Belgium ANMC regional branches). GTZ supports PROMUSAF in Senegal.

2.3.3 Comments

Exceptional circumstances in Thiès: subsidized hospital services

The experience in Thiès is exceptional. It is one of the very few examples where MHOs and their representatives have developed a regional coordinating structure with little interference and support from outside. GRAIM and the CRSMT have considerable know-how gained from 10 years of experience.
To promote the development of health insurance schemes in the Thiès region the hospital St. Jean de Dieu had been offering subsidized hospital services to insurance members. The hospital recently announced its intention to reduce the subsidy and this may change considerably the conditions (i.e. increase of insurance premiums) for the associated MHOs.

Bottom-up approach as a value

The examples demonstrate that the bottom-up approach is more likely to gain acceptance by the target group. It requires extensive knowledge of the cultural roots of the specific area. The value of the bottom-up approach seems to be underestimated by international organisations. But without well functioning small- and medium-scale insurance schemes, all the international consultancy work on national concepts for health-insurance promotion will remain at best a theoretical exercise.

2.4 Development Agency - UTM model

2.4.1 Development Agency for the Mutual Movement (Union Technique Malienne)

Autonomy from government, product of civil society

The concept of the "Technical Mutual Agency" starts from the assumption that the mutual movement needs to evolve from a dynamic established within civil society.

Autonomy from the government is considered necessary in order to be able to represent the interest of existing mutuals and civil society. The agency does not pursue the idea of total separation from the state, but provides an independent interface. It plays a technical advisory role towards civil society (Letourmy). This approach of

decentralized cooperation of projects maintaining a certain distance from the state is proposed for the context of weak governments with inefficient public administration.

Objectives

- Sensitise the government and civil society to the potentials of health insurance.
- Built up human resources and conduct training.
- Organize technical support and advice to MHOs.
- Elaborate technical documents and help in conducting feasibility studies.
- Support the creation of MHOs.
- Study the conditions for reinsurance funds.
- Support the government in refining the legislative environment for health insurance.

2.4.2 Example

Development agency for the mutual movement

In 1997, the French co-operation in collaboration with the French Mutuality Federation (FNMF) and the Malian Ministry of Health (MoH) initiated the project of a "development agency for the mutual movement", the so-called Union Technique Malienne (UTM). Originally the project was planned for a total length of 4 years (Letourmy, 1998).

Political force behind the mutual movement

UTM was conceived to be a technical agency promoting the independent development of the mutual movement in Mali. The agency serves as support structure for concrete MHO projects as well as constituting a political force behind the mutual movement. UTM is obliged to give assistance to all mutualist groups who ask for technical support. Adherence to UTM is voluntary.

The program has two components:

1. Support of the government to provide efficient stewardship.
2. Support to the civil society for the development of the mutual movement in Mali.

At the central level, UTM has 5 technical staff (General director, training coordinator, communications officer, information specialist, accountant, sales representative). A French expatriate is the head of the FAC project. In 1999, it started to develop regional branches.

Development of legislative framework 1997

Mali is the only West African country to develop a legislative framework governing MHOs. It was passed into law in 1997.

Management of Garanties de Santé (GS)

In 1999, UTM developed its own insurance product, the so-called Health Guarantees (GS). In the GS four different types of benefit packages are offered to the population:

The four different benefit packages offered by UTM

Table 2:

	Insurance Product	Benefit package	Price per month
1	Small risks	60% of the costs of PHC care and essential drugs at public health centres is covered	270 FCFA
2	Catastrophic risks	75% of the costs of hospitalisation is covered	210 FCFA
3	Combination of small and catastrophic risks	Benefit package 1 and 2	440 FCFA
4	Private	Private clinics and hospitals can be accessed for	5,000 FCFA

Until now, the "Health Guarantees" products are only offered in Bamako and a few regional cities. UTM negotiates the service agreements (that include quality requirements) directly with the health providers, health centres and hospitals. The whole administration of the GS is taken over by UTM at central level, which includes premium collection, marketing, financial management etc. UTM has launched a marketing plan that targets enterprises in Bamako using social marketing techniques. UTM has also developed a specific software system to administer the GS.

2.4.3 Comments

An internal evaluation by the French cooperation of the impact of UTM came to the following conclusions (Brouillet, 2000):

- The project achieved its goal of making the mutualist movement an independent institutional actor. UTM became the fundamental actor in the development of the mutualist movement and imposed itself as an obligatory partner for the government, international co-operation agencies and donors involved in mutualist support. A good level of competence, of knowledge and sensitisation developed at the level of important actors and in the society in general (Brouillet).
- The results in quantitative terms regarding the number of functional MHOs and of beneficiaries were only modest, but in terms of quality of work they are promising.
- The results concerning the introduction of GS were unsatisfactory, only 2,400 persons were covered by the GS in April 2001 after 1 1/4 years of functioning.
- The share of the budget for the development of UTM and its functioning costs are large in relation to the funds that the mutuals could benefit directly from.
- The technical tools developed and used by UTM are dimensioned for a much larger scale than the current mutualist reality.

Strength in communication activities

In general UTM is strong in its communication activities and has a good relationship with the press. It publishes a monthly information bulletin, produces comic strips and video clips translated into different local languages, and has organized various events promoting the mutuality movement i.e. the month and the week of the mutuality.

Measurable impact presently small but with emerging potential

The measurable impact of UTM at present is small. The potential might be demonstrated by the projected figures of beneficiaries of several rural schemes in the setting-up process.

Garanties de Santé (GS) not truly affordable for informal sector, members not made responsible

Critics of the program say that the amount of 440F CFA per person/month is targeting mainly the formal sector employees and may not be truly affordable for the population of the informal sector. Another problem is the prefabricated insurance product that results in the insured not being made responsible. In addition, UTM realised that the administrative charges of administrating the GS are too high and part of the administration is to be devolved to the mutuals (Ardouin).

Dependance on external support

The operating costs of UTM are very high and only funded by external support. The French donors noted that the current financial set-up cannot be maintained in the long term (Brouillet, 2000). Therefore, the technical agency UTM needs more diversified sources of funding. Ardouin suggested internal and external contracting as a strategy to plan budgets before executing programs and as a way of making the staff more aware of follow-up costs.

Alternatively, an endogenous financing structure could be envisaged. The Malian Government should be able to commission some of the UTM services. The weakness of the UTM model is its large reliance on external financial support.

2.5 Provider – Purchaser Co-Development Model

Linking the introduction of local health insurance with a project to improve the health service system.

2.5.1 Combination of Health Service and Health Insurance Development

This strategy starts from the assumption that a good quality health care offer is a necessary precondition for the introduction of health insurance. Experiences with existing MHOs have demonstrated that successful MHOs are usually set up around health providers with a reputation for good quality. Generally, for public providers to make suitable partners for MHOs, the issues associated with quality of care have to be addressed as part of the implementation plan for the MHO.

A development agency combines activities to improve the health service delivery system along with the introduction of local health insurance. This twin track strategy consists of organising the community to be sensitised to and prepare for health insurance while at the same influencing the quality of care dispensed by the contracted health facilities (health care offer).

Objectives

- Improve the infrastructure of health facilities (hospitals, health centres).
- Organize the provision of good quality medical care of health facilities in the project area (availability of essential drugs and equipment, in-service training regarding clinical and management skills, etc.).
- Promote and provide support for the process of establishing local health insurance systems (Sensitisation of the major relevant stakeholders and the population, support for feasibility studies and training for the setting-up process).

2.5.2 Example

Senegalo-German Co-operation Project for the Rehabilitation of the Regional Hospital of Diourbel (HRD) by GTZ/EPOS

The German consultancy firm, EPOS, is currently implementing this GTZ-project to rehabilitate the regional hospital of Diourbel in Senegal. The hospital was constructed in 1966 by the German Co-operation. Support ended in 1972 and was renewed in 1999. The HRD project has two major objectives:

- Enable the HRD to fulfil its role as a support and referral structure for the regional health system.
- Achieve a durable concept for hospital financing initiatives by promoting the creation of local health insurance systems (insurance as only one component).

Steering committee as central actor for the strategy

In January 2000 the project conducted public meetings for information and sensitisation to plan the activities of the HRD project. A workshop for the promotion of MHOs in the Diourbel region was held with relevant actors. As a result, the steering committee (Comité de pilotage) for the promotion of MHOs in the region of Diourbel was set up and became the central actor for the strategy. A regional plan for the promotion of MHOs (PRDMS) was launched with the support of the government agencies PAMS and CAMICS. The project collaborates with and makes use of other GTZ and PROMUSAF experiences in the region.

Comprehensive feasibility study and multi-sectorial, decentralized, participative approach

A comprehensive feasibility study was conducted to obtain reliable data and to sensitise the population in the Diourbel region (HRD, 2001). The study and the following sensitisation activities were intended to create awareness and establish interest in health insurance. The HRD project did not set out to create MHOs. It was considered necessary that the populations gradually appropriate the idea of MHOs. Proverb: "When one accompanies somebody one should not precede him." To achieve lasting results the project applied a multi-sector, decentralized and participative approach for the implementation of MHOs in the Diourbel region. Groups resulting from the sensitisation process that expressed genuine interest were provided with technical help and funds from the HRD project and PROMUSAF. As a result six groupings emerged which showed interest in initiating mutuals, of which four have advanced in their projects. These four mutuals are currently collecting premiums for about 1,200 beneficiaries. Three mutuals are in the stage of the waiting period and one has started to give benefits.

Benefit package RAGAD

The benefit package elaborated by RAGAD (Réseau d'Appui des Groupes d'Action au Développement) for a premium of 300F CFA/month per individual, provides the following services: three free prenatal consultations, normal delivery 80%, caesarean section and other obstetrical intervention 100%, surgical intervention 75%, diagnostics (laboratory exams, radiography, echography) 75%, hospitalisation 75%, essential drugs 50%. Direct consultation at the outpatient department is only paid for in emergency cases.
The original arrangements whereby members did not have to pass through the primary care level before having access to an OPD consultation were corrected because of the evident dangers around members directly consulting the outpatient department and being prescribed disproportionately expensive para-clinical examinations.

Providing attractive health care

The major aspect of the project is that by providing reliable, good quality health care services while at the same time taking into account the needs of the target population and the technical, public health aspects, community members can be attracted to the insurance concept. The set up and technical support provided by the project should avoid the common errors and traps in MHO implementation. Concrete examples of satisfactory health care provision to insurance members are a very convincing argument. The population sees the advantages of health insurance, which makes the concept attractive (Niechzial).

2.5.3 Comments

Technically sound but sustainable on the long run?

The promotion of mutuals initiated and run by a hospital project may have as its objective the organisation of a stable source of income for financing hospital services. But what is beneficial for the hospital is not necessarily so for the mutuals. The challenge is how to avoid schemes becoming too provider-oriented.

Artificial situation during project length: Considerable external capital and relative control of health care provision

The question has to be posed whether arrangements concluded during the limited time of a project will be sustainable once the external funding underwriting the healthcare offer is withdrawn. This is particularly important for the mutualist movement, where the process led by civil society cannot afford deception, which can be caused by a dramatic change of circumstance.

Another risk is that the hospital favours collaboration with those health institutions (i.e. health centers, pharmacies) which have concluded contracts with mutuals, at the expense of other institutions.

2.6 Entrepreneurial Approach – CHIC Model

2.6.1 Entrepreneurial MHO Approach

CHIC – Center of Health Insurance Competence

In the previous sections of this chapter existing approaches of MHO promotion in West Africa were studied. The authors identified the weakness of managerial capacity and the lack of an adequate compromise between the technical requirements and the participation of the community in the setting-up and implementation process as major obstacles to MHO development.

It is against this background that the GTZ International Project on "Elaboration and Introduction of Social Health Insurance Systems in Developing Countries" proposes a new concept. The guiding idea is that it is neither necessary nor desirable to develop within each MHO the full technical and managerial capacity needed to run a health insurance scheme in a totally autonomous manner. Instead, MHOs may purchase this expertise from a higher level institution. GTZ calls this institution the "Centre of Health Insurance Competence" (CHIC). The administrative status of the CHIC could be private or public and serve as a "holding" for associated MHOs. The essential element of CHIC is that it serves a public purpose.

This entrepreneurial model is currently in the developmental stage and has yet to be implemented as part of a health insurance project. It incorporates important elements of the widely implemented approach, the so-called CEFE project (Competency based Economies, Formation of Enterprises). This training and promotion concept of small and medium enterprises has been introduced in more than 120 countries. It evokes entrepreneurial behaviour and competence in a wide variety of situations (http://cefe.gtz.de).

Objectives

Building a centre of competence for consistent and long term support to a network of MHOs :

- Developing standardized insurance products and administrative procedures suited for local adaptation.
- Providing the organisational and administrative competencies needed to set up and run MHOs.
- Stimulating entrepreneurial behavior and supporting the gradual assumption of responsibility for an ownership of schemes by local actors.
- Pressing for an efficient implementation of schemes, whilst at the same time respecting the principles and time sequence associated with a bottom-up, individualized community-based approach.
- Setting up systems to enable the MHO model to be extended and easily adapted to the needs of interested groups.

2.6.2 Centre of Health Insurance Competence (CHIC)

When seeking to extend a mutual health insurance system to other regions of a country it is necessary to identify what elements the existing products have in common so that appropriate standards for products and administrative processes can be developed. This can facilitate the spread of the insurance-offer within the new regions and its take-up by the target groups.

CHIC – administration center for associated MHOs

GTZ recommends the establishment of a center of health insurance competence (CHIC), that could act both as an administration-center for associated MHO-institutions, as well as an educational and resource center. It is advisable that such a centre is best sited at a strategically important location i.e. a capital city or within a region with a history of MHO development.

Guaranteeing the business performance of MHOs

The CHIC-Center has two main clients: Firstly, the existing and potential MHOs, secondly the personnel from government, the regulatory agencies and from health care facilities. Its main objective is to guarantee the business performance of the MHOs. It does this in a direct way as well as in an indirect way. Directly, by performing certain administrative tasks at a central level on behalf of MHOs and indirectly by teaching the local actors to manage their business affairs autonomously. As part of its role, it seeks to help MHO staff gain an appreciation of the development process.

Facilitating administrative autonomy

The aim should be to keep the outsourcing of an MHO's administrative task to the CHIC to the absolute minimum compatible with maintaining its autonomy and facilitating its gradual expansion.

The challenge is to:

1. Minimize the direct costs of CHIC intervention.
2. Minimize health insurance transaction costs.
3. Increase the business performance of the associated MHOs.

This will usually require prior agreements with other institutions (i.e. federations) to ensure that complementary support can take place and that minimal resources are needed to generate a successful outcome.

The contents of the "MHO support" package are in essence standardised organisational and administrative systems as well as the basic structure of a variety of insurance products. In addition, a standardized MHO set-up process is proposed. A main feature of the standard models is that they are designed to be suitable for individual local adaptation.

Contents of product package "MHO support"

Contents of product package "MHO support"

- Costing exercise model (CHIC – calculation tool)
- Membership administration system with different levels of complexity
- Accounting and bookkeeping system
- Statistics system
- Monitoring system to follow up relevant indicators for financial and institutional functioning
- Training modules: setting up MHOs, accounting and administration training, adequate communication
- Support in contracting with providers
- Methodology for participative feasibility study

Responsibility of MHO

In return for the training, management and organisational support, the MHO needs to accept basic standards in administration, accounting procedures and documentation. A percentage of income from MHOs has to be given to the CHIC for delegated technical administration.
Initially, the bulk of investment to build up the CHIC's centre including payment of technical staff requires significant support from donors.

Responsibility of CHIC

CHIC evaluates the MHOs' reports, follows the trend of technical indicators with the help of an information system (software) and provides MHO managers with the necessary feedback.

Protocol of interference

When important technical indicators deteriorate and the financial viability of the insurance scheme is threatened, CHIC indicates the upcoming problems to MHO officials in order to give opportunity for adjustments. But the role of CHIC is limited to providing advice. The only direct consequence occurs when CHIC is dissatisfied with management and withdraws its support.

Support in contracting with providers

Another important task for CHIC, at least initially, is to support MHO managers in negotiating contracts with providers. The CHIC's role is to give advice on and sometimes to take the lead in negotiating of quality of care aspects such as how providers observe the agreed protocols on essential drug use and other treatment standards.

Monitoring of financial and managerial indicators

CHIC supports the monitoring of financial and managerial indicators and of drug consumption, informs and liases with the health administration about deviations of clinical standards visible in statistical records (i.e. number of prescriptions per patient, high percentage of prescription with injectables).

There are five main factors that are important during the transition to greater autonomy:

- Linking of learning with activity (Learning by doing).
- Provide adequate space and time for processing.
- Create a supporting environment for change.
- Remain sensitive to the culture of the target group.
- Develop technical competence in the field of MHO management.

Eliciting entrepreneurial behaviour

Motivation, competencies and behavior can all be learned. The best way to learn this is through either running or simulating a MHO business, in order to elicit entrepreneurial behavior. A major emphasis of CHIC is directed to support this change process towards enterprising behavior, how to stimulate and reinforce it.

By establishing a causal relationship between changed motivation and changed activity the motivation has to arise from a self-discovery and must be owned by the MHO personnel if the next stage of administrative activity is to have a meaningful impact. Through participation in the activity, enterprising behavior is encouraged and exercised. This has to be reinforced with newly acquired knowledge so in order that sufficient reasons exist to sustain the change (CEFE, 2000).

CHIC- flexible and entrepreneurial itself

CHIC is ideally as close to the target MHOs as possible. This closeness is not in terms of proximity but rather in character. The center should be: relatively small, flexible, aware of its own role and limitations, project a positive image, and be entrepreneurial itself.

Business methods adapted to cultural norms of target group

All business methods need to be adapted to the cultural norms of the target group. Cultural norms need to be identified and associated, if possible with entrepreneurial behavior. At times, it is socially unacceptable to be assertive, business-like, or even openly express one's opinion. But almost every culture, even if it falls into the above category, has its own ways of doing business.

Quality can only be sustained if those producing and delivering the support are sufficiently skilled. For this reason great emphasis has to be placed on qualifying trainers and other support staff. The key variable in the sustainability of the system is to monitor and evaluate constantly results of the self-governed MHOs. This involves collecting data and analyzing the information in order to draw conclusions as to how improvements can be made in the business performance indicators. The tailor-made monitoring and evaluation systems for MHO, InfoSure, has been introduced by the GTZ international project on social health insurance (www.InfoSure.org).

3. MHO - Frequent Problems and Possible Solutions

Prayer of a mutualist

„I commit myself to regularly pay the premiums, as the premium is the source of income for my mutual. I wish never to have to ask for assistance from the mutual for myself or for members of my family. My premiums should contribute to financing the health of mutualists who need it."(Gueye/ GRAIM)

This chapter discusses prominent problems of MHO implementation and related controversies. Ideas and solutions mentioned by the interviewees and relevant information from the literature are presented.

3.1 Low Financial Viability due to Managerial Weakness

Reduced access to health care because of financial barriers

A recurrent criticism of MHO schemes is that they are very expensive to implement. They require extensive preparation and large training inputs for their initial set-up. It is difficult to find qualified staff for the managerial tasks that have to be done on a voluntary basis, particularly in rural areas. There is a conflict between simplicity and complexity. Schemes need to be designed simply enough so that people can understand and manage them. But in order to control moral hazard and to be able to react quickly enough to a deteriorating financial balance, the system needs to be monitored and consequently it becomes more complex. More complex systems need knowledgeable managers. Evidence shows that people can only be trained to a certain extent and volunteer managers can only dedicate a limited amount of time for MHO activities. These are the limitations of voluntary work, but the problem is how professionalism can be financed.

3.1.1 What is the Cause for the Low Management Competence?

Institutional weakness: benevolence versus technicity

Marcadent/ILO believes that the fundamental constraint of MHOs is their institutional weakness. Due to limited availability of human capital in rural areas and the limitations of voluntary work there is insufficient managerial competence to run an insurance scheme effectively. In the MHO concept, a system is developed in which the management of the insurance is located at the level of a multitude of communities. There are limits to the ability to build managerial capacity in each community.

Problems of voluntary work

Gueye/GRAIM - Currently MHO schemes face the problem that they have to rely on the work of elected managers, who work on a voluntary basis and who are often neither sufficiently qualified nor prepared for their tasks. Even with adequate training, there are limits to what level they can be trained. It is not realistic to assume that all groups can be trained in all aspects of health insurance management.

Cost-inefficiency of training input

Marcadent gave as an example one small scheme, where the total amount of the contributions to be administered during one year could be 1,500 USD. Each administrator was responsible only for 300 USD. Much training input in terms of time and money would be required for this very small amount.

Professional dimension/Semi-professionalism

Brouillet/AFD states that a more professional dimension is needed, so that schemes are better prepared to deal with the technical requirements of administration.
CIDR expressed the need for semi-professionalisation of certain administrative tasks (CIDR, 1998). A conclusion of the PRIMA experience was that it is necessary to employ professional staff (nurse, accountant) for certain technical tasks (Sylla, 1999).

3.1.2 How to Handle the Problem of Institutional Weakness?

Need for technical administration at a higher level

Marcadent proposes to solve the institutional problem by separating the community responsibilities and technical administration. In his view, management by professionals is appropriate at the level of grouping of a number of villages. The tasks at the village level should be limited to the collection of premiums and the social control needed to reduce moral hazard. He cited the example of cooperatives, where the management is done at a level of 50,000 or more people. This allows for recruiting professional staff with technical competence, especially accounting and for computerising the system.

Employment of professional staff for technical tasks necessary but currently unrealistic

Gueye considers it necessary for mutuals to improve their management capacities and reduce the workload for the voluntary MHO managers by employing professional staff who can provide the necessary technical skills. But given the small size of most mutuals, it is unrealistic from a financial point of view for schemes to contract out these time consuming activities. He sees two categories of people involved in running MHO schemes. In a situation of sufficient membership, the day-to-day administrative work needs to be paid, whereas elected representatives, i.e. the members of the governing board, the decision makers, should work on a voluntary basis.

Motivating voluntary work

Voluntary work involves opportunity costs. Volunteers could be doing something else that might be more productive to fulfil their immediate needs.
Etté/CEPRASS believes that individuals engaging in voluntary work mainly pursue personal interests to enhance their status and social capital. This is a powerful incentive to be made use of by scheme promoters. Etté does not believe that the "motivation is to do something for the community". But this personal interest can benefit the community when channelled accordingly and when the institutional set-up of the scheme allows for sufficient control. Elected MHO managers assume that long-term benefits will compensate for the short-term loss of income. Promoters need to keep in mind that for elected managers and committee members there is the possibility that instead of monetary returns they are rewarded in a non-material way which satisfies their expectations.

3.1.3 Which Tasks should be Retained, which Delegated?

The majority of interviewees recognised managerial weakness as the major challenge of MHO development and proposed comparable ideas. They divided the managements tasks into simple and complex features.

Management tasks: Basic management and more complex tasks

Atim/PHR specified several basic management tasks for MHO elected leaders and managers. These include: communication with members, insurance promotion, collecting premiums, membership administration, accounting, basic bookkeeping, budgeting and management of funds.

But management tasks can become very complex. For example: setting premiums, determining benefits packages, negotiating contracts with providers, cost and budget projections, assessing the appropriateness of care provided and its pricing to rationalize the utilization of benefits, monitoring financial performance indicators, active marketing and communication activities (Atim, 1998).[1]

"Simplified" management

STEP/Dakar took up the idea, and developed tools and guidelines for simplified management as well as conceiving (specific) training courses.[2]

Simple administrative tasks

Letourmy/MAE (2000) as well distinguishes between two different types of administrative tasks at the technical level. Elected voluntary MHO administrators can collect premiums, pay the providers and deposit and withdraw funds from the bank. These tasks demand time, but they are not urgent and can be done when time is available.

Complicated administrative procedures and monitoring of indicators

In contrast to the above tasks, the analysis of the accounts, complicated administrative procedures, calculating premium rates and the follow-up on financial indicators to ensure the efficiency and viability of the scheme should be delegated to technical people. These tasks require special technical competence and more time for their execution.

3.1.4 What are the Limitations of Outsourcing?

Outsourcing increases administrative costs

Weber/Germany - The disadvantage of relying on external technical staff is that it will increase the administration costs and will put a strain on the financial viability of the scheme. More subsidies are needed. Weber calculated that for a MHO scheme in Cambodia a minimum of 10,000 – 20,000 people are required to pay for technical staff costs.

Confidence as determining condition for outsourcing

For Evrard/ANMC the limiting factor for delegation is that for a mutual system to work, people need to have confidence. Members will only have confidence if they manage the funds themselves at the local level, and if they take the essential decisions themselves.

Core management tasks such as risk management cannot be delegated

For Galland/CIDR the essential criterion is that risk is managed at MHO level.
The delegation of more complex, technical-administrative tasks raises governance issues, but it is possible to delegate and to keep governance responsibility at the same time. A possible delegation should not change the fundamental rule that the financial responsibility towards the providers and the beneficiaries has to be retained by the insurance managers.[3]

Letourmy/MAE - It is necessary to give the MHO leaders the means and the opportunity to control management, but this does not imply that they have to do it themselves.

1 PHR published in 2000 the " Guide to Designing and Managing Community-based health Financing Schemes in East and Southern Africa" which is intended as resource for professionals with a moderate level of experience with health financing concepts and activities

2 BIT–STEP (2001) Guide en gestion administrative et financière des mutuelles de Santé

3 BIT–STEP/CIDR (2001) Guide de Suivi et d'évaluation des systèmes de micro-assurance santé.

3.1.5 Are Detailed Feasibility Studies Necessary?

Expensive feasibility studies can be a financial obstacle

Expensive feasibility studies may constitute an important financial obstacle for putting MHOs in place. In order to conduct such studies, funds have to be raised and much preparation is required. Technically competent studies are often considered a necessary and vital precondition for the future success of MHO scheme. Hoffmann-Kuehnel/EED argues that such studies are needed to avoid the trial and error approach, which carries the risks of shattering the trust of community people (Hoffmann-Kuehnel, 1999).

Predictive value of feasibility studies is poor

Several interviewees questioned the importance of expensive and very detailed feasibility studies. Criel/ITG - The predictive value of feasibility studies is poor. Community members can tell you today that they are interested in and willing to pay for an MHO scheme, but it is not certain that they will actually do so.
Much baseline data can be obtained by other studies done in the same country or sub region. The additional value of having specific data of a particular region in comparison with the costs is often small.

Socio-anthropological, political studies more important

Brouillet sees less necessity for socio-economic studies, but more for socio-anthropological, political studies. It is essential to know about traditional forms of solidarity and common health perceptions. The cultural belief in how illness can be prevented and what previsions for health are acceptable helps to develop a more powerful argument and strategies to counteract common aversions to insurance.

Utilisation pattern and rates will change after introduction of insurance

For Galland/CIDR, a lot of the technical data about utilisation pattern and rates are only estimations and will change, especially after the introduction of the health insurance. The initial figures are not important, but the capacity to detect and analyse changes and adapt the scheme to the changing circumstances are.

Participatory feasibility study

STEP Africa has developed a methodology of a "participatory feasibility study”. STEP considers that in many studies a lot of unnecessary, useless information is accumulated. The methodology stipulates that only practical and useful information should be looked for. It is the steering committee for the setting-up of the mutuals themselves who elaborate and conduct the study (STEP Afrique, 2000).

Participative feasibility studies are important for the awareness raising process

For Villane/STEP, feasibility studies not only serve to gather technical information, but are also a necessary step in the setting-up process of a mutual by increasing awareness among and sensitising the population and interested community members. The participants during household surveys discover in the interviews how often family members fall sick and seek medical care. They find out by themselves the costs of health care, which makes it much easier to accept the results (treatment costs at the health centre, hospital or traditional healer, drugs at the pharmacy or street vendor).

Promoters and managers need to be reliable

Criel/ITG - More important than expensive feasibility studies is that promoters be honest, dedicated and technically skilled. People have been fooled and tricked too often. It is fundamental that those who are running and managing the scheme enjoy credibility and the trust of the local communities.

3.1.6 Should MHOs be set up under Conducive Circumstances?

Set up around health providers with good quality

Atim (1997) stresses that schemes are more successful if they are set up around a health provider with a reputation for good quality in matters such as waiting times, staff attitudes towards patients, and drug availability. Criel (1999) states that the major determinants for high subscription rates are the general performance of a health facility as well as the quality of its interaction with the community.

People need to be able to generate sufficient resources for premiums

The Bwamanda scheme in the Democratic Republic of Congo is an example where MHOs were created in an area where a confessional NGO had initially started with an agricultural and other community development projects. The increased purchasing power made it easier for people to afford premiums for health insurance premiums (Criel, 1998).

The MHO scheme in Nongon/Mali developed in communities that were situated in large cotton production areas. Interviewees argue that it is necessary to combine the introduction of MHOs with a income generating project (e.g. agricultural project, credit and saving scheme to enable productive investments).

Set up MHOs in urban areas?

De Roodenbeke/MAE states that MHOs should be started in conditions that are more favourable for its development like in urban areas or rural areas with high population density. The rural economy is often not monetarized. A good health system is rare, as costs to sustain a rural health system are high. It is difficult to keep good and motivated health staff in rural areas. This view is contrary to the notion of equity, but he considers it important to be less idealistic and more rational. Economy has inherent rules and is not moral or humane. Health services in isolated rural areas should offer subsidized PHC care with low fees, but should not introduce health insurance.

Distance complicates collaboration and coordination

Hohmann/Etté (GTZ/CEPRASS) decided not to include a previously targeted rural area project to avoid the problem of distance and have better chances of success with an urban MHO project. Especially it was feared that for a pilot scheme the necessary contact and close collaboration with the health authorities could not be managed in an isolated rural place.

3.2 Moral Hazard and Irrational Prescribing

3.2.1 How to Avoid Misunderstanding about Insurance?

Misconceptions about insurance are widespread when expectations do not correspond with what the scheme can offer realistically. As a consequence, people feel deceived and lose interest.

Rise of expectations

Mutuals inherently predispose people to increased expectations, especially in the presence of donors.
Ndiaye (Diourbel) - People start to think that the mutual can take care of all their problems. Expectations rise for preferential treatment, access to preferential drugs and para-clinical examinations. Often developing MHOs demand the creation of own health structures, the direct employment of health staff and their own pharmacy.

Difficulty to make people understand the limits of mutuals

Villane (Dakar) - It is difficult to make people understand and accept the limits of the mutual. It is not because the mutual exists that the cost of health care decreases. Sometimes MHO leaders remain vague and avoid making explicit examples what kinds of benefits are excluded from the benefit package. They do not want to weaken their arguments and make the insurance less attractive. But even if this has been correctly done people tend to forget or even overlook certain aspects, which are contrary to their expectations.

Avoidance of misunderstandings or misinformation

Koné (Bamako) - Unrealistic expectations of MHO members need to be prevented right from the beginning by getting the initial set-up right. The responsibilities have to be made clear from the start and a set of rules accepted by all members.

Appropriate information: Best prevention for misunderstanding

Koné (Bamako) – Appropriate information to consumers about the exact nature of benefit package, explaining basics for medical decision making concerning treatment alternatives (e.g. oral drugs versus injections/ iv fluids) can help to pre-empt the common misunderstandings.

Faye (Dakar) - To avoid complications it has to be avoided by any means that in an indirect or unconscious way hopes are maintained that the mutual will take in charge services that it cannot afford. The information has to be passed and understood at all levels.

Ardouin/UTM – Even after being given extensive information people often do not understand or can not recall important information. The promoters think the message has been understood. Important messages have to be constantly repeated and to facilitate comprehension concrete practical examples have to be given. The most difficult task is to convey the linkage of the premiums with the benefits.

Complementary examinations difficult to finance

Insurance members have to accept that mutuals at present with their low levels of premiums, cannot afford to pay for a significant number of para-clinical investigations, especially imaging. These costs go beyond the financial capacities of mutuals. Members have to be made aware that these investigations can be prescribed only in exceptional cases, when the health professional judges them to be really necessary.

3.2.2 Role of Prepayment and Organized Savings

CIDR in Benin, Uganda and Guinea are basing their system not exclusively on insurance, but as well on individual pre-payment without risk pooling. The idea of health insurance is gradually introduced. In the Guinea project, the groupings start with savings for health purposes and only at a later stage an insurance component is introduced (CIDR, 1997).
Hoffmann-Kuehnel/EED - In Uganda, communities opted for prepayment arrangements. The population resettled after the war and very little solidarity for neighbours or other villages was felt.

In the schemes supported by the French Mutualité Societé Agricole (MSA) in Benin, for cultural reasons the people were unwilling to pay for non-returnable funds like an assurance. As a consequence, MSA organized savings for small health risks. Solidarity funds were only acceptable for evacuation to the hospital.

3.2.3 The Appropriate Benefit-Package

A controversially debated subject is whether the MHO schemes should prioritise in their benefit package catastrophic illness (hospital inpatient treatment) or care at the primary health care level.

Arguments favouring catastrophic illness as 1st priority

Brouillet/AFD states that catastrophic illness is the priority, because it implies enormous financial consequences. Timely treatment is essential in these often urgent cases. Time cannot be lost to look for money.

Insuring catastrophic illness most appropriate technical answer

For Letourmy and Weber insuring only catastrophic illness is the most appropriate technical answer to the problems. Premiums may be significantly lower, as high premiums are the major deterrent besides low perceived quality of care. Moral hazard in insurance arrangements for PHC care is very complex to control. It requires a

number of relatively expensive technical, medical and administrative staff for management. The cost for administration of PHC care increases in a linear curve with the number of insured. Catastrophic illness is easier to administer.

Medical and financial needs

Weber distinguishes between medical and financial needs. The response to medical needs is the provision of PHC services by the health care system, but for financial needs it is MHOs coverage of catastrophic illness. MHO schemes are too often organized in a perspective of primary health care medicine but not enough in the perspective of financial and administrative necessities. His experience from Uganda shows that after thorough questioning of potential users of an insurance scheme, they acknowledged that the most serious threat to their existence came from catastrophic risks like appendicitis, obstructed hernia, obstructed labour requiring caesarean section, and bone fracture. They rated the need for insurance against catastrophic illness higher than for PHC care. The payment of fees for services for primary care is often within the reach even of poorer people.

Disadvantages for insuring catastrophic risks

Lack of visibility

The practical problem of insuring only catastrophic risks is lack of visibility of the benefits. The insured events are very scarce or may hardly occur at all (2-6%).
After a year of members being covered, there may be no one in the immediate environment, who can be shown as having benefited from insurance. People easily may get the impression that the MHO does not bring any benefits to them.

Strong communication skills necessary

In order to counteract this disadvantage very efficient marketing and communication activities need to overcome the community aversion towards up-front payments for a deferred return.

Concept of security of the family all year round

To appreciate the protection by the scheme, people need to be aware that even if they did not benefit directly from the scheme, because they did not claim benefits they benefited of living for a year free from fear of the consequences of catastrophic medical risks for themselves and their insured family.

With insurance money is paid for security

Letourmy mentions that CIDR has succeeded in Borgou/Benin in people realizing that with insurance money is paid for security, and as such they do not get something definite in direct return.

Increasing the visibility ratio

Galland/CIDR - In general CIDR tries to prioritise catastrophic illness in its package, but the choice is left with the population. In Benin the population chose to include in addition to catastrophic illness the following benefits: Treatment of snake bites, minor surgery, short term hospitalisation at HC level (severe malaria, acute respiratory infection) and delivery. This had the advantage of increasing the visibility ratio to 15%, which is important for accepting the scheme.

Advantages of insuring PHC care

Insuring catastrophic risks prioritises hospital treatment

The disadvantage of insuring catastrophic illness is that treatment at the hospital is prioritised, whereas the PHC concept encourages early treatment at health centre level. Ndaye (Diourbel) believes it is important to start a scheme including PHC care in order to satisfy the most pressing needs but on the longer run to encourage prioritising catastrophic risks.

Prevention of deteriorating illnesses

Kohn/STEP Africa – There is the risk that a patient does not go to the health centre because the treatment is not covered by the insurance.
Gueye/GRAIM - Certain illnesses, if not taken care of at the primary level, risk that the expenses will be much higher, when surgical intervention becomes necessary at the hospital. For this reason, the regional coordination of the Thiès region in Senegal (CRMST) now recommends that PHC services be included in the benefit package.

Combination of small and large risks

Combination: Insuring small and large risks

Letourmy states that to get people interested in insurance schemes and retain their interest, a combination of small and large risks is necessary. A "produit d'appel" is needed from the small risk package.

A mixture of catastrophic and small risks could raise the attractiveness of MHOs because it combines assets and weaknesses of the different benefit packages discussed above. However every solution remains imperfect because the exclusion of benefits, at hospital or PHC level, is inevitable. In consequence those members who suffer from an illness where the treatment is excluded will be dissatisfied with the insurance.

3.2.4 How to Make a Benefit-package more Attractive?

Another option often considered in an effort to make local health insurance more attractive is to take consumer preferences more into account. There has been criticism that MHOs do not sufficiently consider implications for the perceived equity and acceptability of their design features. A choice between a PHC and catastrophic illness package could be offered. Flexible benefit packages could be considered which take into account distance. A mixture of low frequency, high cost events taken care of by insurance could be mixed with pre-payment arrangements for PHC care.

Geographical impact on equity and accessibility

In a study in Ghana (Yi, 1998) it was noted that villagers of remote rural communities in Ghana saw transport as the greatest obstacle to establish health insurance schemes in those areas. Noterman (1995) observed in Zaire that the payment of the same subscription fee for households living far away from the hospital in relation to the people living nearby penalized them. Remote households cannot see a benefit in joining as they rarely attend the clinic, even if they are sick.

Graduated premiums according to geographical location

Notermann (1995) proposed the introduction of graduated premiums according to household location to improve acceptability of the health insurance in the population.

Members living at a distance insured only for catastrophic illness

People living at a greater distance could theoretically pay lower premiums as they use the insurance less. Evidence from the PRIMA project shows that insurance members living in the 10 – 15 km circumference used the insurance only half as much as those living within 5 km of the health centre (Huber, 2000). Insuring only catastrophic illness could be a much more interesting option for them than insuring PHC care that they will rarely use.

Transport costs for hospital evacuation

Galland/CIDR - Insuring catastrophic risks need to include the transport of the patient to the hospital that can be more costly than hospitalisation. For this reason the MHO "Maliando" supported by PRIMA made a contract with the local transport driver association to organise and pay for emergency transport.

Individualized insurance arrangements are complex to administer

Marcadent/ILO believes that individualisation of insurance arrangements is a problem of complexity, which is not easy to administer. He expresses reservations, as most of the managers of MHO schemes were not able to manage even simple insurance arrangements. More complex systems like taking into account distance, or variable benefit packages will make a scheme's administration even more difficult. Only by employing technical staff with the support of computers to administer the system does this become a possiblity.

In some small communities only one benefit package may be appropriate, because it is not socially acceptable that community members choose different options according to their monetary resources.

3.2.5 How to Prevent Fraud and Abuse?

Identification of the members

Gueye/Graim - Checking the identity of members and their insurance status is important. Member booklets with the name and a photo of each person of the family are necessary. If this is not done, the head of a family of for instance eight children, four girls and four boys will only insure four children. When the others get sick, they will take the place of those insured.

Social control to raise the threshold for consultations

Certain schemes, i.e. the UMASIDA scheme in Tanzania, requires their members to first see an official of the insurance to check identity in order to raise the threshold for consultations and abuse of service (Ginneken, 1999).

Excluding benefits if prevention services are not used

Koné (Bamako) - In the Nongon MHO scheme, a delivery is paid for only if the pregnant woman has attended at least 3 prenatal consultations. To benefit from free family planning services, women who have delivered have to attend postnatal consultations and bring their children for the necessary vaccinations and follow-up for the first 9 months.

Co-payment as standard method to prevent abuse

In addition to the insurance premium, patients are required to pay a pre-determined amount (co-payment) for the treatment cost out of their own pocket. This widespread method is intended to reduce the demand for unnecessary treatment and to prevent abuse.

Gatekeeper system

The bill of hospital patients is only reimbursed when referred by a primary care practitioner.

3.2.6 Which Strategies Counteract Low Premium Recovery Rates?

Finding the adequate periodicity of premium payment

Findings from literature suggest that it is very important for schemes to identify the adequate frequency of premiums and especially to take into account seasonal variations of income. Premiums should be collected in times of cash availability, for instance after the harvest (Atim, 1998). According to the target group, it may be better to collect the premium once a year (e.g. farmers), every three months or once a month or even shorter time spans (e.g. taxi drivers, market women).

Waste collectors (GEU) acting as relay and collecting premiums

UTM (Mali) is testing a new system of premium collection in the regional city of Kaye and in the capital Bamako. Waste collectors collect the premiums. This group act as "relay" to inform the population and collect money for premiums in small portions as soon as it is generated. A payment system based on the number of contacts with the target population is currently being worked out to provide incentives.
Ardouin/UTM - Premium collection should be done as close as possible to the point where the revenue is generated. In certain circumstances it may even be appropriate to collect money on a daily basis.

Linking savings with health insurance

Hohmann states that it is important to provide insurance members with the opportunity to continuously save up for their premiums in a credit and saving scheme (e.g. COOPEC in Ivory Coast) to ensure the availability of funds at the time of premium payment.

Ambulant trader association responsible for premium collection

Another approach was tested by UTM with an ambulant trader association. The association was in charge of the collection of the premiums on a weekly basis and paid the complete amount at the end of the month to the mutual. Ardouin believes that it is useful to work with existing informal sector structures using their internal organisational mechanisms.

In the Philippines insurance managers in charge of premium collection get a percentage of the collected amounts. In Mali the law on mutuals prohibits taking percentages.

Groups as units for premium collection

In Benin/Sud Borgou, in a CIDR scheme, the basic unit for premium collection is not the individual, but the group. At least four families are needed to constitute one group. This unit has a shared responsibility for collecting the total amount of the premiums due.
Gueye/GRAIM - Monthly premium collection overburdens the insurance managers, therefore quarterly collection is preferred.

Incentives against adverse selection

CIDR in Benin gives strong incentives to enrol the whole family to avoid adverse selection. They offer graduated premiums according to family size. The more family members are enrolled the lower the premium for each individual. Family heads see an advantage of enrolling as many members as possible, as savings can be increased with greater risk coverage.

3.3. Technical Quality and Perceived Quality of Care

3.3.1 What is the Role of Quality for MHO Development?

Biggest handicap for MHO development: Low quality of care

All interviewees share the view that the biggest handicap for the development of MHOs is the low quality of care provided by the health care offer. When the service quality is perceived as low, the population does not see any advantages in joining a mutual, because when they fall sick, they will not receive adequate care. Quality and reliability are thus critical for the attractiveness of services.

3.3.2 How does the Population Perceive Quality?

MHO schemes which are well accepted by the population (Thiès region, Bwamanda, CIDR/Benin, ANMC/DRC) often co-operate with private health care providers. In many cases these providers operate on a non- for profit basis (e.g. church related).

Interpersonal qualities and technical competence

Interpersonal qualities

People's perception of good quality goes beyond a mere clinical-medical notion. What the population perceives as good quality does not necessarily correspond with the technocratic perspective. Top of the quality attributes mentioned in semi-structured interviews of villagers in Ex-Zaire were the nurse's interpersonal qualities: respect, patience, courtesy, attentiveness, friendliness and straight-forwardness (Haddad, 1998).

Technical qualities

Technical qualities came second to interpersonal skills such as good treatment, good work, good diagnosis and punctuality. The availability of drugs and recovery from the illness were also given high priority (Haddad, 1995). Users appear to be very sensitive to aspects of interpersonal relations with professionals. Little emphasis is placed on preventive services. User satisfaction is associated with improved compliance (Winefield, 1995).

The reasons and possible solutions to the problem of low quality of care can be situated on three levels: government/donor, health care provider and consumer.

3.3.3 Quality and the Role of Government and Donors

Organisation of an efficient district health care system

It is the governments task to guarantee appropriate structural quality of the health care system: by ensuring sufficient and adequately equipped health care services, appropriately qualified health staff in an adequate ratio to the population and size of the facilities, and regulations allowing inter-institutional collaboration.

Respecting the health care pyramid

The government has to maintain an efficient district health care system to ensure cost-effective service provision. Emphasis should be placed on Primary Health Care (PHC) with an integrated service package including preventive activities (information, education, communication, vaccination etc). The health care pyramid has to be respected. This involves a functional referral system starting from primary health care level.

Providers need autonomy to negotiate contracts with MHOs

One limiting factor in non-decentralized systems is that local providers are not moral personalities and cannot sign contracts. They do not have decision-making power to conduct and conclude negotiations with MHOs without authority from the superior level. The state has to conduct a proactive policy to encourage providers to enter into negotiations with MHOs. A clear authorization for providers avoids a situation that an excuse is used for not getting involved with MHOs.

Autonomy requires room for manoeuvre

The MHO schemes need room to manoeuvre to negotiate for suitable local arrangements in which consumer demands have been taken into account. This requires derogations from standard MoH standard regulations (Criel).

MHO role in exerting pressure on providers to improve the quality of care

Limitation of quality improvement activities

Development agencies have responded to these observed quality problems by integrating quality improvement activities in their programs. This approach has its limitations, because health staff are not provided with the incentives to engage in additional time-consuming quality cycle activities. They fear that some results might infringe their own personal interests or reduce additional personal income.

3.3.4 Quality and the Role of the Health Care Provider

Problem of attitude and lack consultation skills of health workers

Criel/ITG believes that the major problem for the low perceived quality of care by the population is the lack of consultation skills by the health workers. The majority of health workers in Africa does not listen to its patients, does not give adequate explanations regarding diagnosis and treatment and in general treats patients in a rough, patronizing and disrespectful way. People‘s perceptions and demands are mostly disregarded, or considered irrational from the experts perspective.

Climate of mistrust	In a climate of non-confidence, in which serious communication problems prevail, health providers do not instil confidence in the services they provide. The people's sometimes unrealistic demands cannot be dealt with simply by giving adequate explanations. Patients leave the health centre dissatisfied and feel deceived by the health insurance that has raised their hopes of receiving better quality health care in exchange for the premium paid.
Appropriate training of providers to deliver patient centred care	Criel/ITG proposes to focus on training health professionals on patient centred care, to improve their communication skills and the relational and technical quality of the consultation. Specific methodological inputs are needed to correct the negative attitudes. Patients may have unrealistic expectations, but it is important to start from their perceptions. People might only reconsider their demands (request for injections, non acceptance of essential drugs) in a climate of confidence and respect (informed decision making).
Training of health workers in community medicine	Koné (Bamako) argues that training of medical doctors in community and family medicine is required to prepare health practitioners adequately to work in rural areas. Doctors are usually oriented towards university hospital medicine. He believes that health workers can make the services they offer more attractive by giving better quality medical advice. If the health worker is able to enter the mind of a patient by trying to understand his/her motivations and fears, this would already ensure half of the success of a case.
Taking into account the socio-economic situation of the patient	To deal adequately with patients in a primary care setting, the health worker has to take into account the socio-economic situation of the patient. He/she has to respect the financial capabilities of the patient in order to provide the most appropriate and still affordable medical care. Koné believes that the viability of the MHO depends on the scheme's relationship with the prescriber, who can in the case of unnecessary prescription cause avoidable, additional costs which then need to be covered by the MHO.
Judicious use of complementary investigations	Diagnostic and treatment algorithms and guidelines exist to help ensure the use of complementary diagnostic investigations only in appropriate cases. Prescribing drugs or requests for investigations should be done with the knowledge that the prescriber is using the money of poor people, something which should be done judiciously.
Competition through contracting relationship	Galland/CIDR found surprising reactions from nurses in public health centres in Benin who complained that no members of mutuals consulted them but went straight to the hospital. Galland thinks that competition between providers can result in quality improvements.
Quality assurance and monitoring	Continuous monitoring and evaluation of the routine health information system and getting feedback from consumers are necessary for assessing service quality and consumer satisfaction. Health insurance schemes need to include specific quality standards, such as waiting times or staff attitudes toward patients in their negotiations with providers. Atim proposed independent quality assessments or quality audits and scrutinizing provider's prescriptions and treatments offered (Atim, 1998). The review of medical records can identify excess care provision of unusual medical practices (Bennet, 1997). Until now, only a few insurance schemes have been able to monitor the quality and appropriateness of care delivered to their members (Atim, 1998). Sustainable improvement of quality of care cannot be realized by the MHO alone. The most important part remains the responsibility of the health care facilities with its professionals.

3.3.5 Quality and the Role of the Population

Consumer misconceptions and unrealistic expectations resulting in low acceptance of health insurance scheme

In the PRIMA scheme (GTZ/MMB) it was observed that there was an important difference between what the population perceived as good quality health care and what the health services were technically able to provide, following the principle of good standard practice (Huber, 2000).

Non-acceptance of standard treatment

People did not value the comprehensive services offered at the health centre. Injections were considered high quality treatment or "strong medicine", and standard drugs like Aspirin, Chloroquine, and Cotrimoxazol were not appreciated because they were so frequently prescribed. People perceived the drug variety offered at the health centre as too restrictive. The medical act was seen as dispensing drugs and people compared the quantity of drugs and the price they pay for it at the health centre with the cost of the same drugs if purchased directly at the street vendor. The amount of drugs received determined whether treatment was good or bad (Huber, 2000).

Incomprehension between the MHO and its members

The discrepancy between offer and demand of care translated into mistrust, suspicion and mutual incomprehension. A similar observation was made in CIDR MHO schemes where the patients did not believe in the efficacy of generic drugs and preferred injections to tablets. Such habits on the part of the consumers and the resulting behaviour of the prescribers lead to important additional costs (CIDR, 1997).

Unrealistic belief in imaging and other complementary exams

In urban areas like Dakar or regional capitals there is a strong belief in the importance of x-rays and other complementary investigations. The prescribed abdominal ultrasound for pregnant women to get an image of the foetus or other laboratory tests demonstrate the quality of the doctor, nurse, midwife or the institution. The value of imaging or laboratory investigations is overrated and is sometimes considered to be some form of treatment. In a context of limited resources many expensive complementary investigations are superfluous. A test treatment based on differential diagnosis is often more appropriate for a patient who could at the most afford the cost of the treatment. Unrealistic beliefs by insurance members can significantly increase costs for MHOs and need to be avoided.
In the mutual scheme of Khalil Bobo in Dakar the employed midwifes routinely sent patients for unnecessary routine ultrasounds. The costs (25,000F CFA) were not covered by the mutual. This practice however exerted a strong pressure on the MHO to obtain an ultrasound for the mutual in order to increase its attractiveness.

Medical conferences: Education program for curative and preventive health care

Education program for curative and preventive health care

To deal with this problem CIDR in its Guinea project in Nzérékoré plans to incorporate a program of education for curative and preventive care. The objective is to rationalize the health care behaviour of the mutualists via a better understanding of the health care offer. Training sessions are planned regarding essential drugs, injectables and supervised delivery. In addition certain preventive activities are included like the use of impregnated bed nets, vaccination and clean water supply (CIDR, 1997).

Medical Conferences

In Senegal in some MHOs medical conferences are held regularly in order to familiarize consumers about what to expect from mutuals and the health care delivery system. This is considered an important method in avoiding misconceptions and consequent cost escalation (mutuelle des volontaires d'éducation, GRAIM).
Villane (Dakar) - During member meetings of these mutuals not only are administrative issues discussed, but meetings are used for Information, Education, Communication (IEC) activities as well. As an example, the district medical officer is invited to present a talk on how to prevent malaria or to explain the physiology of how drugs enter the system. This is to explain the action of essential drugs and

injectables. At these conferences the people need to be reminded of their responsibilities and the limitations of the scheme. There may therefore be fewer patients dissatisfied when receiving only tablets and no x-rays are ordered by the health professional.

The mutual can make preventive activities more attractive to the individual members by making the use of selected preventive services as a precondition for benefits.

3.4 Ineffective Support of MHO Systems

How can the activities of promoting agencies be made more effective to achieve better results?

The implementation of MHO schemes until today has had only limited success and problems at different levels have to be acknowledged. Agencies have not built sufficiently on existing local knowledge and have not developed local expertise to an adequate level. Sometimes promoting organisations are inadequately prepared for their role and struggle with the technicalities of the process. A frequent criticism is that a culture of training dominates without that knowledge subsequently being put into practice.

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Local promoters did not always pursue the goal of developing MHOs to function as autonomous bodies and in some cases, their dependence was maintained. The collaboration among international promoters is not always optimal, technical documents and management tools are not regularly exchanged and the partners are not informed about each other‘s experiences. MHOs have difficulties to access existing materials. To overcome the existing difficulties major international promoters (WSM/ANMC, BIT/STEP, GTZ, PHR and AIM) have created a joint structure, the concerted action based in Dakar (www.concertation.org), which has as one of its objectives to help to improve collaboration among promoters.

Evrard/ANMC - Setting up MHOs is a complex task and is more difficult than other development projects. MHOs are situated at the intersection of three already complex areas:

1. Health financing.
2. Social affairs.
3. Health service delivery.

To succeed in the implementation of MHOs, these three systems have to be taken into account and insufficient consideration of anyone of them will threaten the success of an MHO project.

3.4.1 Obstacles at the Level of Promoters

Lack of autonomy of MHO managers

Obstacles are noted as well at the level of promoting organisations. In the evaluation of the PRIMA/Maliando scheme (Hohmann, 1999) the lack of autonomy of the MHO managers was criticised. Managers did not know the process of how premiums were calculated and referred for many detailed explanations about the functioning of

the scheme to the promoting organisation. Hohmann criticised that training sessions on health insurance development were organized for the regional and district health administration and the promoters, but only to a lesser extent for MHO leaders. This enhanced the disparity and dependence of the Maliando scheme on the health administration and the promoters.

Integration of the concept of auto-promotion in the approach

Letourmy described the CIDR project in Sud Borgou as an example of where the concept of auto-promotion is purposely integrated in the approach. The technical team consisting of one expatriate and two local experts take most of the initiatives and look at the issue of technical and financial feasibility. At the same time they are very aware that the people concerned are involved in the process and are associated in the decisions.

Atim (1998) maintained that promoters should employ a truly participative approach to enable schemes to take responsibility from the start, with special emphasis on organizational aspects. It is better for the schemes to acquire the capacity to resolve their own problems than for others to resolve their problems for them.

3.4.2 Creation of Local Capacity

Existing competences need to be identified and reinforced

For Sow/PROMUSAF in order to achieve sustainable results it is essential that local competencies be developed and used. Already existing competencies need to be identified and reinforced by capacity building efforts in order to put the competencies in the hands of local resource persons and the populations concerned. Trained resource persons should then be used as multipliers to do the work. As an example, PROMUSAF supported the further training of GRAIM and the CRMST (Senegal). These groupings are now conducting the training of promoters of MHOs and give follow-up advice for all mutuals in the region of Thiès.

Atim/PHR sees an important role for the delegates of existing MHOs in regional coordination (e.g. GRAIM/CRMST) to be developed as technical resource persons to conduct training sessions, do evaluation and follow up and perform other technical tasks. These representatives are part of the mutual movement and they identify themselves with its aims and principles and will not simply work as individuals doing contract work.

3.4.3 Information, Education and Communication (IEC)

Sensitisation activities

Sow/PROMUSAF - The major pillar for successful MHO implementation is the sensitisation of the population. There is no way of introducing health insurance if the people are not convinced of its usefulness. Information, Education, Communication (IEC) and sensitisation are an ongoing process. Health insurance is a new concept that needs to be well explained.

Insufficient "plaidoyer"

Experience from Guinea (PRIMA) showed that MHO officials lacked a good understanding and comprehension of the basic elements of health insurance. MHO officials did not know the major arguments for MHOs and were lacking a convincing "plaidoyer". Only if they themselves have sufficient and convincing arguments

about the advantages of the scheme will they have success in convincing others. Insurance representatives sometimes raise high expectations by making inaccurate advertisements in order to boost adherence (Huber, 2000).

Respecting the proper time sequence, conducting training on the ground

Letourmy/MAE (1999) considers the task of communication and sensitisation of these MHO officials essential and wants to reinforce these skills by conducting IEC training activities specifically for this purpose.

Media and methods for sensitisation adapted to target population

The media chosen for sensitisation of the population has to be adapted to the special conditions of the target population. The majority of the people of the target group in West Africa, - the informal sector- is illiterate and does not understand French. Mass media like newspapers or radio programs in French would not reach these people. Very few people have access to television, but a significant number of radios are available in the rural areas. For the majority of the target population, interpersonal and other traditional forms of communication (group animation, theatre) or radio messages in local languages are the only possible ways of communication. Tools and programs have to be developed for this purpose using simple expressions and concrete examples.

3.4.4 Training activities and its lasting results

Training at the MHO level

Evrard/ANMC - As far as possible in ANMC projects people are trained at the MHO level. In this way a larger number of people can be trained. Experience showed that when the same persons are always trained, the power relationship within the group changes to their advantage, with adverse effects on democracy and internal functioning. Distance is created between those who know and those who do not know. The disadvantage of this method is that the multiplier effect is lost.

Mutualists with long-term practical experience whose knowledge has been reinforced are more suitable and reliable for training and accompaniment of mutuals. They speak the local language and their daily practical experience with the topics make the teaching more credible. Consultants who have been trained in short Training of Trainers (ToT) courses often do not have sufficient expertise to act as an expert in the field and to fulfil the role of resource person (Evrard, 2000).

Per diems disrupting the dynamic in development programs

Evrard/ANMC - Per diems have disrupted the dynamic in development programs. ANMC is very much against paying per diems for people participating in training programs. Evrard prefers to have a training session for fewer participants who are truly interested and afterwards will truly put something into practice than to train a multitude of people who come for monetary interests.

This problem of per diems is widespread in development programs and no easy solution is available. In situations where government salaries are generally low, per diems are seen as compensation. The reality of people often not attending training sessions forces agencies to pay per diems.

Choice of trainees

Evrard thinks it is important that the agency organising training should have a say in the choice of the trainees as too often the wrong persons participate. Training is often conducted without requiring and safeguarding feedback from the organisations sending participants.

People who are trained should ideally come from existing mutual structures and have a sense of identity with the movement. When in a joint program ANMC, STEP/ACOPAM and WSM conducted training sessions in West Africa in 1997-1998, the trained resource persons used the acquired competencies to constitute a

network of consultants without honouring their commitments to train in exchange national staff in MHO development. Their services were contracted out for an established fee schedule.

The message of ANMC is that mutuality is " your own business”. People who want to start something have to organize themselves, but there is no money for individuals.

Respecting the proper time sequence, conducting training on the ground

Letourmy (1999) stated that it is important to respect a proper time sequence of training activities. It does not make sense to train MHO managers in administration and accounting if they have not been confronted with accounting problems in their mutual. He believes training would be better conducted on the ground, using the tools available, and explaining and solving problems when they come up. Later, more general training can be conducted when the managers have a better idea of management.

Opportunities needed to put acquired knowledge into practice

After the training there need to be opportunities to put the acquired knowledge into practice. Only through regular practice can the competencies be incorporated. Otherwise skills will be forgotten quickly.

Ability to absorb the new skills

Atim (1998) stated that it has to be ensured that the individuals trained are capable of absorbing the new capacities provided. Support agencies must recognize the distinction between equipping individuals with new skills and translating those new skills into productive work within the organisational setting.

3.4.5 How to Improve the Coordination among Promoters?

Lack of coordination among promoting organisations

In the inventory of mutuals and promoting organisations in West Africa the mutualists in Senegal complained about the lack of coordination between promoting agencies. Incomprehension was expressed that initiatives were launched without assuring a follow-up. The same types of training activities are conducted one after the other by different organisations. In other regions no activities are offered. There was a lack of synergy and common action plan. Training was overemphasized in relation to guidance for concrete implementation. Tools and training materials were often only available for those MHOs that an organisation supported (Concertation, 2000).

Avoiding duplication: Sharing of common training modules and management tools

Atim/PHR - There is a need for better coordination especially in the production and distribution of common tools. Many publications and tools are produced, but not available. It would be much easier to take from someone who has already developed a tool or manual to adapt it to specific circumstance than to reinvent the wheel.

Management tools and training manuals should be made more readily available to existing mutuals, as well supported by other organisations.

Weber - In many countries multiple donors in the field of health insurance operate independently and are reluctant to coordinate. Coordinating the efforts would create enormous synergy effects and could have significant benefits: Joint training units from specialists, provision of tools, bulk purchases or reassurance.

3.4.6 How to Improve the Relationship between MHOs and Providers?

Support for the co-operation between mutuals and health care institutions

Relationship between offer and demand big handicap

Marcadent stated that the relationship between offer and demand is one of the big handicaps in the development of the mutuals. Most other interviewees share similar ideas. It is not advisable to separate health insurance issues from the design of the health care delivery system. Health system design comes first (Carrin/WHO).

Principle of separation between health care offer and mutuals

Emphasis is usually placed on separating the health care offer and the insuring party by arguing that only this set-up can guarantee that consumers can constitute a counterpower to providers. In the contracting process better standards of care can be negotiated. But MHOs need the collaboration of providers in order to succeed. It is important to avoid a confrontational attitude of the health staff.

Make better use of synergies and common interests

Providers and mutuals, while retaining their independence from each other could make better use of synergies and common interests they share and improve their collaboration. For Brouillet/AFD it is important to better articulate the offer and demand.

Sharing of common interests

The following other interests can be shared:
- Improving the quality and the efficiency of the care provided.
- Improving access to health care translating into adequate utilisation.
- Generating income for the referral hospital and the promotion of preventive services.

A provider with inappropriate interpersonal behaviour towards patients, and prescribing habits in defiance of the essential drug policy will have disastrous financial consequences for the MHO.

Involving health staff in the institutional policy of the MHO

Galland/CIDR - It is important to involve the staff of all collaborating health facilities right from the beginning in the development of the mutual health system. The staff needs to understand what a mutual health insurance is about. They need to become aware of their role in the triangular relationship (delivery of care, payment procedures, co-payment arrangements, documentation requirements). The aim is to obtain the staffs commitment to accept additional insurance related activities in their daily work.

Programs to improve the relationship between MHOs and health workers

Exchanges between MHO officials and health workers

CIDR promotes a special program for regular contacts between MHO officials and health workers in Benin. In this program health workers (2 days) and mutualists (5 days) are sensitised about general aspects of health insurance and other aspects of the health care system. They are especially informed about each other's problems and at the end representatives of both groups meet for an exchange.

CAMICS program in Diourbel region

In Senegal in the Diourbel region CAMICS, the Senegalese government agency for the promotion of mutuals organised special training sessions for providers, addressed to all health staff in superior positions.

Blockages at the level of health care providers

It was noticed that blockages existed in the process of MHO development. After sensitisation activities addressed to the communities, health staff in health centres and hospitals were approached with questions to which they could not respond and refused to cooperate.

Frustrations of providers, request for financial compensation

During the training providers expressed frustration with the mutual movement. They were afraid of losing a part of their authority and were aware of the counterpower

the mutual can constitute. The example of health centre management committees was cited, where providers lost control over the clinic budget. They asked to be compensated for the additional work they had to do.

Change of conditions, self-financing

The message of the trainers was, that the conditions have changed and all health structures have to achieve a certain degree of self-financing for which health insurances are vital.

Mandating health workers to collaborate

Health workers were encouraged to change their behaviour. Although it was always known that patients have rights these were rarely granted. The argument held up by the trainers was that if health staff did not change their behaviour, the health administration will exert pressure and the population will go elsewhere. The health staff was encouraged to collaborate and enter in negotiations with MHOs.

Contracting relationship between providers and MHOs

Regarding financial compensation, health workers were told to look for it themselves. When they are able to attract more clients to their structures, the income for health staff will increase. In the new arrangements with health insurance the MHOs will manage their own money. Health staff offer services that are bought by MHOs. If the MHOs like the services offered by the health centre, they will buy them or else change providers.

4. Key Issues for Health Insurance for the Informal Sector

As a result of the discussions held six key issues for MHO development are presented:

1. **Independence from Government**
2. **Geographical and Socio-cultural Identity**
3. **Making Members Responsible**
4. **Technical and Social Compromise**
5. **Subsidy and its Implications**
6. **MHO Design allowing Development and Extension**

4.1 Independence from Government

Government should not create and manage mutuals

Experience with the excessively interventionist attitude of a government agency (PAMS/CAMICS) in Senegal in particular and state intervention in the cooperative movement in post-independence Africa in general demonstrated the problem of government interference in movements which should be rooted in civil society. The authors of this paper support the view that the government cannot be the central actor in the promotion of mutuals. Legislating, regulating and providing support to the mutual movement can constitute a conflict of interest, as in many countries the government is at the same time the main provider of health care.

Providing stewardship

The role of the government is to provide stewardship, an enabling conducive environment (e.g. effective decentralisation, tax regulation, improving health care delivery system etc) and develop an appropriate legislative framework. It should not create and manage mutuals.

4.2 Geographical and Socio-cultural Identity

People feel solidarity and confidence towards the people in their social environment, the family, and the people at work or within their neighbourhood. The MHO concept requires defined solidarity systems as basic units for the insurance. Some insurance schemes are established within an existing socio-professional group (e.g. taxi drivers, market women, credit and savings scheme members). But socio-professional relationships represent only one base for an MHO structure.

4.2.1 Geographical Location: Villages or Town Quarters

Geographical unit as basis for social cohesion

The authors suggest that an insurance unit should particularly take into account the geographical environment. Because a MHO system relies largely on trust and solidarity among its members to reduce abuse, a strong relationship among community members is a necessary feature. A geographical unit provides a basis for social cohesion. Community members living in the same geographical unit usually have the same traditional leadership and administrative set-up and the same provider.

Gueye/GRAIM even argued that socio-professional relationships do not provide a sufficiently solid base for an MHO structure, and that the insurance unit should be based on geographical location.

4.2.2 Socio-cultural or Professional Association

What should the role of existing socio-cultural and professional organisations in relation to MHOs be? Should existing associations add health insurance as an additional branch to their services or activities? Or should their role be limited to recruit members but not include managing the scheme?

Existing associations: Instruments for social mobilisation and social control

Existing associations can play different roles. They can serve as point of entry for recruiting people into the mutual movement and they can assure part of the health insurance management. But the decision taking, structure and final management of the funds should remain the responsibility of the MHO management. The association may distribute an insurance product governed by mutual rules and use its competencies and system of diffusion. It should neither manage nor represent the scheme itself.

Linking the concept of savings with health insurance

ILO/STEP proposes the introduction of health insurance through existing associations. AFD has great hopes in articulating credit and saving schemes with mutual health insurance. These approaches seem interesting because use can be made of an existing organisational structure with membership and existing know-how in management and financial administration. Credit and savings schemes already have managers with administrative and management skills. The GTZ/CEPRASS MHO project in Ivory Coast established links with a nation-wide credit and saving co-operative "COOPEC" in order to facilitate insurance members to save for insurance premiums in their individual account. The concept of savings is linked to health insurance. Credits should be made available for health expenses not covered by the benefit package.

MHOs have social dimension

The authors argue that MHOs have a social dimension, which differentiates it from other associations and credit and saving schemes that often were created with an economic purpose. The goals, the social dynamic and the mandate are different.

4.3 Making Members Responsible

4.3.1 Specific Conditions for MHO Schemes

Provisions for uncertain illness low on the priority list

MHOs are private non-profit organisations that are primarily targeting the informal sector population. They provide insurance to a population group that lives in a context of widespread scarcity of resources. People are engaged in day-to-day survival strategies where health is only one problem of many. Provisions for uncertain illness are low on the priority list. Income usually does not enter the banking system.

Precarious situation of community members permits only low premium rates

The precarious situation of many community members permits the MHOs to function only with relatively low premium rates. The mutual has to calculate its costs for the minimum in order to have low accessible premium rates that a maximum of people can afford. As a consequence, to keep administrative costs down, the schemes cannot afford professional managers and have to rely on benevolent work.

Financial equilibrium is difficult to sustain

It is difficult to sustain financial equilibrium. Even under optimal administrative conditions, this special situation does not allow any significant irrational prescribing behaviour or abuse of the services by the insured. Fraud and abuse may quickly destabilize the system. The impossibility of taking premiums from a salary via a bank account makes premium collection difficult, leading to frequent delays or payments stops. Another problem is that mutuals, especially in the presence of a foreign donor, inherently cause a predisposition to increased expectations. It is necessary to contain costs throughout. The combination of all these factors makes the implementation of insurance for the informal sector difficult.

4.3.2 Self Governance

Responsibility for financial equilibrium at MHO level

In order to control the moral hazard behaviour of insurance members and health workers, members have to be made responsible for their behaviour. They themselves represented by management board members should bear the financial risk. The responsibility for a financial equilibrium of the mutual should not be placed at the level of an anonymous insurance company, the government or a foreign donor. When members abuse the services or when the providers prescription behaviour is irresponsible and the MHO management board omits to take adjustment measures, the scheme will go bankrupt.

To become a member of a mutual, it is essential to respect these principles. MHO members have to commit themselves to respect the rules and regulations and be aware of the responsibility they have regarding their behaviour. When they abuse the system, they endanger the viability of the entire institution.

Getting the initial set-up right

To make members responsible, it is important to get the initial set-up right. People have to be aware that the structure is theirs and their participation in the decision making will determine whether the insurance scheme will succeed or fail. Promoting organisations and foreign donors only provide assistance in technical matters. The responsibility for the setting up and running the MHO belongs to the MHO management board and the members they represent.

4.3.3 Appropriation of the MHO Concept

Appropriation of the concept

The final decision of community groups and individuals to establish an MHO thereby assuming responsibility for the process has to come from the people themselves. They have to feel the need for a mutual and make a conscious decision that they are interested and prepared to engage in the professional administrative and often benevolent activities which will require their time and energy. Promotion agencies can spread the idea of health insurance and by means of efficient awareness-raising activities can raise the interest of the target population. Yet the development of mutuals can only be facilitated up to certain extent. Going too far would destroy the dynamic and be counterproductive.

Bottom-up approach

The majority of the interviewees believe that the bottom-up approach is the only possible way to successfully implement mutual health insurance in a lasting way. A top-down approach has certain advantages, it may be quicker and more efficient to be implemented, but sustainability will remain a problem in the long run. The disadvantages of the bottom-up approach are that they take time for implementation and are therefore costly. Awareness raising activities need time to achieve results. Proverbs: "You cannot shave someone‘s head in his absence.", "You need the meeting between the tailor and the person for whom the dress is made."

Institution created should be based on the people’s needs and efforts

If people do not feel that the scheme created is based on their efforts and constitute an answer to their needs, the demands for external assistance will be large. Experiences with cooperatives show that the appropriation of a new idea takes time and donors should not expect immediate results. Only under these circumstances can the MHOs survive.

Importance of a waiting period

In the Thiès region (Senegal), interested members during the setting-up period for a new mutual or people who join an already established scheme need to show that they are truly interested and serious by contributing their premium for 6 months before receiving benefits (waiting period). The regional coordination CRMST considers it more important to have some time passed and have truly interested people, and eliminate those with superficial or monetary interests than to progress rapidly.

"Planting a tree"	Proverb: "If you are planting a tree, you cannot immediately benefit from it shade or its fruits. It takes some time to water it and to look after it." The promoting organisation PROMUSAF offers additional technical and material support for new schemes only under these conditions.

4.4 Technical and Social Compromise

Balance between economic/ technical requirements and community expectations	Community participation and responsibility in the MHO system is essential for the success of health insurance in the informal sector. If the MHO satisfies only the wishes of the population, there is a danger that the MHO may become dysfunctional and inefficient. Therefore evidence based health care and economic principles need to be integrated in the design. To guarantee an economically stable MHO a balance needs to be achieved between the expectations of the members and the technical requirements of the scheme.
Support of the process	Communities should not remain unsupported during the setting-up process. This could mean that the same mistakes are always made and essential economic principles and a public health perspective are lost. When groups express genuine interest in the MHO idea and formulate demand for support, a selection of technical support measures adapted to the specific conditions of a scheme can be made available.
Linkage of premiums and benefits	The most important concept to convey to insurance members is to link insurance premiums with the benefit package. In a transparent costing exercise, the linkage between what insurance members contribute and what they will get as a result of it has to be established.
Scenario of a cost exercise (comparison expenditure - revenue)	In this exercise insurance members have to decide which services they would like to have included in the benefit package. The choices they make have direct implications on the premium and co-payment level. The more services they want to include (e.g. PHC care, hospital care, emergency transport or cost for drugs), the higher the insurance premiums. People must choose in full knowledge of all facts and reasons. Including all services would raise the premiums to an unaffordable level. Members need to learn to make choices and prioritise to keep the premium level affordable. The community needs to choose between different options and take full responsibility for the consequences of its decisions. Villane (Dakar) uses the following example in his plea to community people:
Couscous: With a small spoon you only get a small dish	"When you make couscous, you need a certain quantity of grains and other ingredients. If you want a small dish then you only need a small spoon, then this will be enough. But if you want to eat rice with fish in a big pot then you have to put a large spoon with the necessary ingredients. If you want more, then you have to give more." Other proverbs: "Mutuality is a balance between what you put in and what you take out to cure the people." "Mutuality is a financial box, you have to know how to manage it."
Awareness of financial limitations	The exercise makes insurance members aware of the costs, the conditions and especially the limitations of the mutual system. It makes it clear to all participants not to expect benefits from promoters and foreign donors outside the agreed technical assistance. Donor funds should not interfere in the linkage of premiums with benefits.
Benefit package or co-payment level may need to be adapted	As a further step, the members are informed that the agreed benefit package can only be guaranteed as long as the behaviour pattern of the adherents does not change drastically. If the frequency of service utilisation surpasses the predictions and if financial disequilibria occurs, the benefit packages or co-payment level need to be adapted.

4.5 Subsidy and its Implications

The issue of subsidy as a means of facilitating the introduction of mutual health insurance systems is very pertinent. In Europe, compulsory health insurance systems' premiums of the poor or unemployed are subsidised or even directly paid by the government as social assistance. The state takes on the responsibility for those who have less means or who are unable to pay (Eisenblaetter, 2001).

Technical assistance but no subsidy of insurance premiums

In the MHO system, subsidies are granted only as technical support and not as a subsidy of the premium. The question arises as to why affluent European societies subsidize disadvantaged groups, whereas the MHO system designed for poor countries does not make any provisions for such subsidies.

Organize mutuals among the poor?

Marcadent is against the idea of organizing mutuals only based on contributions of the poor as "solidarity between the poor". He believes that subsidies are necessary even on the long run, because the low income of the targeted population groups cannot finance a functioning insurance system.

Costs for technical assistance are high

Evidence of MHO projects reveals that donor support in the form of technical assistance, salary for technical staff, training activities, logistics, infrastructures can easily reach 70 percent or more of the total budget of MHOs. Financing promoter organisations with expatriate staff requires large-scale budgetary support (GTZ Project "Projet de Recherche sur le Partage des Risques Maladie: PRIMA/Guinea, Centre International de Développement et de Recherche: CIDR/Guinea/Benin).

Technicians are very expensive in relation to the low level of people's income

Subsidies to cover technical assistance are absolutely necessary given the low income level of the target group in comparison with the remuneration of technicians (accountants, trainers, managers). If MHOs had to buy these services in the form of temporary consultants or permanent staff, this would leave very little money to pay for benefit packages (Weber).

General consensus about the need for subsidies

There is a general consensus about the need for subsidies, but there are different views at which level these subsidies should come in.

ILO in Argentina and the World Bank (WB) in Tanzania use the principle: "The same amount you put in we will put on top of it." Marcadent argues that subsidies can be a strong incentive for people to join. People see immediate advantages in contributing more of their own means when donors double their amount.

Subsidy of premiums create disincentive

The experience of subsidising premiums like in a World Bank (WB) project in Tanzania proved to be discouraging (Atim). Doubling the amount people paid into the schemes themselves, which was designed to be an incentive, had the opposite effect. People perceived the WB as a rich organisation. Why didn't they pay the whole premium? Although the scheme initially had considerable success, afterwards high dropout rates resulted.

Dangerous to rely on subsidies in the system

It would be unwise to subsidise the premium level. MHOs cannot count on significant budgetary support by the governments of the sub-region. Therefore it is dangerous to rely on subsidies in the system. The promoting agency can provide all the necessary support to set up and make the mutual functioning, but it should not replace the premium payment of the member by external funding. This would take away the essential feature of making the members responsible.

MHOs are not a solution to the health problems of the poor

The MHO system targets people from the informal sector with some form of income. It is not in position to take care of the poor. If a government pursues the objective of covering these disadvantaged groups with health insurance, direct subsidies of the premiums will be necessary (social assistance). But the form of subsidy should be well designed. Offering too much without many preconditions and people's contributions may create an attitude of entitlement by the recipients and make it difficult to enforce premium collection from the less poor.

People's own ability has to be fully used before support should step in

Doyen Gueye (GRAIM) answered when asked what recommendations to give for foreign donors: "Certain attitudes like expecting everything from outside should systematically be discouraged. External assistance should only be the extension of the efforts of the local people. People clearly have to demonstrate that they commit themselves to take care of their health problems. When they go to the limits of their own means, at this moment donors can take the relay. Then donors should provide them with the little bit, that their own means would not allow them to achieve."

4.6 MHO Design Allowing Development and Extension

4.6.1 Inbuilt Mechanisms for Continuous Adaptation

Listening to consumer needs, keeping communications channel open

MHO design features need to be adjusted throughout the operation. Benefit packages and co-payment levels need to be modified in case of financial disequilibria. Feedback mechanisms enable continuous adaptation and fine-tuning. A regular dialogue with the members needs to be maintained. Consumer surveys can give regular feedback on performance. In order to ensure financial viability, schemes may have to adopt major design shifts to respond more flexibly to members' needs. Experience indicated that relatively successful schemes were designed through a long process of negotiations (Bennet, 1998).

Continuous marketing and communications activities

Continuous marketing and communications activities towards potential community members/groups and to members are necessary to maintain the interest in and the perceived usefulness of MHOs and attract new members.

4.6.2 Potentials for Extension

The MHO system in the long run is only valid if a larger section of the population can be covered. Agencies should not install a mutual without reflecting on the potential for extension of these structures into a more broad scale solidarity system. Isolated micro projects with unique design features have little prospects to serve as a basis for a model that can be scaled up to a wider MHO network. There is thus a need to introduce a certain degree of standardisation of financial and organisational procedures in order to facilitate administration and to have a basis for easier extension.

4.6.3 Preparation for a Future Social Security System

The so far limited success of existing mutuals should not detract from the importance of a more comprehensive social security system in the future.

Awareness-raising, strengthening of management capacity

The stage of microexperiences (MHOs) is a necessary step to familiarise people with the concept of health insurance. The principles of insurance and its implications for personal behaviour must be well understood. Gradually setting up an MHO system helps to build up the capacity of the state to organize and regulate the sector. Human resources capable of administering insurance on the central, regional

and local levels have to be trained. Mutuals can be the breeding ground for the technical staff to run a national social security system later on. A sufficient number of trained managers who know the problems and pitfalls of health insurance management are needed. Time and effort are required to improve the conditions for quality health care. Existing MHOs can provide practical experiences and prepare civil society to take charge of the process. In the long run the introduction of a national compulsory health insurance system is probably necessary within the next 10 – 20 years.

4.7 Relevance of Key Issues to the MHO Approaches

Table 3: Matrix

	Essential Principles	Pilot Project Model	Government Agency	Regional Coordin. (GRAIM/ CRMST)	Technical Agency (UTM)	Co-Develop-ment Model	Entre-preneurial Approach, CHIC
1.	Independence from Government	+	-	+++	++	++	++
2.	Geographical and socio-cultural identity	++	0	++	+	+	+
3.	Making members responsible	++	+	+++	+	+	++
4.	Technical and social compromise	+	+	+	++	+	++
5.	Subsidy only for technical assistance	+	+	+	+	+	+
6.	MHO design allowing development and extension	-	0	+	++	+	+++

Evaluation scale:
- no relevance, 0 indifference, + relevance, ++ more relevant, +++ high relevance

5. Recommendations for MHO Development

The findings from this study were compared with recommendations of existing MHO reviews. Atim (1998) called these "recommended MHO design features", Bennet and Creese (1998) "appropriate design". Bennet summarized the dilemma of recommendations stating that many failed schemes have made predictable errors, which appear obvious in retrospect, but were not evident for the designers and implementers of the scheme. Certain recommended design features should be clearly taken into account to ensure success. But this does not mean that a set formula can be applied because of different social environments and quality of the existing provider and health systems. Different designs will be appropriate in different contexts addressing different problems. Getting the initial architecture of the scheme right is part of the challenge, but adapting it as circumstances change is at least as important (Bennet, 1998).
As summary the authors formulated the following recommendations concerning the setting-up process, sensitisation activities, management and administration system and details of design features.

5.1 Setting-up Process

5.1.1 Necessary/Desirable Preconditions

Targeting the intervention in more favourable circumstances

Minimum population size

A minimum population size in the target area should provide the possibility to generate sufficient membership to cover costs. Isolated, sparsely populated areas with long distances to health institutions and administrative centres render MHO implementation of MHOs difficult.

Conducive economic environment

A conducive economic environment is necessary to enable community members to afford the regular payment of premiums. Existing community development programs in the target area providing opportunity for income generation (agriculture-, craft project, microcredit scheme) can help to assure a minimum contributive capacity.

Social cohesion and solidarity links

Social cohesion within the community and existing solidarity links among members of the target group are necessary preconditions for people to accept the principle of risk sharing. Future beneficiaries of the scheme need some degree of confidence in each other and the desire to find a common solution for a perceived problem of access to health care. Communities need to be interested in health insurance. Existing social groups and organisations facilitate the sensitisation and setting-up process (appropriation, accepting responsibility).

Favourable socio-political environment

Political support of community leaders, institutional support from local political authorities and from the local health administration is of crucial importance. The government should put in place a legislative framework to regulate MHO development respecting experiences in the country. A government-led program for the promotion of mutuals by the MoH can be very helpful. Their role encompasses the sensitisation of health staff about health insurance and reinforcing the providers' managerial competence. The government has to put in place essential conditions for health insurance, which is to institute measures improving the quality of care provided by government health facilities which are potential partners for a contracting relationship with MHOs.

Collaboration with providers

Health institutions in a contracting relationship need to have the confidence of the population. Providers and MHOs need to accept each other as negotiating partners. Contracts should stipulate quality of care aspects, which in case of non-compliance

	will entail sanctions. Providers need to accept their role concerning quality of care, observing treatment protocols and accept the right of monitoring of a third party.
Decentralised health care system as precondition	Only a truly decentralised health care system can provide the opportunity for local health facilities to adapt their range of services, quality of care and management to suit local needs.
Competent and trustful promoting agencies	The promoting agency that guides and follows up the process should enjoy the confidence of the population. It should have reputable leaders with technical competence acquired in previous interventions in community development.

5.1.2 Awareness-raising Activities

Participative Feasibility Study

Process of wider stakeholder consultation and participation	Comprehensive, costly feasibility studies are less important in obtaining detailed technical data. Specific technical data is often available from existing databases or can be adapted from more extensive studies in other areas with a similar socio-economic background. The main purpose of feasibility studies, when they are necessary, is to find out about the major stakeholders and to inform and associate these important groups with the process of awareness raising and MHO promotion.
Socio-cultural study to develop convincing argumentation	A socio-cultural study investigating health-seeking behaviour, health problem perception, and cultural practices related to illness, traditional and religious taboos (e.g. attracting misfortune when making provisions for illness) can be very helpful. The knowledge of the socio-cultural particularities is useful to develop a convincing argumention in the sensitisation process, especially to be able to counteract existing cultural preconceptions to health insurance.
Avoidance of misunderstandings or misinformation	To increase the acceptability of the scheme, and ensure that MHOs offer benefit packages covering the perceived health needs and taking into account cultural values of the population, consumers need to be consulted in the set-up phase. Every means should be used to pre-empt common misunderstandings about health insurance and the potentials and limitations of MHO should be explained in a realistic manner.

Appropriation/making members responsible

Making people aware of the realities and willing to accept the consequences	Making people aware of the realities and willing to accept the consequences. The participatory process of the sensitisation process serves to make people aware of the realities and is an indispensable tool for communities to accept the resulting consequences for the MHO scheme. Communities need to claim ownership and be made responsible for the process by the promoting organisation. In the costing exercise the link between the premiums and the benefit package makes MHO members responsible for their behaviour.

5.2 Member Participation in Management

Transparency/accountability, Democratic participation in insurance scheme	Trust is particularly important for MHO schemes. The members will more readily accept decisions taken by MHO managers if they are confident about the system. Schemes need to develop regular dialogue with their members and ensure

transparency in the management. Democratic participation and accountability need to be basic features of the scheme. To sustain the motivation and avoid misunderstandings regular meetings should be convened to report on results, suggest improvements and reinforce ties amongst members. Regular and accurate financial reports need to be submitted. Non-technical language should be used in documents and reports in order that all members can understand and participate in discussions (Bennet, 1998).

5.3. Management and Administration System

5.3.1 Administration System Based on Volunteer Work

Despite the known limits and problems with volunteer managers, it is argued that there is no other option for small mutuals than to have elected officials working on a volunteer basis. Elected representatives who have primarily a representing and deciding role (members of the management board) by definition cannot get paid for their work. Health insurance managers need record keeping, accounting budgeting, and marketing and communications skills. These activities should in the short term be compensated by financial incentives or other provisions and in the long term financially recognised either through fixed salaries or other provisions in relation to the workload.

Limits to volunteer work

Experience has shown that volunteer MHO managers cannot always be trained to a sufficient standard. These managers are often ill prepared to maintain sound and reliable bookkeeping and accounting systems and be in a position to analyse the financial situation of the scheme.

Responsibility at the MHO level

MHO managers can only dedicate part of their spare time for volunteer work. Very technical and time-consuming activities should not be part of the routine work of elected managers. MHO leaders and managers do not need to know how to do everything, but they have to be in a position to evaluate and take into consideration the work of technical people for their decisions. Simpler management activities, like premium collection and administration, social control and marketing and awareness raising (public relations) can be handled by volunteer MHO managers/board members.

Governance, control and risk responsibility remains at MHO level

The possible delegation of the complex, technical administrative tasks does not change the principle that the responsibility towards providers and the beneficiaries is retained by each insurance member or their delegated representatives, the MHO managers/board members. The governance of the scheme, the control and risk responsibility (and the part of decision taking) remain at MHO level. Important management decisions can only be taken by elected MHO leaders. As consequence MHO leaders need to be prepared and trained to control management. Due to their important role, they should have the opportunity to build up a social status to enforce their social standing among the members of the target group.

Providing non-monetary advantages for MHO leaders

Training given to MHO leaders should be seen as non-monetary benefits to leaders and managers, which can serve them for private purposes outside MHO work. There should be a real gain in competencies and self-confidence during the time of volunteer work in the MHOs in order to avoid dependence on promoter organisations or providers.

5.3.2 Marketing and Communication System

Public relations and marketing activities geared towards the general population but also towards existing members need to be part of the routine activities of MHO officials. Research of consumer preferences and consumer satisfaction should be an ongoing concern. Problems with deteriorating perceived quality in the health services need to be rapidly resolved.

Recruitment of new members

Marketing a scheme must go beyond explaining to the public what has been decided and have them informed by leaflets and public campaigns. Stakeholders consultation exercises prior to designing schemes need to have taken place in order for a scheme to be attractive (Atim, 1998).

Member Consultation and Information

Providing information to communities and active marketing

To generate and sustain interest in the scheme, regular provision of information to communities and marketing is necessary to share information about the quality of care and the range and costs of services.

Conferences on medical care

Meetings should be convened or routine meetings used to inform members about basic aspects of the provision of health care. This is to avoid common misunderstandings between what the general population perceives as good quality and what health services are technically able to provide, following the principles of good standard practice. Conferences in collaboration with contracted providers under supervision of the health administration should be organised to inform insurance members and the interested general public about important subjects of health care provision (essential drugs, the difference between oral drugs and injections, value of complementary investigations, prevention of malaria, vaccinations etc). The participation of health staff as lecturers should be part of the insurance – provider contract.

5.4 Details of Design Features

5.4.1 Membership and Coverage

Making use of existing solidarity mechanisms

The basic unit for subscription should be a family to minimise adverse selection. The adherence of larger groups (group assurance) through existing socio-cultural organisations should be promoted (mutual credit and savings organizations, tontines, women's groups, farmer groups, cooperatives, trade unions, and self-help groups). The advantage of larger groups adhering collectively is that existing solidarity mechanisms and management capacity can be made use of. The basic unit for health insurance should be based on geographical (the village or city quarter) or socio-cultural/professional identity.
The French NGO CIDR proposes a grouping („groupement") as basic unit for subscription of at least 4 families, which are collectively responsible for premium collection and payment.

5.4.2 Premium Setting and Collection

The premium level and the corresponding benefits that can be financed by the contributions of the members should be determined in a transparent public costing exercise. Fee levels need to be affordable and acceptable to the members.

Periodicity/frequency of premium payment	The frequency of the premium payment needs to correspond with periods of cash availability, taking into account seasonal variations in income.
Premium collection	Premium collection should be done as close as possible to the place of revenue generation. (i.e. agricultural co-operative, taxi driver association, credit and saving scheme). It can be very useful to rely on existing organisational structures, which are made responsible for premium collection of the whole group.
Strict enforcement of rule	Members need to be made aware that there are no exceptions to not receiving benefits from the health insurance if the payment of their insurance premiums is not up to date.
Open annual enrolment periods	An open annual enrolment period with a defined waiting period is preferable to a fixed premium collection period, which limits the adherence to the scheme for a year after the closing day. It is important not to overburden the workload of MHO officials who are responsible for premium collection.

5.4.3 Benefit Package

Benefits packages need to be pertinent and benefits clearly visible to the members.	Benefits packages need to be pertinent and benefits clearly visible to the members. Insuring catastrophic risks is technically the most appropriate answer to the most existential problem of access to hospital care. Hospitalisation of family members and the cost for emergency transport is usually out of reach and poses a serious threat to the financial equilibrium of subsistence households. The disadvantage of benefit packages that prioritise catastrophic risk is poor visibility. Efficient communication skills are necessary to maintain the interest of members. An intermediate solution to prioritise catastrophic risk is also to include more frequent services like hospitalisation at health centre level, deliveries and specific services high on the priority list of the target population. For public health reasons PHC services should be included in the benefit package to avoid deterioration of the illness and the resulting increased health costs.
Sliding scales according to distance	To attract insurance members who live far away from the contracted primary health care facilities (> 10 km) and therefore rarely use the facility, sliding scales according to distance or the option of insuring only catastrophic risk could counteract the inequity felt by this group. When only limited financial resources are available, a cheaper version of a benefit package covering catastrophic risks could be recommended. Administration of a variety of benefit packages and more complex arrangements could be made possible by standardized management procedures and the delegation of more complex technical management to a body on a superior level (Support Agency).

5.4.4 Contracting with Providers

Active purchasing role of insurance	The role of insurance is more than simply acting as a financial intermediary that collects premium payments and reimburses claims. MHOs have to develop contractual relations with health providers and become active purchasers of services. Insurance schemes can negotiate special prices and ensure the delivery of cost effective

services, which should include preventive and promotional services (Kutzin, 1997). Quality assurance principles can be encouraged by contracting only with health care providers that accept such principles.

Negotiating quality standards

Specific quality standards like standards related to waiting times or staff attitudes toward patients, the availability of essential drugs and the observance of treatment protocols can be negotiated with providers. Guidelines for cost-efficient service provision are commonly available in the countries. Contracted providers should conduct training sessions for their staff in patient-centred care to improve the provider-patient relationship which is important for patient satisfaction and compliance. The viability of the scheme depends to a large extent on the provider, who is responsible for the costs of medical care covered by the insurance. The regional or district health administration needs to play a supervisory role to verify and enforce negotiated quality standards and in certain cases sanction those providers who deviate from their commitments.

5.4.5 System to Control Fraud and Abuse

A constant threat to the efficiency and consequently the financial viability of insurance schemes is the moral hazard behaviour of scheme members (over-consumption) as well as of health staff (over-prescription) resulting in adverse selection and cost escalation.

Direct Control Measures

The identity check, update of premium payment

The identity of beneficiaries and their insurance status need to be checked at the point of health care provision. Family booklets with photos of each enlisted family member or separate photo identity cards are required to reduce abuse by non-insured individuals.

Sick sheets

In some instances sick sheets may be of advantage. Beneficiaries can have their sick sheet signed by an MHO official prior to seeking medical care to discourage abuse.

System of circulating invoices

Circulating invoices held by providers and by patients, which contain information about services rendered and service charges need to be identical before payment to providers is effected. The disadvantage of such features is that it places additional bureaucratic burden on patients and administrators.

Social control essential

The essential feature of social control in MHO schemes needs to be retained. All members are responsible for the behaviour of all other members. The abuse of services by one individual harms all the others.

Risk Management Techniques (tools)

The following risk management tools are useful for the three main hazard groups:

Adverse Selection

To avoid negative risk selection, obligatory family membership or membership through associations or other groups should be introduced.

Moral Hazard

Abuse of health services can be minimized by an efficient gate-keeping mechanism, the mandatory reference for services beyond the PHC level. Members should participate in consultation costs with co-payments. Ceilings on the benefits covered by the insurance is another important safeguard.

Cost Escalation

Within the conception of the insurance design the most important decisions to contain costs are taken. The provider payment mechanism is one of the tools available both to contain costs and to promote efficiency in the health sector. Against this background the capitation payment system whereby providers are paid per insured/year regardless whether they solicit medical care is the recommended mechanism. Otherwise fee-for-service systems for sickness episodes are better than fee-for service per attendance. These mechanisms reduce providers' incentive to drive up costs. Essential and generic drug policies should be integrated into agreements with providers. This can include the development and use of standard treatment protocols, including drug formularies. Good technical supervision of the staff of contracted facilities by the health administration is necessary to assess the appropriateness of care provided.

Monitoring and Evaluation System

A functional Management Information System (MIS) is necessary to follow up the statistics on utilisation and financial performance. Indicators provide managers with the opportunity to have continuous information about the financial viability of the insurance scheme. MHO leaders can make the necessary decisions taking into account financial forecasts, giving the trends in the system based on enrolment statistics and member utilisation (income – expense balance).

Delegation of collected data to superior level

Collection of data needs to be done at the MHO level but the combination and interpretation of the different values should be delegated to a superior level with access to spreadsheets, statistical and accounting software. It is especially important to monitor an increase in consumer demand in order to keep control over expenditures and costs of health care provision. For this reason financial and utilisation indicators need to be routinely updated (and transmitted to a support agency). Financial performance indicators reflect administrative efficiency and need to be made public in financial statements and annual reports.

Monitoring of Efficient Service Provision and Quality of Care

Assessing the appropriateness of care, pricing, consumer satisfaction

Assessing the appropriateness of care, its pricing and consumer satisfaction is crucial to assure the continuous attractiveness of the care contracted and to keep control of costs (Atim, 1998).
Control and audit mechanisms to monitor efficient service provision and aspects of quality of care need medical expertise that is beyond the level of MHO schemes. Only appropriately qualified medical and pharmaceutical staff can carry out such monitoring properly and discuss such issues with providers. Health insurance managers are not qualified to evaluate the quality of care delivered to insurance members.

5.4.6 Financial Administration/Fund Management

Fund investment management

In general schemes need to consider effective strategies for investing their funds to prevent them from losing value (e.g. high inflation). This could provide an opportunity to generate additional revenue. The disadvantage of investment activities is that it contains the risk of serious financial losses (i.e. mismanagement or corruption in the banking system).

Accounting and reporting procedures and regulations for procedures in fund management would become more standardised with the proposed "entrepreneurial concept". More complicated financial administration can be delegated to a superior level i.e. the support agency Centre for Health Insurance Competence (CHIC), such as making budget plans, follow up on financial indicators and financial management.

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Adverse selection	A tendency in insurance by which an applicant who is a greater than average risk seeks to obtain protection from a health insurance at a standard premium rate. Those, who are at greater risk of falling ill, or who are already ill subscribe to the insurance in greater numbers than those who have less risks. Adverse selection stands in opposition to positive selection of "good" risks ("cream-skimming").
Benefit package	Range of (health) services offered to an insured or a monetary sum payable to a recipient for which the insurance has received the premiums.
Capitation	A method of reimbursement under which a provider is paid a fixed amount per person, regardless of the volume of services rendered.
Ceiling on benefit cover	A ceiling is imposed on the total amount of health care bills or benefits per person that will be paid for by the insurance. The total length of coverage of a hospital stay may be limited to a certain amount of days.
Compulsory insurance	The population or members of an enterprise are required by law to be member of a health insurance.
Co-operative	A business organisation owned by a society of persons or a group of persons whose aim is not to make a profit but to give benefits to the members.
Co-payment	Insurance members are obliged to pay a small portion of the health care charges out of the pocket in order to deter abuse of services. The larger part of the charges is then covered by the insurance. For example, for each visit of a health facility a member may be required to pay a certain amount, regardless of the expense of the services rendered. Or, for each prescription for drugs and medicines, the member may have to pay a flat amount.
Cost-escalation	Providers often with the collusion of insured patients, may have the incentive to use costly treatment techniques or to provide excess services in the knowledge that the scheme will pick up the bill.
Coverage	The percentage of the population which benefits from health insurance.
Covered expenses	In health insurance, reimbursement for an insured's medically related expenses, as defined in the benefit package (i.e. treatment at health centre level, drugs, inpatient hospital for certain specified conditions, para-clinical examinations etc).
Equity	The understanding that everyone should have equal access (both, geographical and financial) to existing health care facilities and services.
Exclusion from health services (i.e. financial)	Certain segments of the population are excluded from medical care because households are unable to pay for the medical services (Permanent exclusion). Another group faces temporary exclusion in certain period of the year when households face an important drop in income (temporary exclusion).
Exemption	The freedom from payment of insurance premiums, either in whole or in part, usually given for a specific reason of an economic and social nature such as a very low income (the very poor community members/indigents).
Fraud and abuse	Individuals not entitled to services may take up the identity of those entitled to receive benefits without paying for them (free riding). An effective system to check identities need to be put in place to avoid this risk.
Group health insurance	Single policy under which individuals in a natural group (such as members of an association or employees) and their dependants are covered. Each employee is entitled to the same range of benefits.
Health insurance	System for the advance financing of medical expenses by means of contributions or taxes paid into a common fund to pay for all or part of health services specified in an insurance policy or law. The key elements in health insurance are advance payment of premiums or taxes, pooling of funds and eligibility for benefits on the basis of contributions or employment without an income or assets test.

	Health insurance may apply to a limited or comprehensive range of medical services and may provide for full or partial payment of the costs of specific services. Benefits may consist of the right to certain medical services or reimbursement of the insured for specified medical costs and may sometimes include income benefits for working time lost owing to sickness or maternity leave.
Health insurance scheme	An insurance scheme which provides (financial) benefits in the event of personal accident, illness or maternity.
Health service	All personnel, institutions or administrative bodies of a public nature which contribute to the prevention of illness, to the care of the sick and to the health of the population.
Income related contribution	Amount of money to be paid in proportion to level of income.
In-patient	A resident patient of a medical institution who has gone through the full hospital admission procedure and is occupying a bed in an in-patient department . => Out-patient care.
Insurance	Mechanism for contractually shifting burdens (and consequences, i.e. financial losses) of a number of pure risks by pooling them.
Insurance benefit	A benefit provided under an insurance system.
Mandatory referral	The precondition that hospital treatment is paid for by the health insurance (Outpatient consultation or inpatient hospital stay) is that health insurance members consult a lower-level medical officer who authorizes their referral to the secondary level. This measure helps to prevent inappropriate use of expensive hospital services.
Membership	Participation in a social security system or scheme.
Moral hazard	The tendency of those insured to use the services more intensively than if they were not insured. Health insurance members might seek treatment for minor health conditions that they would ordinarily overlook if they were themselves paying the medical bill. Unnecessary service use results in over-consumption and endangers the financial viability of the insurance.
Morbidity	The incidence and severity of sickness and diseases in a well-defined class or classes of persons.
Mutual health insurance (MHO)	A non-profit insurer, owned and administered by the members and funded by their contributions, to provide benefits in case of sickness, maternity etc. (determined in the benefit package).
Out-patient	A patient attending hospital for minor treatment, consultation, advice, etc., who is not admitted to the hospital.
Payment on a fee-for-service basis	The remuneration of a doctor by the health insurance system (or any other organisation) according to the number of consultations (treatments) carried out. => Capitation.
Provider payment systems	Way in which medical institutions or staff are paid for their work. These will set certain incentives and encourage certain patterns of health care provision. The most common types are: salaries, fee-for-service, capitation, target payments, case-based payments, fixed budgets and contracts.
Premium	The sum paid by an insurance member to keep the insurance policy in force and thus receive continued insurance protection.
Primary care	Community health care provided through staff employed in health centres, health posts as opposed to secondary care (hospitals, specialists) and tertiary care (university hospitals).

Provider	An organisation which provides health care, such as primary care nurse/doctor or hospital and sells its services to purchasers (those who buy medical care, i.e. insurance).
Reimbursement	A payment made to an insured by a social security scheme or by an insurer compensating expenses incurred for treatment.
Reinsurance	Insurance of insurers. That means that an insurer places an insurance with another insurance company in order to diminish the risk accumulated under the own insurance policies.
Risk management	A management discipline whose goal is to protect the assets and profits of an organisation by reducing the potential of loss before it occurs.
Risk pooling	Process by which people contribute to a general fund from which they can be reimbursed if the need arises. This is the basis for all insurance funds. The costs of illness are then shared between members of the fund (risks are pooled).
Risk sharing	Risk sharing is any system which allows payers (patients) to share some of the financial risk (of illness and catastrophic events).
Social health insurance	If a system is financed by compulsory contributions mandated by law or by taxes and the system's provisions are specified by legal statute, it is a government, or social health insurance plan. History: The pioneer work in social legislation was initiated in the 1880s in Germany to cover health and accident insurance, workers' and employees' benefits and pensions, miners' insurance, and the like. Nearly 90 percent of the population of European countries today is covered by compulsory health insurance.
Social security	Compulsory insurance, in which the benefits are prescribed by law and in which the primary emphasis is on social adequacy rather than equity, providing cover in the event of illness, invalidity, old age, death, widow-hood and maternity.
Statutory health insurance	A health insurance scheme in which employees and their dependants are required by law to participate.
Subsidy	The government or foreign donors funds a portion of a health insurance system costs (i.e. insurance setting up, running costs) or pays/ co-finances the premiums of the very poor community members.
User fees for payment	Private, out-of-pocket expenditures for health services.
User	Client (patient), beneficiary in a health care scheme.
Waiting period	A period during which no benefit is paid. This is to avoid that people only join the insurance when they fall sick (usually 3 – 6 months).

(adapted from Glossary Info-Sure and Atim 1998)