



# Mutual Health Organizations in Sub-Saharan Africa – Opportunities and Challenges

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## Introduction

Millions of people in developing and transition countries have no access to quality health care services, often because they cannot afford them. Half of the population of sub-Saharan Africa, for instance, live on less than US\$ 1.25 per day, so that they have hardly enough money to survive, let alone for transport to hospital or treatment. If sick people are not treated, their health deteriorates, and poor health in turn leads to poverty: each year, more than 100 million people become impoverished as a direct result of the cost burden of health care services (WHO 2008: 16). One instrument that cushions the individual's risk of sickness is membership in a Mutual Health Organisation (MHO): these small-scale, community-based and voluntary micro health insurance schemes make health care services accessible to poor people.

Such schemes have taken root in many sub-Saharan African countries during the last decade and often constitute the only available form of social health protection for the rural poor. MHOs do have their limits, however: generally speaking, they have low rates of subscription and low internal management and technical standards, and they lack the financial wherewithal to cover expensive treatments. In the three examples below, sub-Saharan African countries have addressed these challenges and come up with their own context-specific solutions. Although these cannot serve as blueprints for other contexts, they do reveal some best practices for other countries and demonstrate how certain challenges can be addressed.

## Why Mutual Health Organisations?

User fees for health services were introduced in many developing countries in the 1980s and 1990s. The aim was to reorganise inefficient health systems and create greater financial sustainability. In most countries, however, the introduction of fees meant that people – especially poor people – used health services less. In 1978 and 1987, the *Alma Ata Conference* and the *Bamako Initiative* aimed to create broader access to primary health care through greater community participation in the management and financing of

health care. The idea of both initiatives was to mitigate the impact of user fees on poorer population groups through risk-pooling and prepayment. Since then, the international community has confirmed the relevance of social health protection systems as one way of breaking the vicious circle of poverty and illness.

Social Health Protection (SHP) systems ensure that the entire population has equitable access to essential health care services at affordable prices. They are based on solidarity and mutual aid and employ pre-payment and financial risk pooling. The dissemination of SHP systems is a priority of the World Health Assembly (WHA), which in May 2005 underlined their importance for universal health coverage (WHA 2005: 1). One social health protection instrument for the informal sector is membership in a community-based health insurance scheme or mutual health organisation (MHO).

MHOs are run by volunteers from the community they serve or by institutions like cooperatives, churches and self-help groups. They require prior payment of premiums and sharing of risks and offer the security of guaranteed service. The premiums of insured persons are pooled and cover health care according to a defined benefits package. Membership in MHOs is voluntary and most MHOs are small. Still, the number of MHOs grew from 76 in 1997 to more than 800 in 2004 with more than 2 million members in West and Central Africa (UNICEF/ODI 2007: 56).

## Impact and limitations of MHOs

MHOs are considered an important instrument for extending social health protection to the informal sector. There is enthusiasm for and consensus on the value of MHO principles and concepts. There is also consensus about the difficulties MHOs face: there is little evidence that MHOs are cost-effective, that they can cover significant portions of the population, or that they can sustainably increase access to or finance health care. One major problem is the lack of comprehensive studies of the impacts of MHOs on health care

utilisation and the health of their members. Existing studies show that:

- MHOs can enrol individuals from various socio-economic backgrounds, but seem to exclude the very poor.
- MHO members have lower out-of-pocket expenditures than non-members (exceptions are MHO service packages that require high co-payments).
- When struck by illness, MHO members use health services more than non-members do (Miller Franco et al 2008: 831).

Thus MHOs seem to improve people's access to health care. They nevertheless face a number of constraints that threaten the survival of individual MHOs and undermine the general objective of universal health coverage.

The main constraints are:

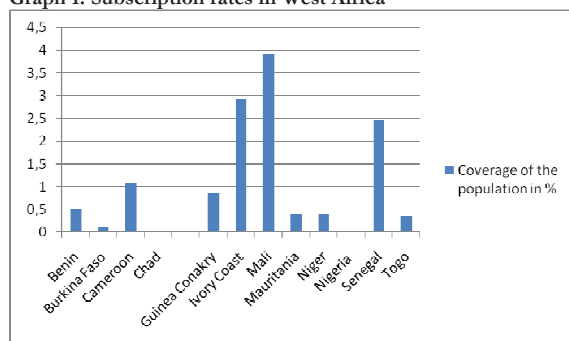
- I. Low subscription rates
- II. Insufficient financial capacity of MHOs
- III. Organisational and managerial problems/lack of technical competence

If MHOs are to play a major role in improving general access to health care in developing countries, especially among the very poor, it is crucial that they overcome these constraints. Not all constraints can be discussed here but it will be focused on low subscription rates, poor MHO managerial and technical skills and exclusion of people living with HIV/AIDS and best practices to overcome them.

### I. Low subscription rates

A major challenge facing MHOs is that too few people subscribe. Although the schemes exist in all West and Central African countries and in most other parts of sub-Saharan Africa, even 5% subscription is rare. In the francophone countries of Western Africa, Ivory Coast and Mali attain the highest subscription rates with 2,93% and 3,92% of the population (UNICEF/ODI 2009: 57).

Graph 1: Subscription rates in West Africa<sup>1</sup>



Source: UNICEF/ODI 2009: 58.

<sup>1</sup> The exception is Ghana with a coverage rate of 54% of the population. Ghana will be discussed below as a best practice.

Reasons for low enrolment rates seem to be:

- That community members are too poor to pay the premiums
- The low quality of MHO services (including inadequate benefit packages, e.g., that do not cover high-cost treatments)
- Insufficient information about the MHO
- Low quality of health care services
- Geographic barriers to health care access
- Scepticism about the MHO (e.g., culturally based or following a bad experience with a MHO)
- Socially and culturally based preference for other health care providers not covered by MHOs, e.g. traditional healers
- Lack of experience with health insurance (the principle of regular payments to reduce risk).

### II. Organisational and managerial problems

One major problem local MHOs face is that MHO managers lack technical and managerial skills. Organisational problems and lack of technical competence are mainly due to:

- The fact that MHO managers are mostly unskilled non-professionals, since MHOs employ volunteers
- Low motivation of volunteers because their work is unpaid
- Financial inability of MHOs to have the responsible persons trained
- Difficulty hiring qualified managers because of high costs.

### III. No coverage of high-cost treatments

Most MHOs cannot cover treatment of chronic diseases like HIV/AIDS, diabetes, etc., because

- They do not have the financial resources.
- Stigmatisation is an obstacle to identification of patients with chronic diseases.

How well an MHO is initially launched determines its future sustainability. If it begins with too few members, a vicious circle results: a low enrolment rate means the MHO does not have the funds to provide quality services. Consequently, the community sees the MHO in a negative light, which again leads to low enrolment.

Graph 2: The vicious circle



In the following, examples from sub-Saharan Africa will be analysed and solutions sought. Three case studies will be presented based on their potential as models for other countries in overcoming the following constraints:

- a) Low subscription rates (Ghana)
- b) Poor MHO managerial and technical skills (Tanzania)
- c) Exclusion of people living with HIV/AIDS (PLWH) (Cameroon).

## Best practices

### Increasing health insurance subscription rates through an integrated social health protection system: Ghana

Ghana, in West Africa, can point to a good governance record and stable economic growth. Well endowed with natural resources, Ghana's per capita output is twice that of the poorer countries in West Africa. Still, the 28% of the population who live below the international poverty line of US\$ 1.25 a day have little access to health services. Thanks to the strong political will of the Ghanaian government and support from development partners, however, the country has nevertheless managed to achieve a high health insurance subscription rate and can thus serve as an example of best practice for increasing subscription numbers.

Although the number of MHOs in Ghana grew rapidly, from 47 in 2001 to 168 in 2003, less than 1 percent of the population were covered (Chankova et al 2006: 6) by health insurance. MHOs run by communities, schools, NGOs and churches spurred the Ghanaian government to introduce the National Health Insurance System (NHIS). The NHIS, which combines social insurance with MHO principles, has been implemented through a network of District Mutual Health Insurance Schemes (DMHIS). Each district has at least one scheme, the larger districts (in metropolitan areas) more than one.

The system is financed from taxes, flat-rate contributions, payroll deductions and a national health insurance levy on goods and services. Taxes are centrally collected and allocated to regional and district levels by means of a needs-based resource allocation formula.

Both formal and informal sector workers make health insurance contributions. For formal sector workers, a payroll deduction of 2.5% is transferred to the NHIS fund as part

of their contribution to the Social Security and National Insurance Trust (SSNIT). These funds are forwarded to the DMHIS according to the number of formal workers/SSNIT contributors that a scheme registers (McIntyre et al 2008: A).

Informal sector workers pay a flat premium of GH¢ 7.20 per annum directly to their DMHS2. The majority of those not covered by NHI use public sector health facilities and pay user fees; a few pay out-of-pocket for health services from the private sector. The benefit package covers outpatient and inpatient services at accredited facilities and community-based health planning services. The benefit package is the same for all DMHISs.

Membership in the NHIS is compulsory for all, with exemptions for the poorest of the poor, dependent children and elderly persons not obliged to pay the annual premium. In 2009, six years after implementation, an amazing 67.46% of the population was covered (Ghana NHIS 2009), a record for the region and second in all of Africa only to Rwanda, with health coverage at 85%.

The success of the scheme lies in combining government and other public initiatives, private sector insurance and community-based health insurance into one all-inclusive national social health protection scheme. Moreover, the NHIS is driven by strong political commitment, a pro-poor focus, and support from several development partners.

### Improvement of MHO managerial competence and technical skills: Tanzania

Of Tanzania's 34 million inhabitants, 51% live below the poverty line, with less than 900 Tanzanian shillings (about 70 euro cents) per day. The rural population, especially, can hardly pay the required user fees to the service provider. Ruinous expenditures leading to the impoverishment of whole families are a major problem.

In order to improve general access to health care, the Tanzanian Government has introduced several prepayment schemes over the past decade, notably the compulsory National Health Insurance Scheme (NHIS) for civil servants and state employees and the National Social Security Fund (NSSF) for formal sector workers.

Then, in 1996, voluntary Community Health Funds (CHF) were introduced to expand social health protection to the informal sector. CHF's cover formal and informal sector workers at district level, including people with no income and the poorest of the poor.

In addition to the government programmes, a range of private non-profit health insurance initiatives (MHOs) have been set up and are managed by informal sector cooperatives, local communities, and denominational organisations. Despite the relatively large number of insurance schemes,

<sup>2</sup> Theoretically, contributions by informal sector working people are to be graduated according to income; but in fact a flat premium is charged due to the difficulty of breaking the population down into different socio-economic groups.

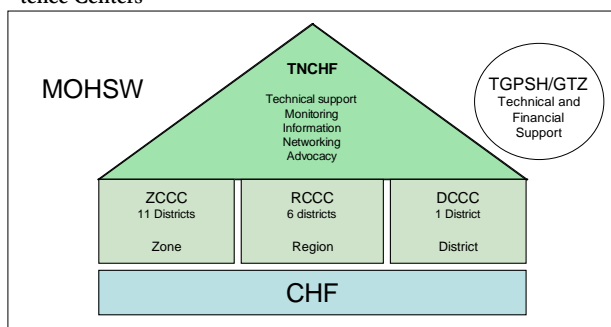
subscription rates remain low at around 6%<sup>3</sup> (Lankers et al 2008: 28).

One reason is that small schemes often have managerial, organisational and administrative problems because of their size, their reliance on volunteers, the minimal financial resources of their membership, and their lack of experience with health insurance. In order to share experience and create synergies between the public and private insurance schemes, the Tanzanian Network of Community Health Funds (TNCHF) was launched in October 2003. Moreover, a national competence centre was established according to the model of the GTZ product Centre for Health Insurance Competence – CHIC (GTZ 200).

In the CHIC concept, an institutional framework is established with technical support and administrative assistance on a paid-for consultancy basis for local health insurance schemes that cannot and do not need to develop all the financial, technical and managerial capacity of a professional insurance company. CHIC thus aims to improve technical competence and the quality of services of local health insurance schemes so that they attract more members and increase enrolment rates.

Until now, three 'Competence Centres' (CCs) have been established in Tanzania: they operate at zonal, regional and district level and are supervised by the TNCHF. The TNCHF operates centrally and supplies information, technical assistance and other managerial support to CCs and is responsible for monitoring their work. The CCs in turn are sub-structures of the TNCHF: they are there to help strengthen the CHF with organisation and management decentrally (on zonal, regional and district levels). The CCs offer services to CHF in 18 of the country's districts.

**Graph 3: Overview of the structure of the TNCHF and the Competence Centers**



Source: GTZ's Tanzanian-German Programme to Support Health (TGPSH)

The establishment of the CCs improved the management quality of the CHF, which led to increased CHF enrolment. In some districts, the registration rate increased from 4% to 20% of the population. Moreover, 83% of CHF

members renewed their membership the following year, so that service providers are now 90% reimbursed (previously 75%) (GTZ/DED/KfW/InWEnt 2009: 10). This indicates that the CHFs used the CC services and translated them into higher quality management. CHF accountancy also improved significantly, and revenues from membership contributions for hospitals increased.

### Including high-cost treatments in the MHO package: Cameroon

Cameroon has long been considered a success story in the economic development of sub-Saharan Africa. The economic crises of the 1980s and 1990s and especially the devaluation of the franc CFA at the beginning of 1994 led to economic collapse and a downturn in people's living conditions, so that some 40% of the population now live beneath the national poverty line, 17% on less than US\$ 1 per day.

Around 40% of the population have no or insufficient access to health services because they cannot afford them. Another problem is the spread of HIV/AIDS and insufficient health care for people living with HIV/AIDS (PLWH). Although PLWH have not had to pay for antiretroviral treatment since 2007, they still have major expenses for examinations (CD4-tests, regular biological follow-up), and this keeps many from getting the health care they need (GTZ-PGCSS/MAMS 2008a: 1).

In 2003, to improve access to health care for the general population, the Cameroonian government decided to extend the establishment and development of MHOs and micro health insurance throughout the country (MIN-SANTE 2002). Since 2004, this has been the objective of the Cameroonian-German health programme, including the identification of best practices. In 2007, a pilot project was begun that included within the MHOs service package HIV/AIDS-related diseases and examinations. Until then, chronic diseases like HIV/AIDS, diabetes and high blood pressure were not part of the MHO offer because of the high costs involved. After the pilot phase, the following successful mechanisms were introduced into other MHOs:

- 100% coverage by the MHO of treatment of opportunistic diseases with no co-payment requirement
- Establishment of a reinsurance fund to cover MHO expenses for opportunistic diseases (at the time paid by GTZ)
- Revision of contracts with service providers to include treatment of HIV/AIDS-related diseases
- Training of MHO managers in confidentiality and the utilisation of an anonymous administrative system for PLWH
- Hiring of consultant doctors for MHOs to check on bills and the quality of care
- Training of PLWH in careful adherence to the prescribed ARV treatment and in methods of preventing the further spread of the disease and deterioration of their health

<sup>3</sup> The NHIF covers about 5% of the total population while the CHF and private health insurance covers only 1%.

- Recruiting of 'patient experts': PLWH with a good knowledge of the disease to help PLWH patients adhere to their ARV treatment both in hospital and at home
- Training of hospital staff in confidentiality
- Improvement in drug availability by involving managers responsible for providing drugs in the negotiation process

The inclusion of HIV/AIDS-related diseases in the MHO service package led to increases in the number of PLWH who used the hospital and were treated (GTZ- PGCSS/MAMS 2008b: 1). As a result of training, better adherence to 'doctors' orders', and healthier living, the number of HIV-positive MHO-members who regularly use condoms increased from 13% to 49%. Moreover, the share of PLWH who maintained their ARV therapy (improved observance) increased from 28% to 99%.

### Lessons learned

The above examples illustrate possible solutions to three main challenges facing MHOs in sub-Saharan Africa: low subscription rates, low managerial and technical competence and the exclusion of HIV/AIDS-related treatments from the MHO service package. Although these solutions cannot serve as simple blueprints for other countries, they offer useful information about possibilities for coping with the constraints on MHOs.

The following conclusions may be drawn:

- Coverage for more people can be achieved through comprehensive treatment and integration of national health protection systems to include the formal and informal sectors.
- Compulsory membership in one of the insurance schemes also supports higher enrolment rates; however, enforcement structures and a subsidy system must be in place for positive results.
- Financial support from the national government and development partners as well as strong political will are needed to set up a national health protection system that includes MHOs.
- Improved MHO managerial and technical competence raises enrolment rates and membership renewals.
- For better coordination among MHOs, they should be linked in a national network.
- The Centre for Health Insurance Competence (CHIC) and out-sourcing of managerial tasks are important for increasing MHO sustainability.
- The inclusion of treatment of HIV/AIDS-related diseases in the MHO service package leads to increased PLWH user rates.
- Such a system must be accompanied by confidentiality training and close adherence to ARV treatment to avoid stigmatisation of PLWH and a cost explosion that could threaten the financial sustainability of MHOs.

- A subsidy system for HIV/AIDS-related and other chronic diseases requires financial as well as technical assistance from development partners.

Extending social health protection (SHP) to the entire population of sub-Saharan Africa is a major challenge. MHOs are an important factor in achieving the overall objective of universal health coverage for all; however, they constitute only one element within a comprehensive SHP system that also includes public, private and commercial health insurance. Therefore, to ensure access to health care for all, the extension of MHOs should be accompanied by development of an integrated national system that addresses all segments of society.



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