What internal conditions does a mutual health organization need to fulfill to ensure its durability?

Major operational difficulties on the way to a successful scheme implementation

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Objective

To identify and discuss major **operational difficulties** hindering the successful implementation of Community Health Insurance (CHI) in sub-Saharan Africa (SSA)

Rationale

- CHI as a valuable financing option to increase access to care and offer financial protection against the cost of illness for people in informal sector

- Field experience shows that schemes suffer from a variety of operational problems hindering their development and impeding them from achieving their potential

Material

- Literature review
- Consulted major search engines, websites of international organizations and international consultancy agencies
- Searched reference lists of retrieved material
- Personal contact to researchers and policy makers in the field

Analytical approach

- No theoretical framework decided a priori
- Inductive approach to data analysis
- Categorized the material according to emerging ideas
- Grouped the material according to five meaningful thematic area

Five thematic areas

a) Lack of clear legislative and regulatory framework
b) Low enrolment rates
c) Weak managerial capacity
d) Insufficient risk management measures
e) High overhead costs

a) Lack of clear legislative and regulatory framework

- Most SSA countries lack the needed legislative, technical, and regulatory framework to support CHI development
- Only 4 countries (Burundi, Rwanda, Ghana, and Tanzania) have explicit legislation supporting CHI as a means towards universal coverage

a) Lack of clear legislative and regulatory framework: why is this a problem?

- Schemes forced to operate in conditions of uncertainty …
- … within the framework of a fragmented national policy
- Negative effects on penetration rates, access to care, and financial protection

b) Low enrolment rates

- Other than few exceptions (Bwamanda, Nkoranza, Rwanda), field experience reports enrolment rates between 1% and 10% of target population
- Problem further exacerbated because of scheme isolation → small pool size

b) Low enrolment rates (2)

- Enrolment generally higher among schemes:
  - a) not community based;
  - b) born out of pre-existing successful institution;
  - c) entailing a certain level of compulsion;
  - d) heavily supported and subsidised by govt.

b) Low enrolment rates (3)

- Substantial fluctuations in membership (high drop out rates)
- Equity in enrolment and in access to care still not achieved

b) Low enrolment rates: why is this a problem?

- Low enrolment → poor resource mobilization
- A threat to long term scheme viability
- A threat to stabilization of resources for providers
- Inequitable enrolment fosters rather than counteracts existing inequities in access

c) Weak managerial capacity

- Reflected in all fields of operation (premium calculation, risk management, social marketing, financial management)
- Lack of CHI specific skills
- More pronounced amongst community based schemes
- Not unique to schemes managed by volunteers

c) Weak managerial capacity: why is this a problem?

- Weak managerial capacity undermines daily CHI activities
- Schemes that are badly managed cannot grow into successful institutions

d) Insufficient risk management measures

- Measures to control (consumer) fraud, adverse selection, over-utilization, and cost escalation
- Some progress has been made, but still too little …
- … and uneven

d) Insufficient risk management measures: consumers' fraud

- Early schemes faced substantial fraud
- Application of social control successful only amongst small schemes
- Individual photo IDs very expensive

d) Insufficient risk management measures: adverse selection

- Early schemes faced substantial adverse selection
- More recently wider application of group enrolment and waiting period
- Waiting periods most common measure since easier to implement
- Group enrolment successful only if means to enforce it are available

d) Insufficient risk management measures: over-utilization

- **Some degree of moral hazard is good**
- Less than 50% of all schemes impose deductibles, co-payments, or ceiling
- Mostly needed for hospital-based schemes …
- … where no gate-keeping is possible
- Social control is not enough

d) Insufficient risk management measures: cost escalation

- Induced by consumers or by providers?
- 80% of all schemes operate on fee for service basis – providers' reluctance to accept capitation as form of payment
- Only a few schemes negotiate special tariffs/contracts
- Progress made: abidance to essential and generic drug lists

d) Insufficient risk management measures: why is this a problem?

- High exposure to the risk of insolvency and bankruptcy
- A threat to long term scheme viability

e) Overhead costs

- Administrative & transaction costs – all that is spent not for health services
- The neglected problem of CHI in SSA
- Recently gained prominence in the light of need for sustainability

e) Overhead costs (2)

- Theory teaches that they should be as low as possible …
- … especially given low capacity for resource mobilization
- Practice shows that they are between 10% and 30% of operating budgets
- Realistic estimates? Integrated in providers' costing systems? Include start up and social marketing costs?

e) Overhead costs: why are they a problem?

- Lack of precise information means that no exact estimates of the magnitude of the issue are available

- High overhead costs mean that schemes cannot be self sustainable, at least in short and medium term

What do you think?
What are possible solutions?
What have schemes experimented?

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THANK YOU
MERCI