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Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care

Synthesis of Research in Nine West and Central African Countries

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Abstract

Mutual health organizations (MHOs) are community and employment-based groupings that have grown progressively in West and Central Africa (WCA) in recent years. With this growth has come interest from governments, nongovernmental organizations, and international organizations, particularly those interested in new and innovative approaches to the difficult issues of health care financing and access in the subregion. From mid-1997 to mid-1998 a consultative group led by the United States Agency for International Development-funded Partnerships for Health Reform, the International Labor Office-Appui associatif et coopératif aux initiatives de développement à la base/Strategies and Tools against Social Exclusion and Poverty, Solidarité Mondiale, and Alliance Nationale des Mutualités de Belgique, with participation from the Fonds d'aide à la coopération, the United Nations Children's Fund, the Institut français de recherche scientifique pour le développement en coopération, and the Deutsche Gesellschaft für Technische Zusammenarbeit undertook a one-year program of research into the actual and potential contributions of MHOs to the financing of, delivery of, and access to health care in WCA.

The study represents an important step forward in documenting and understanding the MHO experience in the WCA subregion. The main purpose is to present information that could be of use to key actors in the development of the MHOs: the members and leaders of those organizations; health care providers; policymakers, especially WCA ministries of health and labor; development partners (external cooperation agencies and technical support institutions); other MHO promoters such as trade unions; and mutualist organizations and associations outside the health sector.

This study has confirmed the emergence of a mutual health scheme movement in WCA. These schemes are generally on a small to medium scale in terms of membership. Most are also young: about two-thirds of the 50 MHOs (from six countries) in the inventory survey were less than three years old. At present, MHO activities affect only a small fraction of the populations of the countries involved. However, this study shows that they have great potential to embrace more people, as well as to contribute more to the health care sectors of their countries. The study analyzes MHOs' actual and potential contributions in the areas of (a) access to health care and extending social protection to disadvantaged sections of the population, (b) resource mobilization, (c) efficiency in the health sector, (d) quality improvement, and (e) democratic governance.

Given the youth of most of the schemes, assessing their long-term sustainability on the basis of experience to date is not possible. However, the examination of some of their design and institutional features; their administrative and managerial capacities; and their financial performance, including dues collection rates, reveals room for improvement. This study makes a number of recommendations for MHOs that principally concern design features to enhance scheme success. Recommendations for promoters and development partners deal with reinforcing the MHOs' institutional, managerial, and administrative capacities. Health care service providers with experience in contracting are advised to assist MHOs with pricing and establishing relationships with providers. Finally, recommendations are made on the role of governments in establishing a favorable legal, fiscal, and institutional context.

No study can deal exhaustively with all the aspects of a phenomenon as complex and diverse as MHOs, and this study does not claim to have done so. In particular, the study did not investigate the social movement dimension or aspiration of the MHOs, which is potentially one of their major and vital contributions to social and civic life. This paper concludes with an outline of a number of areas that would benefit from further examination.

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Acronyms

| | |
|---------------|---|
| ACOPAM | Appui associatif et coopératif aux initiatives de développement à la base (ILO program) |
| ANMC | Alliance Nationale des Mutualités Chrétiennes de Belgique |
| ASACO | Association de santé communautaire (Mali) |
| BIT | Bureau international du travail |
| CBO | Community-based Organization |
| CIDR | Centre International de Développement et de Recherche (French nongovernmental organization) |
| CPH | Community Partners for Health (BASICS-Nigeria) |
| CSCOM | Centre de santé communautaire (Mali) |
| FAC | Fonds d'aide à la coopération (French cooperation agency) |
| FCFA | Franc de la Communauté financière africaine |
| GTZ | Deutsche Gesellschaft für Technische Zusammenarbeit (German International development assistance program) |
| ILO | International Labor Office |
| MHO | Mutual Health Organization |
| MIS | Management Information System |
| MUTEC | Mutuelle des travailleurs de l'éducation et de la culture |
| NGO | Nongovernmental Organization |
| PHC | Primary Health Care |
| PHR | Partnerships for Health Reform |
| STEP | Strategies and Tools against Social Exclusion and Poverty |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| WCA | West and Central Africa |
| WHO | World Health Organization |
| WSM | Solidarité Mondiale |

Foreword

This document represents a synthesis of research from nine West and Central African countries. Data for this study was compiled from an inventory of 50 MHOs in seven countries and more in-depth case studies of 22 selected MHOs in six countries. The selection and analysis of the case study MHOs was based on methodological guidelines developed by the author of this study.

Subsequent to this publication, the Partnerships for Health Reform will publish the following inputs to this synthesis:

- ▲ Methodological guidelines
- ▲ Country case studies (Mali, Benin, Ghana, Nigeria, Senegal)
- ▲ Inventory of 50 MHOs in seven countries

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The first draft of this synthesis attracted a great many useful and challenging comments from both the study partners and individual experts in this field. They include Dominique Evrard of the Alliance Nationale des Mutualités Chrétiennes de Belgique; Philippe Marcadent of ILO-Strategies and Tools against Social Exclusion and Poverty (STEP); Patrick van Durme of Solidarité Mondiale; Christine Bockstal of ILO–Strengthening Small and Microenterprises and their Cooperatives/Associations; and from Abt Associates Inc., Partnerships for Health Reform Project, Richard Killian, Marty Makinen, Sara Bennett, and Allison Gamble Kelley. All their comments were tremendously useful in shaping the final document so that it could address and clarify the issues important to all the key actors in the development of MHOs in West and Central Africa. I also acknowledge with thanks the thoughtful comments of Abraham Bekele of the United States Agency for International Development's Africa Bureau and Wouter van Ginneken of the ILO's Social Security Department on the draft.

In addition to contributing to shaping the paper itself, Richard Killian, Allison Kelley, and Karen Lee of Abt Associates gave me the support and encouragement that were vital throughout the whole process of producing this report. Special thanks to Allison Kelley for assisting with the executive summaries, references, and other essential but difficult tasks. The translation of excerpts from the Francophone case studies for inclusion was done by Andrea Harold, for which I am grateful.

Executive Summary

Mutual health organizations (MHOs) are community and employment-based groupings that have grown progressively in West and Central Africa (WCA) in recent years. With this growth has come interest from governments, nongovernmental organizations, and international organizations, particularly those interested in new and innovative approaches to the difficult issues of health care financing and access in the subregion. This interest led a group of international organizations to join together in early 1997 and work from mid-1997 through mid-1998 to analyze the actual and potential contribution of MHOs to the financing of, delivery of, and access to health care in WCA. Members of the group intended that this analysis would inform their priority setting and assistance strategies, as well as those of others, including the MHOs themselves.

The consultative group, led by the United States Agency for International Development-funded Partnerships for Health Reform, the International Labor Office-Appui associatif et coopératif aux initiatives de développement à la base/Strategies and Tools against Social Exclusion and Poverty, Solidarité Mondiale, and Alliance Nationale des Mutualités de Belgique, with participation from the Fonds d'aide à la coopération, the United Nations Children's Fund, the Institut français de recherche scientifique pour le développement en coopération, and the Deutsche Gesellschaft für Technische Zusammenarbeit undertook a one-year program of research into these questions. The study covered nine WCA countries, compiling data from an inventory of 50 MHOs in six countries and carrying out more in-depth case studies of 22 selected MHOs in six countries. The group based selection and analysis of the case study MHOs on the Methodological Guide developed by a member of the team. The study can be characterized as a successful example of how international organizations can effectively collaborate, sharing personnel and information and co-financing activities of common interest.

The study represents an important step forward in documenting and understanding the MHO experience in the WCA subregion. Both its quantitative and qualitative dimensions are an improvement over previous efforts. Previous studies have not exhibited the same level of integration and comparison of experience, particularly with the inclusion of the Anglophone experience from Ghana and Nigeria. The study systematically examines the contributions, actual and potential, of WCA MHOs to resource mobilization, efficiency, equity, quality improvement, health care access, sustainability, and democratic governance of the health sector.

The study also has some limitations. For example, the size and diversity of the consultative group, while a strength, also resulted in some variation in interpretation of definitions by field researchers, which affected the number of MHOs inventoried and selected for study. In addition, the selection of case study MHOs was based on a certain level of availability of information, which may introduce some bias. A number of areas that would benefit from further examination and observation of trends over time are cited within this paper.

The main purpose is to present information that could be of use to all key actors in the development of the MHOs: the members and leaders of those organizations; health care providers; policymakers, especially WCA ministries of health and labor; development partners (external cooperation agencies and technical support institutions); other MHO promoters such as trade unions; mutualist organizations and associations outside the health sector; and so on. Each of these will find concrete information in this report that could be beneficial in their work with, for, or in the field of MHOs in West and Central Africa.

This study has confirmed the emergence of a mutual health scheme movement in West Africa, and to a lesser extent (because only one Central African country was investigated) in Central Africa. These schemes are generally on a small to medium scale in terms of membership. Most are also young: about two-thirds of the 50 MHOs in the inventory survey were less than three years old.

At present, MHO activities affect only a small fraction of the populations of the countries involved. However, this study shows that they have great potential to embrace more people, as well as to contribute more to the health care sectors of their countries. Even now, they make a significant contribution to health care access and to extending social protection to disadvantaged sections of the population by mainly targeting people in the informal and rural sectors. This also represents a contribution to equity in health care in the areas where they are active. Another area in which the MHOs make a new—and in this case original—contribution is that of democratic governance in the health sector. MHOs are able to claim popular legitimacy in representing their communities or members before the health authorities, including health care providers, to articulate the views of health care consumers. This gives them some weight in influencing the priorities, resource allocation decisions, and responsiveness of the health authorities to the concerns of the public on such issues as waiting times, staff behavior, quality of services, and so on. This is a genuinely new contribution that reflects the role and origins of the MHOs as part of the growing and confident civic society that began to develop in Africa in the 1990s.

Although the MHOs' contribution to resource mobilization is currently limited, the study shows that the potential is large, given that the current contribution is constrained by factors such as low penetration of target populations (probably related to design issues that this study indicates can be remedied), low dues collection rates, and other factors.

The study found that MHOs could improve their own efficiency and their contribution to efficiency in the health sector significantly through a number of design features, many of which are already well known and implemented by some WCA MHOs. These features favorable to scheme success include waiting periods for new members; social control to avoid abuses; co-payments or ceilings on the amounts of coverage; and some level of obligatory membership at the family, association, or target group level. This latter feature avoids having scheme membership disproportionately composed of high-risk people by ensuring that membership is extended beyond just those who wish to join voluntarily.

In the area of health care quality improvement, the study found that on the one hand, most MHOs tend to be set up around a health care provider or providers with a reputation for good quality in terms of waiting times, staff attitudes toward patients, and drug availability. In such cases quality improvement may not be a major issue or problem for the members of the MHO. On the other hand, one could argue that most, if not all, the MHOs are not well equipped to realize the full potential that they possess in this area, especially in the more demanding areas of vetting the quality of prescriptions and other medical care provided to their members. This is partly because of their relative youth and lack of experience, partly because of their lack of managerial skills and insufficient knowledge of alternatives, and partly because of their low levels of negotiating power in relation to health care providers.

Given the youth of most of the schemes, assessing their long-term sustainability on the basis of experience to date is not possible. However, the examination of some of their design and institutional features; their administrative and managerial capacities; and their financial performance, including dues collection rates, reveals room for improvement.

These latter issues are, appropriately, among the main issues in the recommendations: how to expand the coverage of the MHOs and add value to the experience of these organizations by reinforcing existing capacities, building new ones, and helping to create an enabling environment to realize the full potential of MHOs. Briefly, the main recommendations from the study are as follows:

- ▲ For the MHOs, the principal recommendation concerns design features that enhance scheme success, such as a mandatory reference or gatekeeper system; a requirement for compulsory participation, or at least automatic family membership; a waiting period for new members; the use of efficient provider payment mechanisms; and the inclusion of essential and generic drug policies in their agreements with providers as well as of preventive and promotive services in their benefits packages.
- ▲ For promoters and development partners, the major recommendations have to do with reinforcing the institutional, managerial, and administrative capacities of the MHOs in such areas as setting up adequate MIS systems, setting premiums and determining the benefits package, marketing and communication, managing funds, pricing, and assessing the quality of health care.
- ▲ For governments, their role is seen mainly as establishing a favorable legal, fiscal, and institutional context dictated by the needs and stage of development of the MHOs; improving the quality of health care facilities; and implementing health reforms that give autonomy to local health facilities.
- ▲ Providers are seen as having an important role, even if some of their objectives may conflict with those of MHOs. Providers who have learned how to enter into contracts (and have the power to do so) and know how to price their services realistically and encourage good relationships between their staff and the MHOs would make an important contribution to the development of MHOs.

In the end, the primary catalysts and agents of progress will have to be the MHOs themselves. Their motivation, desire to improve their organizations, and capacities to absorb new knowledge and skills will drive the success of any support that development partners may be able to provide.

No study can deal exhaustively with all the aspects of a phenomenon as complex and diverse as MHOs, and this study does not claim to have done so. In particular, the study did not investigate the social movement dimension or aspiration of the MHOs, which is potentially one of their major and vital contributions to social and civic life. MHOs may serve not only as a means to gain access to health care, but they frequently may also provide important human elements, such as comfort, solidarity, and emotional support, to patients and other members.

The examples of medical aid societies in South Africa and Zimbabwe can illustrate how MHOs might grow in the future and scale up to large organizations, and even, eventually, how they might participate in or coordinate with compulsory social health insurance schemes. These aspects, interesting as they are, are not systematically investigated or dealt with here. They could be fruitful areas for extending and building on the work synthesized in this report.

The process of consultation and dialogue between development partners in the subregion that has underpinned this study was taken forward at a meeting in Abidjan, Côte d'Ivoire, from June 16-18, 1998, where representatives exchanged ideas on possible forms of cooperation in the MHO field. Similar gatherings and meetings within the subregion and in Europe around the same period and on themes related to MHOs in Africa have also reinforced cooperation between the development partners, a process identified in the study as an important recommendation to facilitate the development of MHOs.

1. Introduction

1.1 Objectives of the Study

The overall objective of this research is to study the actual and potential contributions of mutual health organizations (MHOs) to the financing of, delivery of, and access to health care with particular reference to countries of West and Central Africa (WCA).¹ This objective has both quantitative and qualitative aspects. One part of the task is to obtain a snapshot of the present size and scale of this emergent phenomenon, which has never before been attempted in this subregion. The other part is an effort to carry out a detailed investigation not only of MHOs' features and characteristics, but also of their evolution, development, and possible role in the context of the subregion's health care sector.

1.2 General Context

1.2.1 Evolution of African Health Care Financing Policies and the Problem of Access to Quality Care

Like African economies in general, Africa's health care sector has undergone dramatic changes in the postindependence years. Many countries began independence with welfare states that provided health care on a free, or at least heavily subsidized, basis to users of public health services, but these services were rarely available to people outside urban areas and mining enclaves.²

However, real public sector per capita expenditure in the health sector has been declining in many African countries since the late 1970s. One of the main impacts of the economic crisis of the 1970s and 1980s on the social and welfare sectors such as health and education was the reduction of state subsidies to these areas in an effort to cut deficit levels. Another aspect of the policy to reduce budget deficits was the introduction of user fees at public health care institutions to recover some of the costs of running such institutions. The circumstances that made implementing such cost-recovery systems favorable included "run-down public services, the compliance of health care providers, competition from private sources of service provision and an increasing cost to the user of access to care of acceptable quality," as well as external "pressure and conditionality" (Creese and Kutzin 1995).

In 1987, African health ministers meeting under the auspices of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), defined a strategy for reforming the health sector based on expanding primary health care (PHC) and decentralizing the management of local health facilities. Other aspects of this new policy included community participation in the management of local health facilities and the use of fees to improve the drug supply situation (revolving drug funds). The ministers saw the re-orientation of health policy toward expanded and more affordable PHC facilities as a way to achieve efficiency, equity, and quality improvement and to extend access to underserved populations.

¹ See definition of MHOs in section 1.2.2.1.

² A notable exception was the missionary providers, who have been active on the health scene in Africa both before and after independence, for the most part provide good quality health care services, and many of whom charge user fees for access to their facilities.

By 1993 nearly all Sub-Saharan African countries had some form of cost-recovery scheme in place, attesting to widespread acceptance of this instrument of health care financing policy. Other elements of this reform included decentralizing management, which chiefly meant devolving autonomy to health care institutions (usually starting with tertiary and quaternary teaching hospital levels), and retaining fees at the facilities where revenue is raised, both to provide an incentive to collect fees and to enable the facilities to improve their services.

The policy of cost recovery has, however, led to increasing concerns about equity and access for the poor (Abel-Smith 1993; De Bethune, Alfani, and Lahaye 1989; International Children's Centre 1997; Gilson 1988; Waddington and Enyimayew 1989). Moreover, policymakers are increasingly recognizing that converting revenue gains into improved service quality and access requires some accompanying, or even prior, changes in managerial and institutional capacity (Creese and Kutzin 1995, p. 22).

Meanwhile the unprecedented waves of democratization and development of civic society that Africa has witnessed since the late 1980s have also created the conditions for autonomous, grassroots responses to the problems people face, including health care access and service quality. A recent initiative of this type has been the emergence and fairly rapid growth of MHOs, which attempt to improve their members' access to quality health care by mobilizing the individual contributions and resources of those members, who may be individuals or families. This study is about these organizations, and so before proceeding any further will reflect briefly on what is understood by the term MHO, as well as on the context and other aspects of their emergence on the health scene in the subregion.

1.2.2 Development of Mutual Health Organizations

1.2.2.1 Definition and Usage of the Term MHO

For the purposes of the field work, the Partnerships for Health Reform (PHR) Project adopted the guidelines following working definition of "health mutuelles:" "A voluntary, non-profit insurance scheme, formed on the basis of an ethic of mutual aid, solidarity and the collective pooling of health risks, in which the members participate effectively in its management and functioning" (Atim 1997a [A summary of these guidelines is included as annex 1 of this report]). The Guidelines noted the existence of a variety of types of MHOs and developed a typology, from which researchers were to choose at least one of each type for study, to the extent that all such types existed in the country concerned. The guidelines stressed that some MHOs adopted features, such as obligating membership of the target group, that are not always in accord with the working definition proposed, but that might, nevertheless, represent an improvement in the design of their scheme (Atim 1997a, pp. 5, 11). As this last point indicates, the guidelines had foreseen the complex reality (that is, the existence of both *mutuelle* and near-*mutuelle* types of organizations) that would be found on the ground, and reflected previous analysis of *mutuelles'* experience in other parts of Africa, as well as the desire by some of the partners involved in the study to learn about the emergent phenomenon of MHOs from the widest possible canvass (Atim 1997c).³

Attempts to translate the French term "mutuelle de santé" into English have always been dogged by the lack of any clearly recognizable equivalent, perhaps illustrating the fact that the reality of mutuals is different in the English-speaking countries. However, in the context of the study of mutual health schemes in the English-speaking parts of Africa, the term MHO has recently come to be used in the discourse to describe these kinds of *mutuelle* and near-*mutuelle* organizations characteristic of such countries.

³ The near-*mutuelles* would be organizations that might, for instance, insist on obligatory membership of the target group (contrary to the principle of voluntary participation inherent in the strict definition of a *mutuelle*), or rely on mechanisms of financing other than risk pooling, such as described later as third-party subscription with discounted pricing (see box 5).

The following definition of the term MHO arises from experiences in the English-speaking countries of Africa: they are nonprofit, autonomous organizations based on solidarity between, and democratic accountability to, their members whose objective is to improve their members' access to good quality health care through their own financial contributions and by means of any of a range of financing mechanisms that mainly involve insurance, but that may also include simple prepayments, savings and soft loans, third-party subscription payments, and so on.⁴ This definition expresses both the emergent character and the varied forms of mutuals.

Other terms used in the English literature were not considered adequate or sufficiently accurate for describing the phenomena encountered, for example, community financing (attributed to Hsiao), which is most frequently applied to provider-based and Bamako Initiative schemes and excludes a large segment of the *mutuelles*, especially those types based on social movements such as trade unions; health insurance for the nonformal sector (Bennett, Creese, and Monasch 1998) does not capture noninsurance-based schemes and others such as trade union schemes organized in the formal sector; and voluntary, nonprofit health insurance (Atim 1997b), which, if democratic participation is added, describes the *mutuelle* types of schemes reasonably well, but does not include the near-*mutuelle* types.⁵

Note that as this study is largely based on Francophone African experience, it essentially concerns voluntary, democratic, and nonprofit health insurance (namely, *mutuelle*) schemes. This is illustrated by the fact that all but 2 of the 50 inventory studies correspond more or less exactly to that type of scheme, as do at least 19 of the 22 case studies.⁶ Apart from corresponding closely to the reality of *mutuelles* in this part of Africa, such an emphasis also coincides with the interests of some of the partners in the study who wish to address the specific issues concerning that kind of MHO.

The analysis that follows will therefore focus on *mutuelles* as defined at the beginning of this section. Nevertheless, in line with the interests of some of the partners to learn more about what we have called the near-*mutuelles*, some indications of the specific implications for these kinds of mutual organizations will be provided at appropriate points in the study.⁷ The emphasis on the analysis of *mutuelle* types is further justified not only because some general principles derived from such analysis could be adapted to the situation of the near-*mutuelles*, but especially because, as explained later (see section 1.3) virtually all the case study MHOs that are not strictly speaking *mutuelles* have declared their intent to move in that direction, so they may have something to learn from this focus of the analysis.

The use of the term mutual health organizations, or sometimes just mutual organizations or mutuals, throughout this synthesis reflects, in part, the fact that the study encompasses both Anglophone and Francophone countries and the need to address the concerns and expectations of the different partners in the study, even though, as explained earlier, in practice the main focus of the synthesis is on the voluntary, democratic, and nonprofit health insurance schemes among these mutual organizations.

1.2.2.2 The Emergence of MHOs

MHOs began to spread in response to the health care sector crisis, and more specifically, because of the following four factors:

⁴ The groups concerned have described this as a process of the mutualization of health risks (see the Beninese case studies).

⁵ In this study, the terms *mutuelle* and near-*mutuelle* refer specifically to health sector mutual organizations. This clarification is important, because some near-*mutuelles* in the health arena may be full-fledged *mutuelles* in other areas of socioeconomic life.

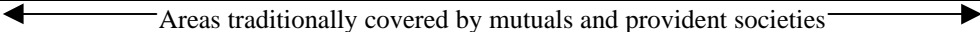
⁶ The exceptions are Senegal (Education Volunteers, which has compulsory membership, and a street children's *mutuelle* in Kaolack financed by sponsorship); Mali (MUTEC Health Centre, which although it is owned by a social movement has no participation by subscribers); Ghana (the West Gonja scheme is provider owned); and Nigeria, (COWAN is based on soft loans).

⁷ The analysis of near-*mutuelles* here is neither exhaustive nor systematic, as they were not the main object of this study; however, where possible, we have attempted to indicate the kinds of supplementary data that might be required to carry out a more rigorous study of such organizations.

- ▲ The introduction of user fees at existing, publicly provided health facilities
- ▲ The introduction of such fees in a context of generally unacceptable quality of public services, which reinforced people's willingness to pay for better quality care, for instance, as may often be obtained at missionary hospitals
- ▲ The rise of alternative, private sources of health care provision, frequently associated with good quality
- ▲ The general democratization and development of civil society in the last decade or so.

In most cases, individuals or organizations set up MHOs with the aim of providing their members with access to good quality care. Therefore such organizations tended to be formed where facilities of acceptable quality already existed,⁸ so the main task was to improve their members' access to such facilities through risk sharing or similar mechanisms. In a few cases, MHOs have created their own provider facilities to ensure their members of access to quality care.

Another important feature of MHOs in Africa is that they often grow out of mutual aid organizations set up initially to provide their members with a range of social security benefits, such as funeral grants, marriage and birth allowances, and retirement benefits. To such organizations, health care benefits are just an additional area of need to be covered, although when they use an insurance mechanism as their mode of financing, the sustainable provision of such benefits calls for different or new managerial skills.⁹ The contributions for the former kind of benefits are more like a savings plan than insurance, because those events are relatively more predictable. Table 1 illustrates the gradual differentiation between insurance (for highly unpredictable events) and savings (for the more predictable ones).

| Table 1. Differences between Savings and Insurance | | | | | | | | | | | |
|---|------------|-----------|------------|------------|-----------------------|---------------|----------|------------------|--------------|---------|----------------------------|
| Insurance < ----- > Savings | | | | | | | | | | | |
| Highly unpredictable < ----- > More Predictable | | | | | | | | | | | |
| House fire or storm damage | Car damage | Crop loss | Theft loss | Disability | Emergency health care | Hospital care | Delivery | Out-patient care | Life/funeral | Pension | Purchases of durable goods |
| <div style="text-align: center;">  Areas traditionally covered by mutuals and provident societies </div> | | | | | | | | | | | |

Mutuelle des travailleurs de l'éducation et de la culture (MUTEC), founded by a teacher's union in Mali in 1987, is an example of a pioneer in this field. MUTEC was initially formed to address teachers' specific need for pension benefits. By contrast, the MHO of Fandène in Senegal, founded in 1989 by a village community, is an example of an MHO formed specifically to address the problem of its members' access to quality health care by means of risk sharing.

⁸ In this context quality of care refers principally to standards expected by the public concerning waiting times, staff attitudes toward patients, and availability of drugs at health facilities. While these are legitimate quality expectations that the public has a right to demand of its health facilities, as the study will show, other aspects of quality are also important, both in improving health outcomes and possibly in lowering health care costs (and therefore enhancing efficiency), that WCA MHOs rarely, if ever, address.

⁹ With other benefits they can usually assume that everyone or most people will eventually benefit, for instance, they can assume that in the case of maternity benefits every young woman or couple will benefit, even though they do not know when or how many times. With old age and funeral allowances, eventually everyone or their relatives will some day be a beneficiary. The risks, and thus the actuarial calculations, involved are therefore different and less complicated than with health care insurance benefits, where the presumption must be that not everyone will benefit, and the risks, such as the dangers of free-riding, are substantial.

What this study refers to as traditional MHOs are social solidarity organizations composed of individuals or families from the same ethnic group or clan, usually living in cosmopolitan urban communities away from their villages of origin, who come together to help each other in times of need. Initially, the main focus of such organizations was, and usually still is, to provide coverage primarily for the costs of funerals, marriages, births, and other similarly expensive traditional social events. However, in the new context described earlier that led to the rise of MHOs generally, the traditional social solidarity organizations increasingly began to play a role in mobilizing their members' resources to spread the costs associated with the risks of illness among all their members.

In addition to the development of MHOs in the ways described above, health care providers, finding themselves in an environment of cost recovery and decentralization and faced with the task of raising some of their revenues directly from the public, also initiated schemes to pool the risks of many individuals, create a wider revenue base, and increase community access to the health care provided by the initiating facility. An early pioneer of this type of provider-based scheme was the Bwamanda Hospital Insurance Scheme in the Democratic Republic of Congo (formerly Zaire), formed in 1986.

By contrast, co-management schemes like the Nigerian Community Partners for Health (CPH) schemes in this study, represent a partnership established between health care providers and surrounding communities to improve the health of the communities concerned while contributing to the viability and financial objectives of the providers. In the Nigerian case, the schemes arose essentially because, on the one hand, competition among private health care providers in the community led some to conclude that becoming involved in initiatives that would increase their client base and reduce their bad debts would be in their best interests, and on the other hand, community organizations sought such an arrangement because it offered their members good quality care at considerably reduced prices. The partnership takes the form of a democratic organization that brings together representatives of both the community and the health care providers. At a minimum this organization is responsible for managing the financing scheme, but such a body often also takes responsibility for carrying out some preventive and promotional health activities, including health education and sanitation.

What these various kinds of schemes have in common is that they all seek more equitable alternatives to user fees through risk-pooling mechanisms such as insurance or other kinds of financing mechanisms acceptable to their members (see Atim 1995; International Children's Centre 1997).¹⁰ They seek also to improve access to health care of acceptable quality.

Moreover, as the analysis proceeds bear in mind that MHOs represent an emergent phenomenon in the subregion. The recent character of the MHO phenomenon can be gauged from table 2, which shows the age of the inventory MHOs. At the time of the research, 43 percent of the inventory MHOs were less than a year old, and 68 percent were less than three years old. A similar analysis shows that 15 (68 percent) of the 22 case study MHOs were less than three years old (but all case studies were older than one year), while the rest, 7 MHOs (32 percent), were three or more years old.

This relative youth of the MHOs in the study makes analyzing their viability difficult. However, for the same reason, the study may also serve as a baseline that future studies may use to assess MHO sustainability in the subregion.

¹⁰ Note that while all these schemes talk of members, membership has different connotations in the provider-owned schemes, where member participation is usually small or nonexistent, and in the social movement schemes, where members can, at least in principle, participate fully and democratically in the management of the scheme.

| Table 2. Age of Inventory MHOs (from the start of the health insurance activity)¹ | | | | | | | |
|---|---------------------|------------------|---------------------|--------------------|---------------------|--------------|---------------------|
| <i><1 year²</i> | | <i>1–3 years</i> | | <i>>3 years</i> | | <i>Total</i> | |
| Number | Percentage of Total | Number | Percentage of Total | Number | Percentage of Total | Number | Percentage of Total |
| 19 | 43 | 11 | 25 | 14 | 32 | 44 | 100 |
| Notes: ¹ The age of one inventory MHO in Cameroon [4], is not known. | | | | | | | |
| ² Includes those not yet started, but planned. | | | | | | | |

External development partners—donors, health sector nongovernmental organizations (NGOs), international agencies that provide technical assistance, and so on—have often played a crucial part in the emergence and development of the MHOs. A Belgian NGO was crucial in the initiation of the Bwamanda scheme in the Democratic Republic of Congo, and since the start MUTECH (Mali) has relied heavily on assistance from the Fonds d'aide à la coopération (FAC) and the Fédération Nationale de la Mutualité Française. In the Francophone West Africa subregion, the Solidarité Mondiale-Alliance Nationale des Mutualités Chrétiennes de Belgique/International Labor Office-Appui associatif et coopératif aux initiatives de développement à la base (WSM–ANMC/ILO–ACOPAM) joint program of technical assistance to MHOs has proved instrumental in developing the skills for setting up and managing such organizations.

In some countries like Mali, Senegal, and to a lesser extent Burkina Faso, governments have taken notice of these organizations and are seeking to play a role in their further development through appropriate legislation and other forms of assistance. Some governments have tended to see the MHOs essentially as one of the mechanisms for raising revenues from communities to run health services in an era of dwindling budget allocations to the sector. However, they also usually acknowledge that such organizations can play a crucial role in extending access to health care to poorer communities.

In Côte d'Ivoire, Ghana, and Nigeria governments have opted to design national health insurance schemes to be phased in, beginning with the formal sectors. However, in Côte d'Ivoire and Ghana at least, policymakers have not ruled out the possibility of building informal and rural sector social insurance schemes on mutual organizations, should they prove to have a comparative advantage in those areas.¹¹

Note that MHOs are more than a financing mechanism. They are above all a system of social solidarity, and in most cases, when built from the grassroots level, they are also self-help groups (through, for instance, visits to sick people and discussion of common community problems), and thus make a positive contribution to social life, and as intermediate bodies between the state and the citizen help in the development of democracy. They therefore have the potential to be a tool of empowerment for ordinary people and to contribute to the building of civic society. This latter feature of MHOs is what most notably differentiates them from private insurance schemes. The social movement aspects of MHOs are all the more important to stress, because the research work on which this synthesis is based focused on the health care financing and other technical contributions that such bodies make, or have the potential to make. The wider social aspects will therefore not be immediately apparent when reading through this synthesis.

Another aspect that will not become apparent in the synthesis because it was not investigated in the underlying research is the diverse kinds of services such organizations frequently offer. In addition to health care benefits, the subject of this study, MHOs often offer their members benefits related to marriage, child birth, bereavement, retirement, credit, and so forth. For example, in addition to MUTECH, described earlier, the Teachers' Welfare Funds in Ghana are another example of an MHO in the study that offers benefits in addition to health care, in this case funeral, marriage, and similar benefits. The provision of such services will

¹¹ This opens up interesting opportunities for examining the possible future evolution of mutual organizations and their articulation with national schemes (see the Ghanaian case study, forthcoming from PHR).

have an effect on the performance, viability, and potential of the organization, and this will need to be borne in mind even though this study does not directly address such issues.

1.2.2.3 Key Actors

It follows from the foregoing that the key actors involved in the development of MHOs are

- ▲ Members of the MHOs themselves
- ▲ Mutualist organizations and associations outside the health sector (as promoters)
- ▲ Trade unions
- ▲ Health care providers
- ▲ Governments, especially ministries of health
- ▲ External cooperation agencies
- ▲ Technical support institutions, for instance, those that provide training.

1.2.3 The Need for This Study

This study, a synthesis of research in nine WCA countries, was initiated by the PHR Project, a U.S. Agency for International Development (USAID) project, and carried out in collaboration with ILO–ACOPAM/ILO–Strategies and Tools against Social Exclusion and Poverty, the Belgian NGO WSM, and ANMC. The purpose was to study the actual and potential contributions of MHOs to health care financing in the subregion so as to

- ▲ Establish whether and how to extend or add value to the experiences and efforts of MHOs in the subregion (this expresses the specific interests that MHOs could have in the results of the study).
- ▲ Shed more light on the role that development partners, policymakers, and other interested parties could play in helping to realize any potentials identified. This did not, however, include defining intervention or support strategies.¹²

In addition to the direct study partners mentioned above, some other cooperation institutions—such as FAC, the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), UNICEF, and the Institut français de recherche scientifique pour le développement en coopération—participated in the wider collaborative process underlying the study, and their representatives have attended at least some of the technical meetings and workshops. This collaboration has produced a level of subregional cooperation that was reinforced at the 1998 Abidjan workshop.

1.2.4 Potential Users of This Study

The potential users of the study are first and foremost those listed as key actors in section 1.2.2.3, plus

¹² This discussion was part of the agenda of a dissemination meeting held in June 16-18, 1998, in Abidjan, Côte d'Ivoire.

- ▲ NGOs, local and international, especially those in the health sector
- ▲ Other government organs in addition to health ministries
- ▲ All promoters of mutual organizations
- ▲ Social movements other than trade unions, such as cooperatives.

For each of the key actors among the potential users, chapter 3 contains specific implications for their interventions or work in this field, as well as a set of general recommendations. If you are one of the key actors identified above, the best way to use this study might be to read through the general findings in chapter 2 before looking at the specific suggestions for your area of intervention in chapter 3. To acquire more background information on the MHO or health care context of a particular country or countries so as to follow the findings section better, see annex 2, which presents a country by country synthesis of the health care and MHO context in five countries.

1.3 Methodology, Scope, and Choice of Case Study Countries

1.3.1 Research Methods and Selection of Cases

The study has been organized around two related pieces of research work: an inventory survey of MHOs and more detailed case studies of selected MHOs in selected countries of the subregion. The methodology of the case study research is described in greater detail in annex 1.

Briefly, the inventory of MHOs was carried out by means of a survey that employed a questionnaire, which was sent to researchers in each of the six countries concerned—Benin, Burkina Faso, Cameroon, Mali, Senegal, and Togo—to administer and return for collation, checking, and analysis. The aim of the surveys was, to the extent possible, to gather comparative data on the basic features of all the MHOs in each country.

The case study researchers interviewed the leaders and members of the MHOs, as well as key people and players in the health sector of the area and country. They also examined documentary evidence of the MHOs' activities and mode of organization, such as rules and regulations, constitution, annual reports, financial statements, membership files and registers, and accounting records. These were supplemented by literature reviews, and in some cases by focus group discussions with users and nonusers of the MHOs, “walk-through” visits, and interviews with providers or health facilities linked to the MHOs.

The reviewers also gained insights by reviewing published and unpublished materials on MHOs in East and Southern Africa, principally in South Africa, Tanzania, and Zimbabwe, which they used to enrich the studies by drawing on lessons from that part of Africa that they considered to be relevant to the themes of the WCA research (the main source of primary data consulted for this purpose was Atim 1997c).

The countries chosen for more intensive and detailed case study research were Benin, Côte d'Ivoire, Ghana, Mali, Nigeria, and Senegal. This choice was based partly on the existence of ILO–ACOPAM and WSM–ANMC networks in some of the countries (Benin, Mali, and Senegal), and partly on the need for representation of Anglophone countries in the region (Ghana and Nigeria [the latter was also chosen because of its regional importance and the size of its population, which is well over half that of the entire region]). Côte d'Ivoire was included because both PHR and the ILO have the capacity to support research in that country. Originally, the partners had intended to study MHOs in the Democratic Republic of Congo,

one of the countries with a long history of MHO development and a significant number of MHOs in the region. However, this did not prove possible, and has limited the representation of central African countries in the study.¹³ In all, this research project identified and studied 67 MHOs in nine WCA countries (see annex 3 for a list of the MHOs surveyed for the inventory). Of these, 22 MHOs constituted the case studies from the six countries listed above. (All the studies were carried out during September to December 1997).

During the field work for this study, the inventory survey was based on a strict interpretation of the definition of MHOs as given in the guidelines (notwithstanding the qualifications stated therein), while nearly all the case study researchers adopted a relaxed interpretation of that definition (as the guidelines themselves suggested) so as to cover as wide a range as possible of MHOs in the countries concerned.¹⁴

Even though the case studies were based on a relaxed interpretation of the guidelines, the justifications for selecting the near-mutuelles for study illustrate that the mutuelle principles were uppermost in the minds of researchers:¹⁵ the Education Volunteers MHO in Senegal is studying the implications of moving from a mandatory to a voluntary membership base; the MUTECH Health Centre in Mali has apparently accepted, in principle, that an MHO of members is necessary; the West Gonja scheme in Ghana has aspirations toward community participation;¹⁶ and COWAN, the Nigerian women's organization, has explained that it wants to move toward an insurance system, but is currently hampered by existing legislation.

Analysis of the inventory MHOs reveals interesting information about the state, features, and some of the constraints of MHOs in the subregion. This information is analyzed and presented in tables at appropriate points throughout the text.

| Table 3. MHO Selection Matrix | | | |
|--|--|-----------|---|
| | <i>Geographical and socioprofessional criteria</i> | | |
| Type of MHO | Rural MHO | Urban MHO | MHO based on profession, enterprise, association, trade union, or other social movement |
| 1. Traditional type (clan or ethnic-based social network) | * | * | |
| 2. Inclusive mutual health social movement or association type | * | * | * |
| 3. Co-managed (provider and community) mutual health scheme | * | * | |
| 4. Low participation community financing (or provider-managed) insurance scheme | * | * | |
| Note: The asterisk means that an MHO of that category exists and should be included in the country case study. | | | |

A typology of MHOs based on their ownership, the socioprofessional base of their membership, and the target group of case studies in each country is presented in annex 1. However, to take account of factors

¹³ Note that one of the partners in this study (ANMC) has undertaken an extensive investigation of the MHO situation in that country, which it intends to publish. This publication should help to fill gaps left by this study as far as central Africa is concerned.

¹⁴ Note that because the inventory of MHOs was based on the narrower interpretation, some MHOs, especially near-mutuelles, were not counted. The number of MHOs found is therefore related strictly to that definition, and a different interpretation would probably have found more MHOs emerging or already in existence. For instance, the Institutions de Prévoyance Maladie of Senegal were all excluded from the inventory as a result, even though analysis of their experience might have enriched the study.

¹⁵ See the relevant country case studies. Information about the MUTECH Centre came from the author of the Mali case studies.

¹⁶ Moreover, Carrin (1987) argues that "Community financing always implies a certain level of community involvement in the running of the scheme." Thus this aspiration appears to one of the leitmotifs of the scheme. If so, it has much to learn from the *mutuelle* types of schemes.

such as rural/urban and formal/informal sector spread and representativeness of the studies, researchers were advised to choose cases for study in accordance with the matrix presented in table 3.

| Table 4. Distribution of MHOs Studied by Type | | | |
|---|------------------------------------|---------------------|----------------------------|
| <i>Type</i> | <i>Number of MHOs investigated</i> | | <i>Percentage of total</i> |
| | <i>Inventory</i> | <i>Case studies</i> | |
| Traditional clan or ethnic-based social networks (all urban-based) | 9 | 2 | 13 |
| Inclusive mutual health social movement (rural) | 15 | 6 | 22 |
| Inclusive mutual health social movement (urban) | 22 | 8 | 33 |
| Inclusive mutual health social movement (based on profession, enterprise, or union) | 18 | 3 | 27 |
| Co-managed or high participation model (peri-urban) | 2 | 2 | 3 |
| Community financing or provider-managed model (rural) | 1 | 1 | 1 |
| Total | 67 | 22 | 100 |

The synthesis uses the typology proposed in the guidelines wherever it permits insights into the actual or potential contributions of MHOs. However, other classifications are possible, and may sometimes be more useful when examining certain features and contributions of the MHOs. For instance, when assessing the financial contribution or resource mobilization potential of the MHOs, more useful insights may be obtained by examining the specific financing mechanism involved (simple prepayment without risk sharing, insurance, savings and credit, third-party subscription payments with discounted pricing, and so on).¹⁷ Such a focus will also, of course, yield interesting information about the level of risk sharing inherent in the scheme. Another potentially fruitful approach is that proposed by Bennett, Creese, and Monasch (1998), which is based on the nature of the health risks covered by the scheme, whether these are high-cost, low-frequency events (that is, big risks such as hospitalization or catastrophic illness) or low-cost, high-frequency events (that is, small risks such as PHC services). The authors labeled these two types as Type I and Type II schemes, respectively.¹⁸

This synthesis uses all of the ways of looking at types of MHOs described according to a judgement as to which approach permits gaining the best insights into the feature or features being examined.

1.3.2 Criteria of Analysis

The case study research aimed to examine the contribution of MHOs in accordance with the following criteria of performance and contributions to the health sector:

▲ Resource mobilization

Analyzing the contribution of MHOs to the financing of health care is one of the key objectives of this study, and such analysis will help us assess that contribution. Measurable parameters

¹⁷ See box 5 for the distinction between third-party subscription payments with discounted pricing and insurance types of subscriptions as used in this synthesis.

¹⁸ Viewing Type I schemes as "true" insurance and Type II schemes as not so is tempting; however, as the authors explain, for poor people, even the high-frequency events may have a catastrophic impact, not least on their incomes, and to that extent are insurable.

examined include the budgetary contribution, whether or not dues collection is synchronized with income earning periods, and the health care financing mechanism used by the MHO.

- ▲ Efficiency impact

One of the key issues in the health care debate in Africa concerns the efficiency of service delivery. This is also a key objective of many health reforms on the continent. The analysis here aims to find out the extent to which MHOs contribute to the achievement of such an objective. The analysis looks at the MHOs' risk management techniques, provider payment mechanisms, and PHC services and incentives packages.

- ▲ Equity aspects

Protecting the poor and vulnerable groups against the adverse impacts of certain aspects of health care reform is another key objective of health care policy. The analysis seeks to understand the impact of MHOs on equity in health care financing and delivery.

- ▲ Quality improvement

The often inadequate quality of health care, especially in the public health services, is one of the main problems of health services in Africa. MHOs can help improve the quality of health care in various ways. Even though many MHOs are formed around health care providers whose existing quality is already quite acceptable to their members, the way in which their members assess quality of care, although relevant and crucial, is not usually exhaustive. Other crucial aspects of care quality, which users may not be able to assess, may either escape the attention of MHOs or be beyond their technical competence to assess. The analysis aims, in particular, to ascertain the extent to which MHOs in WCA can or are contributing to quality improvements, especially in areas not readily assessable by users, such as prescription practices and appropriateness of the medical care provided.

- ▲ Access to health care

A major objective of MHOs is to enable better access to health care for communities or people who currently or previously faced constraints to access (financial, geographic, cultural, and so on). The analysis of this criterion aims to find out how far MHOs have been able to reduce such constraints and therefore allow greater access to health services.

- ▲ Sustainability of MHOs

All the potential benefits and contributions of MHOs would not be worth anything if the viability or sustainability of the MHOs themselves as organizations were not assured. However, as noted earlier, the relative youth of most of the MHOs would appear to rule out an assessment of their viability. Nevertheless, examining some indicators related to the organization and setting up of MHOs to assess the potential for sustainable development is still possible. The study examined institutional issues, administrative and managerial capacities, and financial performance indicators for those MHOs with such records to assess how sustainable these MHOs are.

- ▲ Contribution to democratic governance in the health sector

A completely new function in the health sector that has been made possible by the development of MHOs as representatives of the community before the health care authorities is being able to influence directly the decisions those authorities make on behalf of the communities. MHOs are ideally placed to play such a role, and therefore contribute to democratic governance in the health sector. As a result, issues such as resource allocation and priority setting in the health sector, which used to be taken entirely by bureaucrats and technical personnel, may now have to take account of the community's organized views as expressed by MHOs. The study looked at how MHOs are fulfilling this emerging role.

- ▲ Legal and institutional framework

In terms of the wider context in which MHOs are developing in the region, researchers were also asked to collect data on the legal and institutional framework (promoting institutions, training organizations, programs, regulations on autonomy of providers, and so on) of the countries in which case studies were being carried out. The purpose was to enable better appreciation of the overall institutional context in which these organizations operate and the areas that might require reinforcement to improve the enabling atmosphere for MHO development and activity.

2. Findings

2.1 Legal and Institutional Context for the Development of MHOs in WCA Countries

The legal and institutional framework can significantly affect MHO development, either positively (if, for instance, the country has adequate promoting institutions well attuned to the needs of the MHOs or laws that facilitate the development of MHOs) or negatively (for example, legislation or procedures that restrain freedom of association and expression). The analysis of such frameworks is therefore necessary before delving into the details of MHOs' contributions.

As table 2, which presented the age of inventory MHOs, demonstrated, the experience with MHOs (with the exception of the traditional MHOs and some based on trade unions) in the subregion is relatively young.¹⁹ Table 5 shows that the majority of inventoried MHOs (53 percent) are not formally registered with any public authority, but that 40 percent are. However, the overwhelming number of them (93 percent) possess their own internal rules and regulations.

| Table 5. Formal Status of Inventory MHOs | | | | |
|--|--|---|---|-------|
| Status | Formally registered with the authorities | Has internal rules and regulations, but is not registered | Not formally registered and has no internal rules and regulations | Total |
| Number of MHOs | 18 | 24 | 3 | 45 |
| Percentage of total | 40 | 53 | 7 | 100 |

In the last three years, several factors have transformed the institutional environment for the development of MHOs in the subregion, namely: (a) the increased attention by governments to the role that such organizations can play in mobilizing resources for community health facilities and extending access to health care; and (b) the availability of technical and material support for the development of MHOs from development partners, promoters, and support institutions, especially the Bureau International du Travail (BIT)-ACOPAM/WSM-ANMC joint program of training and technical assistance to mutual organizations in selected West African countries (Benin, Burkina Faso, Mali, Senegal, and Togo). This favorable environment has encouraged the emergence of more MHOs and enhanced the development of existing ones through the dissemination of the knowledge about how to set up such organizations and the acquisition of the skills needed to manage and administer MHOs.

One of the crucial factors in the rise and the design of new MHOs, as illustrated in the Thiès region of Senegal, the area with the densest network of MHOs in the subregion, is the example provided by a successful experience.

Another factor that has been crucial in the development of nearly all but the traditional type of MHO is the role of external development partners. However, this may also reflect the possibility that the studies

¹⁹ However, MHOs have a considerably longer history in the former Belgian colonies, originating as far back as the early 1950s, as well as in South Africa and Zimbabwe. Equally, and in contrast to the MHOs, other kinds of mutual organizations and provident schemes that offer funeral benefits, marriage and birth allowances, and similar services have had a much longer history in Africa.

were identified largely through the existing networks of development partners and promoting institutions in the subregion.²⁰

For instance, in Benin, the mutual environment is largely dominated by the nine initiatives in South Borgou, which are technically assisted and promoted by a French NGO, Centre International de Développement et de Recherche (CIDR), which in turn is backed by the Swiss cooperation agency. Other development partners play similar roles in Nigeria (USAID-Basic Support for Institutionalizing Child Survival Project), Ghana (the Danish International Development Agency and the Catholic Church), Senegal (the FAC and the BIT-ACOPAM/WSM-ANMC program), and Mali (the FAC, the government, and the BIT-ACOPAM/WSM-ANMC program).

Mali is the pioneer in the creation of a national-level MHO development and support agency, the Union Technique de la Mutualité Malienne, which is jointly supported by the FAC and the Malian government. This agency was still being set up at the time of the research, therefore experience from which others could draw lessons is not yet available.

Of the nine countries involved in the study, only Mali had developed legislation specifically pertaining to mutual organizations. Some other countries such as Burkina Faso and Senegal were in the process of drafting, discussing, or studying the introduction of similar legislation. The governments of Benin, Cameroon, Côte d'Ivoire, Ghana, Nigeria, and Togo were not considering such legislative projects; however, state efforts to encourage the “mutualization” of health risks through MHOs are under way in Côte d'Ivoire and Ghana.

In Mali, the general Law on Mutualité (Law No. 96-022) was passed on February 21, 1996, followed by a number of decrees specifying implementation details such as the model rules and regulations, the procedures for registration, and the management of the funds of mutuals.

In those countries with no specific laws regulating them, MHOs have tended to register under the laws governing the registration of associations, cooperatives, or social welfare organizations.

Although a project aimed at introducing MHO-specific legislation is being studied in Senegal, the associated research concluded that such legislation is not a priority issue for the MHOs. There was concern among MHOs and their advocates that legislation should not precede, or define the context for, the development of the MHOs, but rather ought to be built on the experience of the latter.

This illustrates a more general point, which is that government “support” or interest can be a mixed blessing for MHOs, in as much as it can compromise their autonomy and independence and, even though the process of democratization makes this less likely now, they need to guard against what happened to cooperatives in an earlier era, that is, co-optation into the government’s bureaucratic apparatus or the ruling party. The challenge is to balance the need for some minimum amount of statutory regulation by the state to protect members from, for instance, fraudulent misuse of their contributions, as well as to ensure external audits of MHOs’ accounts, with the need for autonomy, hence freedom from state control.

Another area that influences the institutional context for the development of MHOs is state regulation of the provision of health care, in particular, the ongoing reforms aimed at giving greater autonomy to local health facilities. Such autonomy, if effectively carried out and accompanied by the necessary reinforcement of

²⁰ This is a real possibility because, for example, in Ghana, where the identification was not dependent on such a network, two of the three cases identified have no dependence on outside assistance of any kind.

Table 6. Main Features of Case Study MHOs

| Name used in this synthesis | Country code and MHO founding date | Target group(s) | Titular membership (also beneficiaries and total target population) | Initiators/owners | Revenue generation mechanism | Services offered |
|-----------------------------|------------------------------------|--|---|--|--|---|
| Sirarou UCGM | Benin [1] 1995 | Villages under the commune of Sirarou | Total beneficiaries: 1995/96: 269 1996/97: 1,535 1997/98: 3,080 Target pop.: 13,000 | Commune members | Insurance | Hospitalization, delivery, minor interventions, surgery and snake bites: 100% coverage |
| Sanson UCGM | Benin [2] 1995 | Villages under commune of Sanson | Total beneficiaries: 1995/96: 128 1996/97: 531 1997/98: 584 Target pop.: 7,300 | Commune members | Insurance | Hospitalization, delivery, minor interventions, surgery and snake bites: 100% coverage |
| Ilera MHO | Benin [3] 1996 | Porto Novo town (approx. 100,000 inhabitants) | About 50 (1996) | Centre Afrika Obota, and especially Dr. Paul Ayemona | Insurance | PHC services: consultation, drugs, delivery, laboratory services |
| Alafia MHO | Benin [4] 1995 | Village of Gbaffo (pop. approx. 2,000 or less) | Less than 100 | Initiated by director of provincial hospital and staff of communal health complex but annual general assembly put in place | Insurance | Consultation at communal facility level (PHC) and admissions, plus surgery at reference hospital |
| MUGRACE | Côte d'Ivoire [1] 1995 | Residents of the Commune of Abobo in Abidjan, mainly informal sector people | About 40 members; all household members are beneficiaries | Initiated by unemployed, retired, and uneducated people; owned by members | Monthly contributions (insurance) and ad hoc contributions | Fixed allowance (FCFA 15,000) for hospitalized member and lower amount (FCFA 6,000) for minor illnesses |
| CARD | Côte d'Ivoire [2] Aug. 1993 | Residents of the Rue Dimbokro or Avenue de Man in the commune of Marcory in Abidjan, but mainly youth membership | 61 members; beneficiaries include all household members | Owned by members | Monthly (insurance type) contributions plus ad hoc contributions | Fixed grant for hospitalizations |

Table 6. Main Features of Case Study MHOs (cont.)

| | | | | | | |
|-------------------------|--|---|---|--|--|--|
| AMIBA | Côte d'Ivoire [3] 1994 | Mainly informal sector at Bagoué in the commune of Koumassi in Abidjan | 192 members; spouses also benefit from medical coverage | Owned by members | Monthly (insurance) dues | Fixed allowance for hospital admission costs for member or spouse |
| MC 36 | Côte d'Ivoire [4] Jan. 1994 | Women of the formal (e.g., secretaries, teachers) and informal (e.g., housewives, retirees, traders) sectors of Canal 36, Abidjan | 40 members (nonhealth care benefits extended to other relatives) | Owned by members | Monthly (insurance) dues plus ad hoc contributions | Fixed amount (FCFA 15,000) for hospital admission and lesser figure (FCFA 6,000) for minor illnesses |
| Les Intimes | Côte d'Ivoire [5] 1986 | Open to all Abidjan residents, but in practice targets the "Nouveau Quartier" | 126 members; beneficiaries include wide range of relations | Owned by members | Monthly (insurance) contributions | 25% of medical costs |
| MUGEFCI | Côte d'Ivoire [6] 1973 | Judicial magistrates, civil servants, public sector and temporary staff | Members: 1990: 170,083 1991: 178,027 1992: 186,230 1993: 196,545 1994: 117,118 Dependents: 1990: 324,925 1991: 354,862 1992: 374,901 1993: 403,814 1994: 368,435 | Was initiated and owned by the government at start; however, from 1989, a presidential decision to disengage the state from direct involvement has led to greater autonomy | Insurance | Drugs, dental care and prosthesis, prescription glasses and frames |
| West Gonja | Ghana [1] Oct. 1995 | Inhabitants of West Gonja, catchment area of district hospital (total pop. of 120,000, but scheme being extended in phases) | Dec 1996: 6,169 Nov 1997: 13,360 out of a potential population in 1996 of 25,000 | District hospital | Insurance | Hospitalization at 100% |
| Teachers' Welfare Funds | Ghana [2] 1992 in Kintampo District | Teachers | Approx. 1,000 in Kintampo; all teachers automatically members | Ghana National Association of Teachers, Kintampo Branch | Contributions with insurance element | Supplementary health care beyond that provided free by the government to teachers |

Table 6. Main Features of Case Study MHOs (cont.)

| Name used in this synthesis | Country code and MHO founding date | Target group(s) | Titular membership (also beneficiaries and total target population) | Initiators/owners | Revenue generation mechanism | Services offered |
|---------------------------------|------------------------------------|---|---|---|---|---|
| Dagaaba Association | Ghana [3] 1996 | Members of Dagaaba ethnic group living in Duayaw Nkwanta district and surrounding villages | 82 members in 1997 with 160 beneficiaries | Members | Contributions with insurance element | Admissions |
| MUTEC Health Center | Mali [1] Feb. 1990 | Teachers and general population of Bamako and surroundings | 833 subscribers in 1996; total target population unknown | MUTEC (Mutuelle des travailleurs de l'éducation et de la culture) | Insurance type subscription payments entitling subscriber to reduced tariffs at health center | PHC services of health center |
| Kolokani | Mali [2] Jan. 1997 | Villages of Didiéni: (pop. 17,350), Massantola (pop. 6,717), Nossombougou (pop. 14,942), Sabougou (pop. 11,820) | Around 50,000 out of potential population of 200,000 | Health authorities of Kolokani (principally) in partnership with community health associations (ASACOs) | Insurance type subscription payments, community contributions (via ASACOs) and user fees | Hospitalization, including evacuation and surgery |
| COWAN's Health Development Fund | Nigeria [1] 1989 | Rural women of Nigeria | No. of contributing <i>groups</i> (each of 5–25 members): 1992: 6,264 1993: 6,960 1994: 7,800 approx. 78,000 members assuming average of 10 members per group | COWAN | Savings (for health care loans to members) | Catastrophic illness (admissions, etc.) |
| Lawanson CPH | Nigeria [2] Dec. 1995 | Peri-urban and deprived communities of Lagos | 21 community-based organizations (CBOs) with estimated membership of 58,000 | 4 health facilities in partnership with community-based organizations (CBOs) | Savings, third-party subscription payments (with discounted pricing for subscribers) | PHC services |
| Jas CPH | Nigeria [3] Dec. 1995 | Peri-urban and deprived communities of Lagos | 13 CBOs with estimated membership of 10,000 | 1 health facility in partnership with CBOs | Savings, third-party subscriptions (with discounted pricing for subscribers) | PHC services |
| Ibughubu Union | Nigeria [4] | Members of Ibughubu village (in Anambra | More than 300 | Members | Contributions including insurance | Hospital admission |

Table 6. Main Features of Case Study MHOs (cont.)

| Name used in this synthesis | Country code and MHO founding date | Target group(s) | Titular membership (also beneficiaries and total target population) | Initiators/owners | Revenue generation mechanism | Services offered |
|-----------------------------|------------------------------------|---|--|--|------------------------------|---|
| | May 1972 | State of eastern Nigeria) living in Lagos | | | element | |
| Education Volunteers | Senegal [1] Nov. 1995 | Teaching volunteers recruited for 4 years each | Nov. 1995: 1,200 Nov. 1996: 2,400 Nov. 1997: 3,704 Compulsory; families excluded | Volunteers (but Ministry of Education gives technical backing) | Insurance | 100% hospitalization including evacuations and surgery |
| FAGGU | Senegal [2] Oct. 1994 | Pensioners registered with the Institut de Prévoyance et de Retraite du Senegal (IPRES) in the Thiès region | 814 out of 4,550 pensioners in 1997 (approx. 3,500 beneficiaries out of potential 13,650 (at 3 beneficiaries per person) | Pensioners | Insurance | Hospitalization costs beyond IPRES cover, minus surgery |
| Lalane Diassap | Senegal [3] Jan. 1994 | Villages of Lalane and Diassap and the Medina Fall sector of Thiès (all in the Thiès region) | 189 in 1997 (989 beneficiaries out of total population of 1,200) | Initiated by youth association of Lalane, owned by members | Insurance | 15 days maximum hospitalization, excluding surgery |

Note: In this synthesis, whenever the term subscriptions is used without the qualification third party, it refers to insurance types of subscriptions or premium payments.

institutional and managerial capacities, will greatly aid the development of MHOs in the subregion. Among other things, it will enable local facilities to enter into binding contracts with MHOs as legal entities with such powers.

2.2 Basic Information about the Case Study MHOs

Annex 3 presents the full list of all the MHOs studied, and includes two boxes that set out the group of case study MHOs and the group of inventory MHOs. Table 6 presents basic information about those MHOs that were the focus of the case studies.

Analysis of the information in table 6 shows the range of titular membership presented in table 7. Note that 63 percent of the schemes have membership that ranges from less than 100 up to 1,000 people. While many MHOs—36 percent—are medium sized (100 to 1,000 members), 37 percent have more than 1,000 members. Knowing what percentage of members are active members, that is, those who regularly pay dues, attend meetings, and discharge the obligations expected of members, would have been useful, but in many cases this information was hard to obtain. Nevertheless, on the reasonable assumption that not all the nominally registered members are active, even without further data, the impression of WCA MHOs as generally small or medium organizations is reinforced.

| Table 7. Range of Titular Membership | | |
|--------------------------------------|---|--------------------------------------|
| Number of members | Number of MHOs serving that number of members | Percentage of the 22 case study MHOs |
| Less than 100 members | 6 | 27 |
| 100–1,000 members | 8 | 36 |
| 1,001–10,000 members | 3 | 14 |
| 10,001–100,000 members | 4 | 18 |
| More than 100,000 members | 1 | 5 |
| Total | 22 | 100 |

2.3 MHO Performance and Contribution to Health System Development

The evaluation of MHOs' performance and contribution to health system development that follows is done in accordance with the six criteria listed in section 1.3.2.

2.3.1 Resource Mobilization

MHOs' contribution to resource mobilization by health facilities and the health sector as a whole was analyzed by looking at such indicators as the direct impact of MHO payments for the health care of their members on the budgets and cost-recovery position of the health facilities concerned and the actual financing mechanism involved, (with insurance presumed to be likely to have a better impact than direct user fee systems, as argued in the guidelines. Some other indicators not examined here include the impact of MHOs' in reducing health facilities' bad debts, payment defaults, and administrative costs).

Another important indicator, particularly relevant for people in the rural and informal sectors, was whether the MHO enabled poorer people with no savings to make their financial contributions at a time when they had cash, for instance, during the harvest period in a rural community, thereby ensuring that they can still go to a clinic or hospital when they actually fall sick, which might be during the lean period when no cash is

available.²¹ While this question of synchronizing contribution collection with periodicity of revenues is principally a matter of easing access to health care, such provision can also help to raise revenues for health facilities, because more people in the community are enabled to contribute to health care financing, whereas some or many might have been deterred from seeking timely help (and therefore contributing) if they had to pay for it under a user fee system.²²

2.3.1.1 Budgetary Contribution

Some might argue that the crucial (and for the MHOs, fairer) question to ask is not what share of the total resources of health facilities are mobilized by MHOs, but to ask what level of resources is mobilized per capita by MHO members in comparison with per capita government allocations and per capita out-of-pocket spending in the country overall, and what level is raised by similar or peer groups. This possibly more interesting approach was not demanded of the field researchers, and therefore they did not collect the data for such an evaluation. Instead the study assessed the contribution of MHOs to the budgets of providers as a way to evaluate their cost-recovery roles.

With regard to direct budgetary contributions, the evidence from all the studies where such evidence was unambiguously available indicates fairly consistently that MHOs have had little impact on the finances of health facilities. In the Thiès region of Senegal, which with about 15 MHOs has the highest concentration of MHOs around a single health facility (8 of these MHOs have formal agreements with the private St. Jean de Dieu Hospital), the contribution of MHOs to the hospital budget is less than 2.5 percent, although the MHOs account for about 30 percent of hospital admissions.²³ However, the more relevant measure of the MHOs' financial contribution would have been the share of total inpatient revenue represented by MHOs (because the MHOs do not cover ambulatory care here), but this information was not available. Nevertheless, the per capita contributions of the MHO patients there are probably less than average, as the members pay only 50 percent of the rate other patients pay.²⁴ The relatively low contribution of MHOs to the hospital is therefore attributed partly to the 50 percent reduction in tariffs that MHO members automatically enjoy when they are admitted into the hospital.²⁵ However, we also contend that the hospital makes most of its revenues not from admissions, for which it charges a fixed fee that may not cover all its true costs, but from ambulatory care, for which services are charged on a fee-for-service basis and are not covered by the MHOs.

At the West Gonja District Hospital in Ghana, where a community financing MHO, Ghana [1] (see table 6) is based, the MHO's contribution to gross hospital revenues is estimated at 4 percent; however, this is a new mutual health scheme and its services have not yet been extended to the entire district. Analysis of the contribution to total hospital inpatient revenues (the scheme covers only inpatient care) shows that the insurance scheme contributed between 13 and 26 percent of total hospital inpatient income in the first half of 1997, with a tendency to increase over time, though not consistently (see figure 1).

²¹ Evidence from the Mali case studies shows that rural people tend to put off seeking treatment if they fall ill during the farming period, because they estimate the opportunity cost forgone by their absence from work to be too high.

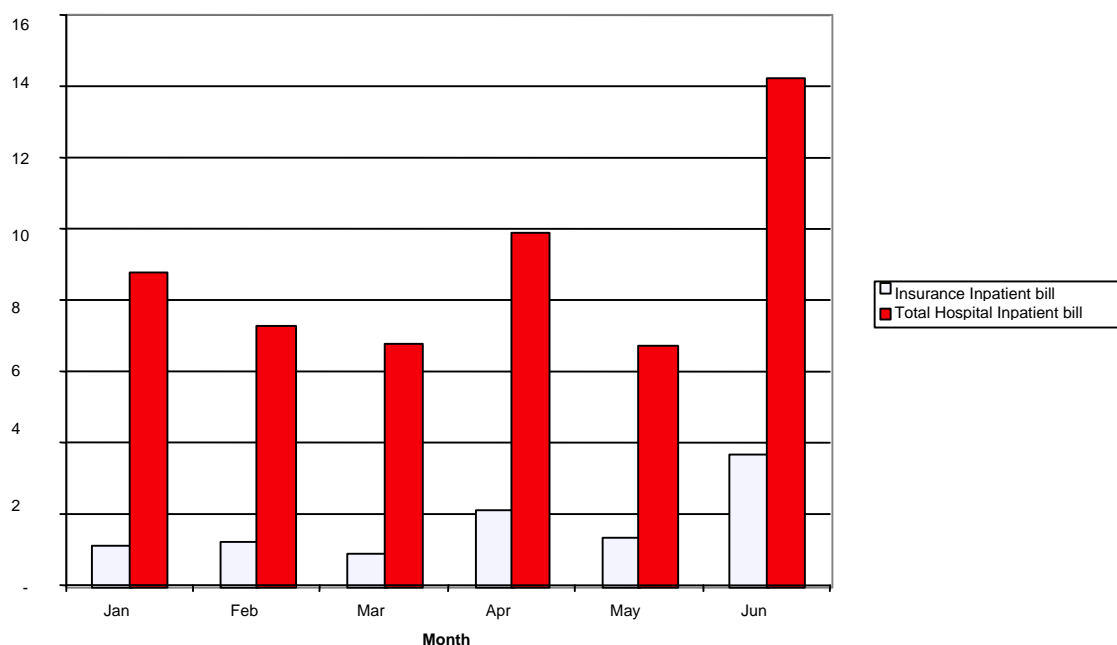
²² Empirical evidence from Ghana and the Democratic Republic of the Congo shows that when rural people were offered a choice of when and how often they preferred to pay their dues, they opted for annual payment soon after the harvest. However, it is equally possible that some communities or individuals might prefer to spread the burden of payment over a longer period rather than pay it all at once. The essential issue is, therefore, whether people have a choice of payment period and frequency.

²³ This figure does not reflect the fact that the hospital bills the MHOs directly for all the admission costs of a member, including those that are beyond the MHOs' maximum coverage, leaving it to the latter to recover the excess directly from the member concerned. An important part of the hospital's administration costs with respect to such patients is therefore shifted onto the MHOs, while counteracting this is the fact that the 2.5 percent stated therefore overstates the MHOs' payments, because the part of it later recovered from members is included in that figure.

²⁴ The data available from the case studies also does not enable us to determine whether the prices MHOs paid to the hospital were more or less than the hospital's variable costs, which could be an indicator of whether or not the MHOs are contributing to the hospital's financial viability.

²⁵ This illustrates the possible tradeoffs between the need to negotiate attractive discounts to increase MHOs' coverage and the goal of mobilizing resources for the health facilities to be able to make a genuine impact on quality and sustainability of services.

Figure 1. West Gonja MHO's Contribution to Hospital Income, January–June 1997



Source: Ghanaian case study.

In Mali, the MUTECH Health Centre, Mali [1], derives about 84 percent of its revenues from direct user fees and only around 15 percent from insurance-type subscription fees. Table 8 shows the evolution of revenues during 1994–96. The reasons for the decrease in the proportion of revenues derived from subscriptions are (a) increased difficulties in paying regular subscriptions have led some people to opt for paying on the spot as the need arises; and (b) even though the subscription rates had not changed since 1990, many individuals may have decided that opting for direct payments at the time of need was economically more rational than paying subscriptions (see the Malian case study).

| Source of Revenues | Percentage of total revenues | | |
|-----------------------------|------------------------------|------|------|
| | 1994 | 1995 | 1996 |
| Payments for Medical Visits | 19 | 34 | 54 |
| Payments for Drugs | 25 | 26 | 30 |
| Subscriptions | 42 | 32 | 15 |
| Source: Malian case study. | | | |

The Education Volunteers MHO, Senegal [1], contributed about FCFA 5 million to health facilities in 1997. While data on the facilities' gross revenues are not available, because the figure represents payments to all health facilities in the country, FCFA 5 million is unlikely to have a major impact on the financing of health care in Senegal.

The two CPH MHOs, Nigeria [2, 3], are not organized to contribute directly to the budgets of the health facilities, and so have a minimal direct impact on such revenues.²⁶

About 7 of the 22 case study MHOs have no direct links to any health facility and rely mainly on fixed cash payments or reimbursement of invoices, thus assessing the relative contributions of such MHOs to the finances of any health facility is inherently difficult. For other MHOs, including those in the inventory, insufficient data are available to assess their relative contributions to resource mobilization for the health sector, but all the qualitative indications are that such contributions are no more significant than those of the other MHOs discussed in this section.

2.3.1.2 Synchronizing Contribution Collection with Income Earning Periods

Of the 22 case study MHOs, 16 (73 percent) appear to have achieved synchronization of the collection of contributions with the income earning periods of the target population. However, three MHOs based in rural communities (Ghana [1, 3], and Senegal [3]) are collecting monthly premiums, while a fourth MHO, Senegal [1], is collecting four years worth of contributions in advance by automatic deductions spread over just the first three months allowance of the teaching volunteers. No equivalent data are available on a further two case study MHOs (Benin [3, 4]).

The picture from 45 inventory MHOs (that is, excluding the case study ones among them) shows that 35 (78 percent) rely on monthly contributions, even though 9 of these (8 Senegalese ones plus 1 from Togo [3]) are rural MHOs, and so presumably the target populations' incomes would be bunched at harvest time (which usually occurs no more than twice a year). Of these, 11 MHOs relied on annual dues' collection, including all those from Cameroon except 1, [10], and 2 from Burkina ([1, 2]). This includes two Cameroonian MHOs, [4, 6], that are professional or enterprise-based MHOs, whose members would therefore be on monthly salaries.²⁷

2.3.1.3 Health Care Financing Mechanism

As far as the health care financing mechanism of the MHOs is concerned, 19 (86 percent) of the 22 case study MHOs rely on some form of insurance, which includes monthly membership dues and subscription payments to a health facility that are used to subsidize health care costs. Another two of the case study MHOs use third-party subscription payments systems, whereby people pay a subscription fee (usually annually) to a third party (in this case the MHO), which then entitles them, and possibly their relatives, to reduced or discounted tariffs at the health care facility whenever they fall ill. Three MHOs, including two of those using third-party subscription payment systems, use a saving and credit mechanism, which entitles members to a loan at zero or much reduced interest rates when they need it for defined health conditions. Note, however, that while the savings and credit mechanism may be attractive, more readily accepted by the population, and easier to administer, it may also deter people from seeking financial assistance from the fund because they have to consider the repayment terms and their income levels (see box 1 for an example of an MHO).

²⁶ It is highly probable, however, that they provide indirect contributions by attracting more people to these private health facilities than might have been the case if the MHOs did not exist, but these sorts of contributions are difficult to assess and were not investigated in any of the studies. This paper therefore ignores them.

²⁷ Note that whereas synchronizing dues collection with income is generally important, probably even more important is the need to ensure that contributions are paid regularly and promptly. Moreover, though this is by no means a general rule, some rural people may earn income at other than harvest times.

Box 1. Successes and Constraints of the Lalane Diassap MHO

The Lalane Diassap MHO was established in January 1994 in Thiès, Senegal, following the model of the Fandène mutual organization. Lalane Diassap covers two villages—Lalane and Diassap—as well as the Medina Fall sector of the town of Thiès. It has 989 beneficiaries out of a total target population of 1,200, or an 82-percent penetration rate.

This type of rural MHO has already demonstrated that it is reproducible: a dozen other MHOs in the region operate according to the same principles. An essential element that favors their success is the partnership they have entered into with the missionary St. Jean de Dieu Hospital. The negotiation of preferential rates allows the MHOs to offer considerable benefits while assessing acceptable contribution rates.

The success of the Lalane Diassap MHO, as seen, for instance, in its high penetration rate among the target group, is thus connected to its relationships with the private care provider. A similar experiment could probably be developed elsewhere if a health facility were available that provides quality care and accepts a lowering of its rates in exchange for a more reliable revenue flow.

The unique nature of the Thiès region is also relevant: the diocese was the initiator of mutual organizations in the region and continues to support them. This favorable context has played an important role in the development of the mutualist movement in the region.

However, the Lalane Diassap MHO also faces some difficulties as follows:

- ▲ The contributions recovery rate is low and needs to be improved.
- ▲ The MHO's development is restricted by its members' limited ability to contribute. Currently, no extension of benefits is foreseen, because members cannot afford increased contributions.
- ▲ The MHO lacks material resources, has no premises, and documents are kept in a school teacher's desk. Administrative and management documents (registers, notebooks) are perfunctory and poorly preserved.
- ▲ The MHO's meetings take place in a classroom, and the administrators receive no compensation, even for travel.

The lack of resources thus hampers the MHO's development, but conversely, this example probably also proves that an MHO can still be operated with extremely limited resources.

Source: Senegalese case study.

2.3.1.4 Summary and Potential Contribution to Resource Mobilization

Because of the relatively recent growth of the MHO phenomenon in the subregion and the limited numbers of MHOs as shown by the inventory survey, the finding that MHOs are not currently making significant contributions to overall levels of health care financing in the subregion is not surprising. However, for the specific population groups or areas participating in MHOs, the level of contribution could be very different if relative per capita contributions were considered. Moreover, current contribution levels reflect, among other things, the low levels of dues collection (see section 2.3.6); the possibly low subscription rates; the quality and availability of health care services; the problems of marketing; the low levels of membership or penetration of target groups, which is related to inadequacies in MHO design; and the lack of synchronization of contributions with income earning periods. In relation to the last point, individuals may already be making substantial payments for their health care through “parallel” payments for care at public health facilities, user fees, payments to traditional healers, charges for drugs, and so on. Presumably, more of these payments could be channeled through MHOs if their design (and perhaps other aspects) were improved. Although this might not result in an overall increase in the resources going to the health sector as a whole, it could contribute to some of the other beneficial MHO impacts highlighted elsewhere in this study.²⁸

²⁸ Another possible argument is that the main issue is to ensure that people spend their money on health care more efficiently and effectively.

From the foregoing, one could argue that the MHOs' potential to contribute to resource mobilization in the health sector is a good deal better than the analysis of their actual contribution to date leads us to conclude.

The study also shows the need to collect different kinds of data, such as resources mobilized per member and share of members' health consumption in services covered by the MHOs, to evaluate fully actual and potential resource mobilization by MHOs.

2.3.2 Efficiency

There are several indicators of the technical and allocational efficiency impact of MHOs, both on the health care system and on the way MHOs carry out their own operations. As far as an MHO itself is concerned, the efficiency of its operations depends on such factors as its risk management techniques, if any; how effectively it can control or minimize abuses of its services; and, where drugs costs are part of the benefits package, whether it implements an essential drugs list and a generic drugs policy. Such measures will mainly affect MHOs' technical efficiency.

MHOs' design can also affect allocational efficiency in the health sector and have an impact on the technical efficiency of particular health facilities. For example, whether the package of services encourages the use of PHC services—by not only directly including such services in the benefits' package, but also by requiring mandatory reference from a PHC facility as a condition of access to higher-level benefits—will have implications for allocational efficiency in the health sector. The provider payment mechanism can also be designed to encourage cost savings (technical efficiency) on the part of the provider, or it may unintentionally encourage greater use of resources, as a fee-for-service payment system tends to do. The intent of the analysis here is to bring out the efficiency implications of relevant design features of the MHOs in the study.

2.3.2.1 Risk Management Techniques

If MHOs are to succeed financially, one of the most important skills that their management or leadership should master is how to assess the risks that MHOs are exposed to (particularly where they are based on an insurance mechanism), and the appropriate measures to put in place to minimize the threat the risks pose. The risks involved are principally moral hazard, adverse selection, cost escalation, and fraud and abuse (See box 2 for an explanation of these risks.).

(a) Moral Hazard

The precise tools that an MHO's management can deploy will depend in part on the type of MHO and the efficacy of the tools that are available to it. For example, to combat moral hazard (as well as fraud or abuse), the traditional, ethnic-based type of MHO may be able to rely quite effectively on social control, which tends to be strong in such groups, and the smaller the group, the easier and more effective will this tool be. For larger and more heterogeneous MHOs, for example, the community financing types with low participation (see table 3), this kind of tool is unlikely to be available, and so they often deploy other measures, such as imposing co-payments or deductibles.

Box 2. Risk Management and Types of Risk

1. *Moral hazard.* This is the tendency of those insured to use the services more intensively than if they were not insured. Such often unnecessary use results in overconsumption and imperils the financial viability of the insurance system. This is different from fraudulent use of the services, because it relates mainly to the fact that to those insured, the price of using the service is often much lower than the actual price of the service (especially in the absence of co-payments or deductibles), so that they might seek treatment for a minor health condition that they would ordinarily overlook if they were paying the full price.
2. *Adverse selection.* This is the tendency of those who are at greater risk of falling ill (high risks), or who are already ill, to subscribe to the insurance scheme in greater numbers than those who are less at risk (low risks). This also imperils viability, because the premiums are calculated on the basis of the whole community's or target group's average risk of illness, and if the actual subscribers tend to be those who will use the services more intensively than the average person, then the scheme is likely to become insolvent.
3. *Cost escalation.* This refers to the danger that an insurance scheme will face rapidly rising costs for a variety of reasons related to the behavior of both providers and patients once such a scheme is implemented. Providers, with the collusion of insured patients, may have incentives to use costly treatment techniques or to provide excess services in the knowledge that the scheme will pick up the bill. In addition, as points 1 and 2 explain, patients might tend to behave in ways that drive up the costs of the scheme.
4. *Fraud and abuse.* An insurance system is open to the dangers of free-riding, that is, to individuals who want to enjoy the scheme's benefits without bearing the cost involved. For example, some individuals not entitled to services may usurp the identity of those entitled to services to receive the benefits without paying for them. If no effective system of checking identities is in place, knowing whether people demanding the benefits are entitled to them or not is difficult. Insurance is particularly open to such risks, because people often perceive that somebody else is paying for the services, not the direct user of those services, which arguably gives incentives for abuse.
5. *Risk management.* This covers the range of tools or techniques that the scheme managers can deploy to minimize the impact of the above risks. The two crucial steps involved are identifying and quantifying the risks. Identification depends to a large extent on available data, which could be gathered from existing sources such as providers or from research. Quantification depends on the use of the tools of actuarial science, or sound judgment, or a combination of both. An MHO's level of risk is greatly affected by the benefits package it offers and its terms of membership. Features of the design of the system (co-payments, deductibles, mandatory reference, compulsory membership, family coverage, waiting periods) can also affect the level of the risks.

Of the 67 MHOs involved in this study, 9 are traditional, ethnic-based ones, of which 7 are Cameroonian [1, 2, 3, 5, 7, 9, 10], 1 is a case study MHO from Ghana [3], and 1 is a case study MHO from Nigeria [4]. The available evidence indicates that in these MHOs social control is strong. Moreover, their benefits are usually limited to a fixed cash subsidy for hospital admission, and often members are required to visit someone in the group who is hospitalized. While the main purpose of visiting a sick person in the hospital is usually to show solidarity and concern for other members, at the same time it is also a way to check on possible usurpation of a member's identity, and therefore to control fraud. Benefits relating to hospital admission (or to catastrophic illness in general) are less subject to moral hazard than those relating to minor illness and ambulatory care, especially if this is reinforced by requiring mandatory reference. Therefore, moral hazard is less likely to be a problem in the nine traditional MHOs in this study.

Indeed, the MHOs based in rural communities (nonprovider), which tend to be closer to the traditional type in the sense that exercising social control among such communities is easier, often rely to a considerable extent on this mechanism to control abuse. In the study, 15 of the MHOs are of this type, including 6 case study MHOs. The evidence from the study indicated that at least eight Senegalese rural community-based MHOs (those that are contractually linked to St. Jean de Dieu Hospital) make regular use of social control.

In the Senegalese case, the main benefits of social control are related to hospital admission costs. It seems unlikely that the Malian [2] rural community MHO and two of the Benin ones [1, 2], which target fairly large villages, can depend on social control to a similar, or even significant, extent. As the benefits these MHOs provide are linked to hospitalization, the risks of moral hazard or fraud are reduced, but could still be substantial, especially in the Benin cases, where the structure and conditions of the benefits package encourage individuals to go straight to the hospital for care rather than entering the system through a lower-level, PHC facility.

What about the types of MHOs that cannot rely to any significant degree on social control of their members' behavior? This applies to all the other kinds of MHO except those that are extremely small, say fewer than 50 beneficiaries in total. Four study MHOs fall into this category: the Ilera MHO (Benin[3]), MC 36 (Côte d'Ivoire [4]), MEUMA (Mali [3]), and USYN COSTO (Togo [6]).

Mandatory reference from a lower-level facility for schemes that offer secondary or higher-level care benefits, co-payments, and deductibles are among the most frequently used measures to check or limit moral hazard in insurance-based schemes (see box 3). Used wisely, they can help make individuals behave responsibly, enhance efficiency, and limit the scheme's exposure to moral hazard.

Box 3. Risk Management Tools*

1. *Mandatory reference.* Well-designed insurance-based schemes that offer benefits related to secondary or higher levels of health care usually require members to be properly referred by an approved agent, usually a lower-level medical officer, before they can report to the hospital or higher-level facility in order to qualify for benefits under the scheme. This measure helps to prevent inappropriate resort to a higher-level facility, which some individuals will tend to do to avail themselves of the scheme's benefits. Mandatory reference is reported to be an element in the relative success of the Bwamanda scheme in the Democratic Republic of Congo.

2. *Co-payments.* When insured individuals or MHO members are asked to pay a usually small portion of their health care charges out-of-pocket when they go to a health facility, with the other, usually larger, share being paid by the insurance scheme, then individuals' personal share is called a co-payment. The Kolokani MHO in Mali [2] involves a co-payment of 25 percent that members have to pay when they go to the hospital. The case of Les Intimes (Côte d'Ivoire [5]) is unusual, but illustrates the same principle: the MHO pays only 25 percent of members' medical charges, and members pay the 75 percent co-payment.

3. *Deductibles.* In this case, insured MHO members are asked to pay up to a fixed amount of their health care bill, and the insurance scheme or MHO pays the whole of the rest of the bill. To illustrate, an MHO may ask its members to pay up to, say, the first FCFA 1,000 of any health care bill. If the total bill is FCFA 10,000, then the MHO pays FCFA 9,000. If the bill was FCFA 950, the MHO pays nothing. Deductibles may be applied on a per visit or on an annual basis. The Babouantou MHO in Cameroon [2] implements a similar principle by asking its members to pay for the first seven days of hospitalization, with the MHO paying the bill for all days after the first seven (see Atim 1997b).

4. *Ceilings on benefit cover.* Many MHOs also use the device of imposing a ceiling on the total amount of health care bills or benefits per person that they will pay for either per visit and/or per year. This is more usually deployed to check cost escalation and to ensure the scheme's financial viability. The Lalane Diassap and some other MHOs in the Thiès region of Senegal limit their coverage to the first 15 days of hospitalization. The individual concerned must bear any expenses beyond that time.

* Insurance schemes often use tools 1 through 3 to limit moral hazard; however, many schemes may be more likely to use tools 2 and 3 to limit their financial commitment (and hence to enhance their viability), as evidenced by the frequently high levels of co-payments and deductibles, which are arguably higher than what might be considered necessary to minimize those risks, as the Babouantou example indicates.

The study did not investigate the risk management techniques of the inventory MHOs, but of the case study MHOs, four (Senegal [1], Benin [1,2], and Ghana [1]) are open to substantial moral hazard, because even though their benefits are related only to hospital admissions, they provide 100 percent coverage with no mandatory reference system in place to prevent unnecessary resort to hospital care.²⁹ MHOs that provide third-party subscriptions with discounted tariffs or savings and credit benefits for members are less likely to be subject to moral hazard, because members still face a significant cost when they use the services.

On the possible relationship between the nature of the benefits offered and moral hazard, one MHO, MUGEF-CI (Côte d'Ivoire [6]), provides benefits related only to the costs of drugs, dental care, and eye glasses (including frames), apparently without co-payments or deductibles. Whether this type of coverage is a good design is doubtful: all three areas of coverage are liable to substantial moral hazard.³⁰

(b) Adverse Selection

Adverse selection is more difficult to counter in any voluntary insurance system, but some MHOs, especially those based on professions, enterprises, and trade unions, may require all members to join the scheme, thereby eliminating the problem altogether. Where compulsory membership is not the case, as in a great many, if not the vast majority, of MHOs, schemes often use such measures as requiring a waiting period during which members pay contributions, but are not entitled to benefits, and insisting that the entire family register once one member joins.

Of the 22 case studies, 3, based either on profession or trade union (Senegal [1], Ghana [2]) or on an existing social movement (Nigeria [1]), require compulsory membership of the target group. Three others (Mali [2], Nigeria [2, 3]) have effectively eliminated adverse selection through an innovative design feature: they are based on collective membership, not individual adhesion. In other words, the unit of membership is an association, such as the Association de santé communautaire (ASACO) in Mali, which is an organization that covers all the members of the village concerned, or as in the Nigerian CPH examples, informal sector groupings such that the group's or association's membership in the mutual health scheme automatically opens the way for all its members and their dependents to benefit from the services. The Lalane Diassap MHO, Senegal [3], has nearly eliminated adverse selection by achieving high penetration of the target group (82 percent), mainly because the target group is relatively small, and social cohesion is probably strong in the villages concerned.

When membership is not at the discretion of the individual beneficiary, as in all the above cases except the Senegal [3] case, the imposition of a waiting period to discourage adverse selection is unnecessary. This is, however, essential when membership is entirely voluntary, but some MHOs go even further and limit the period during which individuals can join the scheme to say a few months of the year, such as the harvest season. This advice, which is frequently encountered during MHO design, is being challenged by at least one MHO (Ghana [1]), on grounds set out in box 4.

Of the case study MHOs for which pertinent data are available (six MHOs in all, excluding those based on some form of obligatory or automatic membership), a waiting period of three months (or two months in the case of the Dagaaba Association, Ghana [3]) is generally included as a design feature to minimize adverse selection. However, one of the six, the MUTECH Health Centre (Mali [1]), does not have a waiting period, which, in the absence of compulsory membership, probably implies some degree of adverse selection.

²⁹ The two Benin MHOs probably do reduce moral hazard to some extent by requiring that a person in need must first receive the attestation of the secretary of the *groupement mutualiste du village* before going to the health facility.

³⁰ In addition, drugs are generally the most expensive item in the health care bill in Africa, and so there is a high risk of cost escalation as well. The deficits run by the scheme despite the level of dues may be related to these aspects.

Information is available on dependent or family coverage for 21 of the 22 case studies (it is not available for MC 36, Côte d'Ivoire [4]). Of these 14 involve compulsory or automatic family coverage, and 5 others permit family membership, but it is not required, and not all provide incentives for such registration. One MHO in Benin and one in Senegal exclude family membership, but one of those (Senegal [1]) is based on compulsory membership of the target group, and so no problems of adverse selection arise. In the case of the second, Alafia MHO (Benin [3]), the situation is clearly the result of a lack of knowledge by its leaders of the organizational and risk management principles of MHOs. All four Benin MHOs are probably subject to adverse selection, because none of them requires the entire family to register when a person joins. Whether these MHOs have a waiting period or not is not known.

Box 4. Should MHOs Limit the Registration Period?

The West Gonja MHO in Ghana challenges the conventional wisdom that the period during which individuals can join the scheme should be limited to a few months of the year in the interest of minimizing adverse selection, on the following grounds:

With the compulsory waiting period of three months for new members, the danger of adverse selection from this source is minimal.

People should be able to register as soon as they become convinced of the usefulness of doing so, otherwise, some months later, they may have forgotten why they had wanted to register. Some of the practical arguments are (a) with the constant sensitization campaigns mounted by the scheme, if people become convinced of the benefits of membership, they should be able to register then, or else they are unlikely to do so later when other priorities and problems arise and the insurance arguments have become a distant memory; and (b) many people tend to register only after personal misfortune, such as a serious illness resulting in heavy expenditure, or the misfortune of others, which forces them to concentrate their minds on the solutions, for example, many patients rush to register immediately upon discharge from hospital, too late for the last illness, but at least a hedge against future catastrophe.

Year round registration is convenient for people such as civil servants, whose income is not bunched at a particular time of the year like that of farmers. People should be able to choose a time to register that is appropriate for their particular income or cash flow profile.

Year round registration gives scheme managers a great deal of flexibility to raise the registration fee at any time during the year if their inflation predictions and budgetary projections at the beginning of the scheme year prove to be too optimistic. This might well prove to be the most decisive factor in favor of year round registration.

Source: Ghanaian case study.

(c) Fraud and Abuse

The use of members' identity documents by people not entitled to the benefits poses a real danger when the controls are not effective enough to prevent or minimize this. As noted earlier, traditional ethnic-based types of MHOs and those in small rural communities tend to use strong social control to check fraud and abuse of services. In these cases, however, there is an implicit assumption that the members can repose all their trust and confidence in the leaders, who are responsible for preventing these abuses. If they do not carry out their duties well, or worse still, if some of them collude in such practices, then the system of social control breaks down.

Some of the MHOs in the study were not responsible for checking or were not in a position to check the identification of beneficiaries. In the case of two MHOs, Senegal [1, 2], this task is in the hands of other agencies (the education inspectors and the statutory pensioner's body, IPRES, respectively), not the MHOs' management. In other cases, such as the West Gonja MHO (Ghana [1]), the task of checking identification is left to the hospital staff at the time of admission. Thus in these cases much depends not only on the motivation and diligence of the outside body responsible for doing the checking, but also how fool-proof the identification documents are. Many MHOs include the photograph of the beneficiary on the identification card or document, thereby facilitating identification, but frequently only the titular member's photograph is

affixed to the document, but photographs of other beneficiaries (family members) are not, and this is a potential source of abuse.

A good practice in effect in the South Borgou MHOs (Benin [1, 2]) and the two CPH schemes in Nigeria [2, 3], is that an MHO leader or manager is the first line in the reference system, and to receive benefits beneficiaries must first obtain a reference slip or sick note from the leader before going to the health facility.³¹

(d) Cost Escalation

The tendency toward cost escalation in MHOs arises from two sources: the behavior of MHO members or patients on the one hand, and provider behavior on the other. The risk of moral hazard is one example of patient behavior that can lead to cost escalation for an MHO. Fraud or abuse on the part of members will also increase costs. On the provider side, behaviors that can significantly raise the costs of the MHO's services include providing excessive or unnecessary care to members, using the most expensive treatment options or procedures, and prolonging the hospital stay of insured MHO patients unnecessarily.

The following paragraphs discuss some options for dealing with dealing with the problem.

Ceilings on MHO Cover

A number of MHOs have set ceilings or caps (see box 3) on the amount that they will cover (all those that offer only a fixed subsidy or grant per case) or on the number of days of hospitalization that they will cover (all the MHOs of the Thiès region in Senegal that are linked to the St. Jean de Dieu Hospital).

Arguably, ceilings on MHO coverage have a more regressive impact on access to health care than, say, deductibles, because those liable to incur the most expensive charges beyond the ceiling charges are usually a relatively small number of people. By contrast, a much larger number of people will tend to incur smaller charges. Deductibles are usually designed, among other things, to minimize the administrative costs of a large number of small charges.

One alternative to ceilings would be to have a system of re-insurance for MHOs; however, this option is little developed in the commercial insurance sectors of the subregion.

Essential and Generic Drugs Policy

One tool available to MHOs that they can use to control costs is a generic drugs policy coupled with an essential drugs list. Next to salaries, drugs are the most expensive item in the health care bill of most African countries. An MHO can cut its drug bill substantially by insisting that health facilities adhere to the national essential drugs list and the use of generic drugs wherever possible in their prescription practices. This is usually backed by an agreement under which the MHO will only pay for bills that adhere to this policy. Four of the MHOs studied, Mali [1, 2] and Nigeria [2, 3], reported that they were practicing an essential and generic drugs policy.

Obviously, an essential and generic drugs policy can only be enforced if the MHO has direct contact with the health providers. Those that practice cash reimbursement after members have paid their hospital bills can insist that they will only reimburse members for the cost of essential and generic drugs, but even this policy may still require the MHO, in the interests of its members, to contact the health providers to make them aware of the policy. MHOs that provide only a fixed cash subsidy to the member to help them pay their own bills cannot normally enforce such a policy.

³¹ Possible problems with this system include not only the honesty of such gatekeepers, but also their qualifications and incentives to carry out such a function. Its advantage is that such people are likely to be familiar with individual members and their circumstances.

One possible constraint to implementing essential and generic drug policies is the widespread preference for brand name drugs and their erroneous association with better quality care. This demands educating members and providers about these drugs and the MHO's policy. However, this presumes that the MHO has the technical capacity not only to conduct the educational work, but also to process claims for reimbursement in a way that differentiates between approved and nonapproved drugs.

Provider Payment Mechanisms

The mechanisms MHOs employ to pay providers is crucial in determining whether providers have an incentive to drive up costs or not. In general, the most effective way to ensure that providers do not have an incentive to push up costs, but rather to reduce them, is to pay them by capitation (see box 5). This method ensures that providers do not stand to gain by providing unnecessary services, but by keeping costs down. This works best, however, where MHOs have a choice of providers or an effective quality control system is in place to ensure that such economy of resource use is not at the expense of quality of care, as the MHOs can switch providers if they are not satisfied with the quality of care. Experience from Tanzania has shown, however, that providers tend to resist this payment model, because it compels them to make efficiency improvements that they may be reluctant or unable to carry out, and MHOs may need to have sufficient negotiating clout or market power for providers to accept this method of payment.

The fee-for-service method of reimbursement (see box 5) is by far the least efficient from the perspective of cost containment in as much as it does nothing to encourage providers to use resources efficiently, and actually tends to encourage the wasteful practices described earlier. So long as providers are paid according to the amount of services supplied, they have an incentive to supply, say, more drugs than strictly required, to encourage more visits by insured patients, or to prolong patients' hospital stays.³²

In the MHOs studied, with the exception of those linked to the St. Jean de Dieu Hospital in the Thiès region of Senegal, whose situation may be unique, wherever the MHOs have direct payment arrangements with health providers, the payment mechanism most frequently used is fee-for-service. Of all the MHOs investigated, 25 (including the Thiès MHOs) organize service benefit insurance payments for the portion of their members' health care costs for which they are responsible. The other methods of provider payment offered by MHOs in the study are cash indemnity, a fixed cash subsidy, a repayable loan advance, or an annual subscription to a provider that enables the member to obtain care at the health facility at reduced tariffs (see table 9).

³² For instance, in Ghana, various evaluations of the Nkoranza Hospital Health Insurance Scheme showed convincingly that insured patients were being kept in hospital longer than noninsured ones, and the West Gonja case study in this study (Ghana [1]) concludes on the basis of qualitative evidence that similar tendencies are probably present there too.

Box 5. Provider Payment Mechanisms

1. *Capitation payment.* The insurance scheme or MHO pays the provider a fixed, agreed amount per member for all members per month, quarter, or year, and the provider contracts to provide all the defined care for any member who needs it during the period without extra cost. By paying for the number of people enrolled instead of the number of services offered, the provider's economic incentives to provide more, possibly unnecessary, services are reduced. This system works best in the presence of provider competition or good quality control measures, otherwise providers will have incentives to lower the quality and/or the volume of services provided to members. Another possibility for controlling quality and the incentive to undertreat is for the agreement between the MHO and the provider to include some kind of independent quality assessment or quality audit.
2. *Fee-for-service.* The provider bills for each individual service or treatment performed. A modified and, for the patients, better system is the fee per episode (or case payment), under which the provider bills for each episode or case of illness, including return visits and treatments, so long as they are related to the same illness episode.
3. *Cash indemnity.* This refers to an arrangement where MHO members must first pay out-of-pocket for their health care and then seek reimbursement by presenting the invoices or proof of payment to the MHO or insurance scheme.
4. *Fixed cash subsidy or grant.* This refers to the situation where the MHO gives sick members a fixed sum of money irrespective of the actual health care charges incurred, as a contribution to help them pay for their health care. This payment may be made before members receive the bill (in the case of hospital admission) so long as they present clear evidence of the qualifying health situation, or it may be made after members have paid the bill. This method is more commonly used for social risks covered by MHOs other than health, such as births, funeral grants, or marriages.
5. *Service benefits.* A third party, in this case the MHO or insurance scheme, pays health care providers directly for expenses incurred by members. However, if a co-payment or deductible is involved, then members must still pay that portion, usually out-of-pocket and directly to the provider. Some MHOs in Thiès, Senegal, however have an agreement with the provider whereby the MHO pays the entire bill for a member's hospitalization, and then the MHO claims the co-payment or beyond ceiling portion of the bill from the member.
6. *Third-party subscription with discounted pricing.* This term is different from insurance-type subscriptions or dues in that it refers to a situation where the subscription or dues payments are made to a third party, but where the funds are not used to pay the provider for even part of members' health care bills. In the case of the CPH schemes in Nigeria, for instance, dues are paid to the CPH, which uses the money to run its offices and pay for administrative and similar expenses. These dues or subscriptions are, however, a prerequisite that open the way for members to enjoy the special (50 percent) fee discounts for certain defined, priority PHC areas the provider offers as part of its contract with the CPH to improve community health. The provider gains because the system reduces bad debts and the administrative costs of debt recovery, and more important, attracts a greater clientele to the facility than would otherwise have been the case (see the Nigerian case study).
7. *Loan advances to members.* MHOs use soft loans, that is, loans at either no interest or at interest rates well below their normal rates for productive or commercial loans, to assist members facing health care expenses that they cannot afford. Organizations such as cooperatives or savings and credit societies that provide loans for health care expenses as part of their normal portfolio of lending activity (that is, at their normal rates of interest for commercial or production purposes) are not included in this definition and were not investigated in this study. More usually, as with the CPH schemes in Nigeria and Les Intimes in Côte d'Ivoire, such loans are an additional, optional benefit that members can draw upon after they have exhausted their main nonoptional benefits under the scheme. COWAN in Nigeria, however, offers zero interest loans as its main form of assistance.

| Table 9. Provider Payment Mechanisms Used by MHOs | | | | | | | | | |
|--|---------------------|-----------------------|---------------------|---|---------------------|---|---------------------|---------------------------------------|---------------------|
| <i>Service benefits insurance payment</i> | | <i>Cash indemnity</i> | | <i>Direct cash subsidy or grant to member</i> | | <i>Annual subscription to facility or MHO with discounted pricing</i> | | <i>Loan to member for health care</i> | |
| Number of MHOs | Percentage of total | Number of MHOs | Percentage of total | Number of MHOs | Percentage of total | Number of MHOs | Percentage of total | Number of MHOs | Percentage of total |
| 25 | 38 | 13 | 20 | 19 | 29 | 7 | 11 | 4 | 6 |

Note: Total number of MHOs for which data are available is 65, but as some MHOs use more than one payment method, the total number of payment frequencies is 68. For this reason and because of rounding, the percentages do not total 100.

¹ This includes both third party noninsurance subscriptions and insurance-type subscriptions to a health facility.

The eight MHOs linked contractually with St. Jean de Dieu Hospital in Thiès have a modified fee-for-service system, whereby they pay a fixed fee per day of hospitalization that is 50 percent less than that for noninsured patients.³³ This clearly removes many of the incentives to overprescribe, because the hospital does not gain by prescribing unnecessary treatments. However, it does not eliminate the possibility of prolonging the hospital stays of insured patients, which would certainly be a way to increase the providers' revenues. Whether this actually happens in practice is not known, but note that (a) the 50 percent reduction in charges to MHO members (including for some services not covered by the MHOs' benefits packages) is itself a significant cost reduction measure to the MHOs;³⁴ and (b) the hospital's management is clearly predisposed to encourage the development of MHOs within its catchment area. Box 6 describes some of the specific features of the Thiès MHOs.

| Box 6. The MHOs in Thiès, Senegal: A Unique Experience? |
|---|
| <p>The Thiès region of Senegal is arguably the area with the most concentrated MHO presence in the subregion. This experience may, however, be unique, because the development of MHOs here is greatly enhanced by the presence of hospital management at St. Jean de Dieu who are committed to the principle of MHO promotion, the provision of good quality care, the presence of a minority Christian and homogenous ethnic (Sereer) community, and the early encouragement of MHO development by promoters linked to the Catholic diocese. Whether these conditions are replicable elsewhere is open to question, but they have proved highly favorable to MHO development in the region. Note that the South Borgou MHOs in Benin are also linked to a Catholic hospital known as St. Jean de Dieu.</p> <p>Indeed, one could argue that the primary goal of missionary health facilities like the St. Jean de Dieu hospitals in Benin and Senegal is to provide quality care, not to maximize profits, hence the use of fee-for-service payment systems does not necessarily lead to cost escalation. However, this is not the case for many other, especially private, providers, and so limits the replicability of this example to other MHOs not served by such a benign provider. Therefore developing provider payment methods that can help control quality and limit unnecessary services is still important for the many other cases.</p> |

The preponderance of fee-for-service agreements between MHOs and providers in the study probably reflects the reality of the preponderance of provider power; the lack of provider choice that faces many, especially rural, MHOs; the MHO leaders' lack of knowledge of alternatives; and the lack of requisite management skills on the part of MHO leaders.

The lack of requisite management skills at the MHO level is important, because even where MHOs are forced to rely on fee-for-service payment methods, with skilled management they can insist on a range of

³³ However, one MHO in the area, the *Ménagères de Grand Thiès* (Senegal [10]), offers just a cash indemnity for drug costs. Note also that surgery is excluded from the hospitalization coverage offered by the Thiès MHOs, though their members still enjoy a 50 percent reduction of such costs (see the Senegalese case studies).

³⁴ Whether this also enhances efficiency at the hospital depends crucially on whether such tariff lowering leads the hospital to reduce costs without impairing quality. The evidence in the Thiès case seems to be that rather than resulting in efficiency improvements, cost shifting is taking place, that is, the noninsured patients and the services not affected by the tariff reductions are bearing the costs of the subsidy to the MHO members.

managed care procedures to minimize the cost escalation inherent in the system. Such techniques might include case-based methods and utilization reviews (see box 7) to control inefficient provider behavior. The evidence, however, does not show that the MHOs reviewed regularly use any such procedures. Even at Thiès, whether skilled MHO management is a predominant factor in the favorable climate for the development of MHOs is not clear.

Box 7. Utilization Review Methods

Utilization review usually involves evaluating providers' decisions before the scheme will pay the bill. Below are some of the methods that can be used to help contain costs and improve or maintain quality (Getzen 1997). Although not all of these will be applicable or practical for small MHOs, they do demonstrate a range of options for controlling costs and vetting the quality of care, which perhaps could be recommended to groups of small MHOs.

1. *Second opinion*: Asking a second doctor to review the first doctor's decision before dispensing expensive care such as surgery.
2. *Precertification*: Requiring providers to obtain the MHO's prior approval before performing elective surgery.
3. *Concurrent review*: Having a case control nurse carry out regular evaluations to determine whether continued hospital stay or additional care is required.
4. *Pre-admission testing*: Requiring as many tests as possible to be performed on an outpatient basis before the patient is admitted, thereby cutting down on the hospital stay.
5. *Database profiling*: Maintaining comparative records of the services used by providers in the area to identify abnormal patterns of utilization. This could also be used to identify providers who do not conform to "usual, customary, and reasonable" fees as well as a standard of care over time.
6. *Intensive case management*: Having a nurse attached to the scheme follow and manage any case expected to cost more than a certain amount.
7. *Generic substitution*: Replacing a prescription for a brand name drug with a cheaper generic version if the two are chemically and/or biologically equivalent.
8. *Retrospective review*: Carrying out an evaluation after discharge from hospital to identify medically unnecessary services for which payment will not be made.
9. *Audits*: Ensuring that all services billed were actually performed.

2.3.2.2 Primary Health Care Services of MHOs

Allocational efficiency in the health sector is affected by whether MHOs structure their benefits packages to include and/or promote the use of PHC facilities, especially preventive and promotive services, for example, through mandatory reference. To the extent that they do this, MHOs help reduce the demand for relatively expensive secondary and tertiary care by directing patients to use cheaper PHC facilities first. At such facilities those with minor illnesses can be taken care of adequately, and only the more complicated cases are referred upward. Also, by encouraging disease prevention and health promotion, MHOs can help reduce pressure across the health care system as a whole.

Of the 67 MHOs in the study, 28 (42 percent) include PHC services directly in their package in one form or another, and 13 of these offer only PHC services. In addition, two case study MHOs, Senegal [3] and Mali [2], whose benefits are based on hospitalization costs, require patients to be referred to the hospital by the MHO before coverage is provided (mandatory reference).

A majority of the MHOs investigated, 37 (55 percent), have benefits relating only to the costs of hospital admission.³⁵ In some of these cases the MHO merely offers a fixed cash subsidy or reimbursement for expenses incurred, and such MHOs are unlikely to be bothered about whether or not the person was referred to the hospital. (Though one could argue that it would be in their real interests and would encourage rational allocation of health care resources if they insisted on mandatory reference for payment of refunds or subsidies.) In other cases, for example, Ghana [1] and possibly all the MHOs around mission hospitals such as those in Thiès, a problem often arises from an absence of adequate integration between the district hospital and the PHC services that makes it difficult for the district hospital to require reference from the lower levels. For instance, in Ghana, the Christian Health Association of Ghana runs mission hospitals while the Ministry of Health supervises government facilities, but the lack of adequate integration sometimes leads to the impression that mission hospitals, even those that are the government designated district hospital for the area, and government run PHC facilities around them are competing rather than complementing each other in terms of attracting patients and revenues.

Even in the case of those MHOs that offer service benefits payments, most do not appear to require mandatory reference as a condition of coverage.

Indeed, even in the case of MHOs that provide coverage for a mixture of PHC and higher levels of care, in 15 (22 percent) of those investigated where the relationship between the MHO's financial viability and the level of care chosen by the member is possibly most direct, only in the case of Kolokani (Mali [2]) is mandatory reference required. In this latter case (see box 8), an officer of the Centre de santé communautaire (CSCOM), which the community manages through the ASACO, must call the ambulance service to come and evacuate a sick person who needs to be referred, and thereby acts as the first line of reference. The CPH mutual organizations in Nigeria [2, 3] require a person to be referred from the community level by the leaders of their own association before they can benefit from the MHO's services at the PHC clinic, but they require no such reference to seek treatment at a hospital, even though some reduced benefits (loans) are available to those who go to a higher-level facility.³⁶

2.3.2.3 Summary and Potential Contribution to Efficiency

The more successful MHOs in the subregion appear to have built up a body of design features and practices that are favorable to scheme success, and in particular, to the efficient delivery of their services (see table 10). These include waiting periods for new members; social control to avoid abuses; co-payments or ceilings on the amounts of coverage; and some level of obligatory membership at the family, association, or target group level that ensures that membership is extended beyond just those who wish to join voluntarily.

As concerns their impact on the health system as a whole, some MHOs have also succeeded in finding ways to keep health care costs down by negotiating reduced tariffs and fixed fees per day of hospitalization (the MHOs of Thiès) in a situation where MHOs generally lack the negotiating power and managerial skills to opt for the more efficient capitation models.³⁷

Almost half of the MHOs studied, 28 out of 67 (42 percent) provide their members with PHC services either solely or in addition to other coverage, and to the extent they encourage greater use of such services, they contribute to the health sector's allocational efficiency. To enhance this contribution further, MHOs need to be able to insist on mandatory reference as a condition of access to their benefits.

³⁵ Secondary and higher-level care is traditionally viewed as an insurable risk, because its occurrence is random, expensive, and less subject to moral hazard.

³⁶ There is evidence from the Nigerian case studies of MHOs' direct impact on their members' health, namely, the CPHs have significantly increased vaccination rates among the target group and COWAN has increased contraceptive uptake. However, other evidence, such as the lowering of illness rates and of birth and other complications, for peer group non-MHO members has not been studied.

³⁷ Evidence from the UMASIDA MHO in Tanzania indicates that providers' lack of financial and managerial skills may be at least as big an obstacle to implementing capitation models as is MHOs' lack of such skills (see Atim 1998).

Box 8. Charges and Coverage in the Kolokani MHO

Discussions with the four ASACOs operating in the Kolokani region of Mali have led to the setting up of a referral financing system shared by the user, the user's ASACO, and the Circle Health Center (referral facility). The calculations for this coverage are based on the average cost of transportation during a health care evacuation between the CSCOM and the Circle Health Center and on an estimate of the average cost of the treatment provided.

For transportation, the Circle Health Center has an ambulance and a radiotelephone system. The person in charge of the CSCOM authorizes the patient's evacuation and referral and, if necessary, calls the ambulance. The average cost of evacuation is estimated at FCFA 10,000 (fuel and driver's allowance).

Coverage is organized as follows:

- ▲ 25 percent charged to the patient (patient's contribution) = FCFA 2,500
- ▲ 25 percent charged to the Circle Health Center = FCFA 2,500
- ▲ 50 percent charged to the ASACO = FCFA 5,000

At Circle Health Center the patient can be treated in the ambulance, referred to a regional hospital, or hospitalized on site. In the case of hospitalization on site, the average intervention cost was estimated at FCFA 20,000.

In the case of hospitalization, the breakdown of coverage is the same as for transportation:

- ▲ 25 percent charged to the patient (patient's contribution) = FCFA 5,000
- ▲ 25 percent charged to the Circle Health Center = FCFA 5,000
- ▲ 50 percent charged to the ASACO = FCFA 10,000

Calculations are based on the assumption that there would be an average of two referrals per month for each of the four CSCOMs, half of which would require surgical intervention. In a fund managed separately in the Circle Health Center, each ASACO pays 50 percent of these two referrals, or FCFA 20,000 per month, and the Circle Health Center pays 25 percent x eight referrals x FCFA 20,000 = FCFA 40,000. Monthly revenues are thus FCFA 120,000 plus the contributions (FCFA 5,000 each or FCFA 40,000) paid by patients.

For their members to benefit from the collective coverage, the ASACOs must have contributed to the system for at least three months (waiting period). The payments began in January 1997. After six months of operation, the mutual solidarity fund for the referral/evacuation system has a positive balance of FCFA 500,000.

To collect the FCFA 20,000 per month, each ASACO is free to organize itself as it sees fit. The Circle Health Center does not interfere in the internal organization of each ASACO. Some make monthly payments to the referral fund, others prefer quarterly payments. To date, there have been no late payments.

The ASACOs generally have two separate funds: the drugs fund used exclusively to resupply the drugs inventory and the activities fund. ASACOs are funded by fees for service, family contributions, collective areas, or other sources. The FCFA 20,000 monthly contribution to the referral system comes from this fund. Some ASACOs plan to establish a system with a periodic assessment per inhabitant specifically for the mutual referrals fund. Circle Health Center administrators manage the mutual referrals fund. They are supervised by a management committee that includes representatives from each ASACO in the system.

Source: Malian case study.

The key advantages of MHOs that rely on the savings and credit system lie in their ability to manage risk. However, they face major disadvantages in terms of equity and access to care, in so far as the mechanism tends to discourage ready recourse to such forms of assistance in times of need.

Thus while MHOs have the potential to influence efficiency in the health sector quite significantly given the range of design tools and mechanisms available, the knowledge and significance of many of these may not yet be apparent to all of them, and much room exists for greater use of such tools and mechanisms.

Table 10. Some Recommended MHO Design Features

| Objective | Control measures | MHOs in study using the feature ¹ | Comments |
|--|---|--|---|
| Minimize moral hazard | Social Control | 17 case and inventory MHOs | Reinforced by democratic participation and accountability |
| | Mandatory reference (gatekeeper system) | 2 case study MHOs | None |
| | Deductibles | 1 case study MHO; 1 inventory MHO | None |
| | Co-payments | 3 case study MHOs | None |
| Minimize adverse selection | Membership through association or grouping | 3 case study MHOs | None |
| | Obligatory or automatic family membership | 14 case study MHOs | Reinforced with incentives for registration of the entire family |
| | Waiting period | 5 case study MHOs | None |
| | Mandatory participation | 3 case study MHOs | |
| Contain costs | Essential and generic drugs policies | 4 case study and inventory MHOs | Including cost sharing for nonessential and generic drugs |
| | Capitation payment | None | None |
| | Re-insurance | None | None |
| | Managed care | None | Including utilization review |
| Control fraud or abuse | Identity card for each beneficiary | None | None |
| | Rigorous checks at health facility | None | None |
| | Social control | 17 case study and inventory MHOs | None |
| Promote consumer participation and accountability for health services ² | Involve first-level health workers in organization | None | None |
| | Create joint management structure | 3 case study and inventory MHOs | None |
| | Create association of members if none exists | None | With regular meetings and presentation of reports |
| Promote the use of preventive and promotive services | Include PHC in benefits package | 15 case study and inventory MHOs | None |
| | Mandatory reference for benefits beyond PHC level | 2 case study and inventory MHOs | None |
| Improve quality of care | Negotiation with provider concerning waiting times and staff behavior | 4 case study and inventory MHOs | Assuming that members face such concerns or problems |
| | Assist provider to set up revolving drug fund | 2 case study and inventory MHOs | None |
| | Independent quality assessments or quality audits | None | None |
| | Vet providers' prescriptions and treatments offered | None | A crucial area of quality control, but where MHOs have no competence to check |

Notes: ¹ This list is indicative only.

² This suggestion and the first two measures under this objective are from a thesis by Bart Criel of the Institute of Tropical Medicine, Antwerp, and were kindly made available by Patrick van Durme of World Solidarity.

2.3.3 Equity

Two aspects of the equity implications of MHO interventions need to be analyzed: equity in the financing of health care and equity in the delivery of care. As concerns equity in financing, the structure of financial contributions and the presence of elements of individual risk rating are pertinent. As concerns equity in delivery, the relevant issue is whether benefits are related to financial contributions and, even though this is not one of the main objectives of MHOs, what provision, if any, has been made for the poorest of the poor, that is, those that cannot afford the contributions. Another feature that impinges on equity is what sections of the population and what regions of the country the MHOs target.

2.3.3.1 Equity in the Financing of Health Care

Only one case study MHO, MUGEF-CI (Côte d'Ivoire [6]), has a fully sliding fee scale based on income, because the contribution is a percentage (3 percent) of the member's income, which means that those who earn more pay more in absolute terms (actual fees range from FCFA 300 to FCFA 7,004 per month). Nearly all other MHOs collect a flat fee per person, irrespective of individual circumstances. This is not only for the sake of administrative simplicity, but probably also corresponds with most of their members' notions of fairness. Two MHOs, Benin [1, 2], use a kind of fee scale based on the size of the family, which is structured to make membership as a family more attractive than as an individual (unless the family consists of two people, in which case joining as individuals is cheaper).³⁸

More clear-cut and easily comprehensible is the two-stage sliding fee arrangement another MHO, Côte d'Ivoire [5], uses, which implements one fee for men and a considerably reduced fee (less than half the rate) for women. If this is done to enhance equity, then it depends on the crucial assumption that women earn considerably less than men. If that assumption is correct, then the arrangement promotes equity in health care financing to the extent that benefits are not related to the amount of the contribution, which indeed is the case here. Although not universal, and probably not even typical, in some informal sector settings in West Africa, such women as market "mammies" in Ghana may earn as much or more than men in those communities, therefore such a system would not promote equity in those locations.

The two MHOs of South Borgou (Benin [1, 2]) are the only ones in the study that have systematic exemption mechanisms targeted at the very poor.³⁹ These MHOs have set up a solidarity fund for the handicapped and the elderly based on traditional solidarity principles. The financing of this solidarity fund is not entirely clear, but the presumption seems to be that the paying members of the MHO finance the care of the poorest. A third MHO, West Gonja (Ghana [1]), has a limited solidarity fund that is available to just three indigent persons in each of the communities participating in the MHO, identified by the communities themselves. This fund, however, is not financed by members' contributions, but with money from a foreign development partner.

One MHO, Senegal [24], has an interesting mechanism of financing whereby sponsors pay the subscription fees for street children. This obviously enhances equity in the financing of health care, and some have suggested that this could serve as a model for assisting the very poor to gain access to health care. Under such a scheme, governments would pass their subsidies for the poorest through MHOs as purchasing agents. This might be more effective than current exemption mechanisms for the poor, especially those based on income levels or means testing.

³⁸ No clear or rational progression in cost per person as family size increases seems to be in effect, so the intended purpose of encouraging family registration may be somewhat mitigated by the somewhat complicated and illogical fee system.

³⁹ Many ministries of health in the subregion have exemption policies to protect the poorest from the adverse equity and access impacts of user fees; however, these tend to be more successful when they are targeted at particular vulnerable, demographic groups, such as children under five or pregnant women, than when they are based on means testing and income levels.

In general, MHOs' insurance-related contributions are fully community rated, and elements of individual risk (age, sex, pre-existing conditions, and so on) are not taken into account.

2.3.3.2 Equity in the Delivery of Health Care

Apart from two of the four MHOs whose mechanism of financing is at least partly through loans to members and another MHO (Senegal [2]) that offers different benefits for each of two contribution levels, the benefits offered by the other case study MHOs are not related to how much beneficiaries contribute.

Where loans are involved, inequity arises if the total amount that beneficiaries can borrow in the event of illness is related to the total amount saved. This is the case with the loan aspects of the two CPH schemes in Nigeria [2, 3], but not with COWAN's health loans (Nigeria [1]), or with those Les Intimes (Côte d'Ivoire [5]) offers. In the CPH schemes, the amount a member can borrow is a multiple of the monthly saving rate of that member, and this monthly saving rate varies according to each member's ability to save. In the cases of COWAN and Les Intimes, the amount that sick members can borrow is not related to what they have contributed, but the criteria for receipt of the loan may be related to ability to repay. Note, however, that with all these loan-based schemes, their interest rates are usually far lower than loans for productive or commercial ventures (if the MHO also provides such a service). In the COWAN case loans are interest free if repaid within three months.

2.3.3.3 Equity across Geographic and Sectoral Boundaries

The target groups for 17 (25 percent) of the MHOs investigated are rural populations, and for that reason alone, the MHOs can be assumed to be contributing to equity in health care delivery in their countries to the extent they make health care more available and affordable for rural people. Another 32 (48 percent) MHOs are targeted at those in the urban informal sector, who are another disadvantaged group in terms of access to good quality health care in the subregion.

Both the rural population and the urban informal sector are often disadvantaged with regard to formal social insurance or free health care provision by the state, and so the concentration of MHOs in these sectors, 49 (73 percent), indicates that such organizations are most likely to target the disadvantaged.

2.3.3.4 Summary and Potential Contribution to Equity

The contribution of MHOs to equity in the financing of health care is open to question. However, while flat rate premiums are a regressive form of financing, obtaining accurate information on the incomes of people in the rural and informal sectors is inherently difficult, which makes the use of flat rate premiums unavoidable if MHOs are to avoid a great deal of controversy, as well as possible incentives for free-riding and underdeclaration of incomes. Nevertheless, MHOs seem to be making an important contribution to equity in the delivery of health care, given that their target groups are predominantly those sections of the population that are currently benefiting little from state social security and insurance arrangements. They thus contribute to the extension of social protection to the rural and informal sectors.

The last conclusion must be qualified however, when equity within target groups is assessed, because on the whole they do not cater to the poorest of the poor, namely, those who do not have gainful occupations and cannot work (the old, the severely disabled, and so on), and so cannot afford the financial contributions. However, catering to the poorest is not the aim of MHOs, but a legitimate area of public policy and government intervention. The MHOs' primary objective and responsibility is to provide services to their members on a sustainable basis.

2.3.4 Quality

Public health care systems in Africa have acquired a reputation for poor quality of services: lack of drugs and other supplies and equipment, long waiting times, discourteous staff attitudes toward patients,

shortages of skilled staff, and so on. These problems are reflected in demoralized staff and in the health-seeking behavior of many individuals who prefer to self-medicate, consult traditional healers, or attend private health facilities where the fees are typically much higher than at public facilities.

One of the most important contributions that MHOs can make in this kind of situation is either to help restore confidence in public health systems by making resources available for improving quality or by intervening in the health care system in various ways. Alternatively, MHOs can enable their members to afford existing good quality private health care facilities through risk pooling.⁴⁰ In other words, the key problem in much of Africa is frequently not merely how to extend access to existing, probably poor quality, facilities, but how to enable access to better quality care than what is currently available. However, in those circumstances where the services currently available already meet popular expectations of quality, the problem is then reduced to extending financial, and possibly geographic, access to those facilities. In this context note that a close relationship is often apparent between the quality of health care and access to care. The possibility of setting up an MHO and its subsequent success usually depend crucially on the existence of health care services of acceptable quality.

MHOs can intervene to improve the quality of health care by entering into negotiations with providers (for instance, with a view to reducing waiting times and improving staff attitudes toward patients), checking the prescriptions and quality of care provided to their members before effecting payment, and helping to set up revolving drug funds. MHOs can also create their own health facilities if the existing ones are inadequate or if none are available within reach of the proposed target population.⁴¹

Of the MHOs that have service benefits payment arrangements, 25 enter into negotiations with their providers, but mainly in connection with the tariffs they have to pay. For instance, the eight MHOs linked to the St. Jean de Dieu Hospital in Thiès, Senegal, enter into regular individual (not group) negotiations with the hospital to set the tariffs, the range of services covered, and the mode of payment for the hospital's services. As the hospital already has a good reputation for quality among the MHOs' target groups, the MHOs have apparently not needed to raise issues relating to quality. Similarly, Les Intimes (Côte d'Ivoire [5]) undertakes negotiations with providers to obtain better tariffs for its members.

Some other MHOs do take up quality issues when they engage in such negotiations, for instance, Sirarou and Sanson UCGMs (Benin [1, 2]) and the CPH organizations (Nigeria [2, 3]). The UCGMs of South Borgou in Benin are reported to be actively taking up issues related to waiting times and staff behavior toward patients, while the CPH organizations in Nigeria (see box 9) have used their direct contacts with private providers to argue for (and assist with where possible) improvements in such aspects of quality as drug availability and staff attitudes.

What no MHO appears to be doing, however, is checking providers' prescriptions and the quality of the care provided to its members. This is undoubtedly due to the lack of the requisite medical and pharmaceutical skills, but it represents an important shortcoming, because apart from the opportunity to influence quality of care, the MHOs cannot be sure that the bills that they have to pay are fully justified.⁴²

⁴⁰ Evidence from the CPH system in Nigeria shows that MHOs can help even private facilities improve their quality of care.

⁴¹ As the MUTECH example in this study illustrates; however, in that case it would be more efficient to separate the management of the MHO from its health facility to maintain a separation of purchaser and provider and to recognize that different skills are required to run each of them.

⁴² As an example, in a case where the requisite skills were available, namely, a private health insurance organization in Ghana, this kind of checking has reportedly led to significant savings, because the private medical practitioners were found to be systematically overprescribing, for instance, prescribing two or three antibiotics to a patient during one visit; using inappropriate, but expensive techniques; and overbilling (see the introductory part of the Ghanaian case studies).

Box 9. The Jas CPH, Nigeria

The CPH organizations are MHOs based on a partnership—a contractual relationship—between a PHC provider or network of providers and a number of community-based organizations in the providers' catchment area. The Jas CPH is one of six such partnerships currently operating as pilot projects in Lagos, Nigeria. The founding members of Jas CPH were:

- ▲ Jas Medical Services (the PHC provider)
- ▲ Holy Trinity (Anglican) Church, Mushin
- ▲ Bosby Private School, Ilesamaja Oladeinde (Coker and environs) Landlord/Residents Association
- ▲ Alfa-Nda Welfare Association
- ▲ Foursquare Gospel Church Ilesaja II
- ▲ National Union of Road Transport Workers Union, Ilesamaja branch
- ▲ Kayode Native Doctor, Itire Road
- ▲ Kingdom Christian Ministry.

At the time of this research, the number of participating community-based organizations had increased to 13.

At one of the first meetings of the CPH, the partner organizations met and identified the key health problems of the community. At Jas, in the Mushin area of Lagos, these were defined as malaria, diarrhea, acute respiratory infections, and fevers and the lack of potent vaccines, family planning services, and health education. In addition, the organizations' representatives felt that the issues of women's empowerment, sustainability of the CPH, and democracy and governance were of such importance that they deserved attention among the objectives and activities of the CPH. Some strategies for dealing with these problems were also agreed. For instance, for malaria, they agreed that regular campaigns to remove stagnant water (the breeding place of the malarial parasites) and clean up streets and gutters would be undertaken. Each community-based organization is responsible for mobilizing its members to this end. To improve the stock of vaccines and drugs, a financing scheme was devised whereby each individual member of the CPH pays a participating fee (annual dues) of ₦100 (about US\$1.20) per adult, ₦70 (about US\$0.85) per adolescent, and ₦50 (about US\$0.60) per child under 12. This is used both to run the CPH secretariat and to buy essential drugs, defined as those generic drugs required to treat the common ailments identified by the community. In effect, some of the dues are used to constitute a revolving fund for drug purchases.

To achieve its health and access improvement objectives, the scheme's design incorporates some further novel and interesting features. For example, if a member's health problem is one of the key health problems identified by the community at the start, that member is entitled to a 50 percent discount on his or her health bill, including drugs, if properly referred by the leader of the community-based organization.

The clinic's gain in this respect, and therefore its ability to offer the 50 percent discounts in the appropriate cases, stems from the virtual elimination of bad debts, a major problem before the CPH, and the greatly increased number of patients it now attends to daily. Note that members' contributions are not used to offset the discount, which is absorbed by the clinic, that is, it does not operate as a classical insurance mechanism. To explain this more succinctly, if members or their dependents fall ill, they or their relatives must first obtain a referral slip from the leader of their community-based organization. This slip entitles patients to treatment at Jas Medical Services Clinic even if they have no means of paying the bill immediately. They will also not be asked for a deposit before being treated, which a nonmember is required to do. The patient has two weeks to pay after the treatment, and the leader of the community-based organization follows up to make sure payment is made.

Source: Nigerian case study.

The provider-owned schemes are less likely to be able to make a positive impact on the quality and efficiency of service delivery because of their lack of independent negotiating power in relation to the health care institution. Nevertheless, such organizations can gradually incorporate elements of autonomy and democratic accountability, as indeed has happened in some cases, and thus approach the high participation models described in the guidelines. Although one could also argue that a provider-owned scheme, with possibly greater control over quality than an independent MHO, may see improving the quality of its services as an effective marketing tool and therefore deliver better services, experience in WCA does not bear out this argument. The reasons are that the argument is predicated on assumptions that rarely pertain in the subregion:

competition between facilities is needed to compel providers to seek out more patients and revenue through competing on quality grounds, a condition limited to urban areas, and more significantly, it assumes that such insurance schemes are led by staff who have a decisive say in the management of the care facility or can otherwise influence the quality of care. In practice, as the West Gonja and Nkoranza schemes in Ghana show, this is rarely the case, because the schemes are often reduced to a department within the hospital managed by staff who are neither trained for that work nor senior enough in the facility's hierarchy. The last point illustrates another issue, namely, that different kinds of skills are required to run an insurance scheme than a provider facility, hence a purchaser-provider split could be beneficial in itself if it helps to make this point clearer.

MHOs can significantly affect the quality of care delivered to their members by using their purchasing and negotiating powers. In most cases, however, MHOs have been started around health facilities with a good reputation for quality in so far as waiting times, staff attitudes, and drug availability are concerned. In a few cases, MHOs in the study were negotiating such aspects of quality with their providers. However, in other crucial areas of care quality, the study provides no evidence that MHOs were addressing those aspects. For example, no MHO in the study appears to be checking the quality of care provided to its members (for instance, prescriptions) and the pricing of this care (where fee-for-service systems are in force), which may be due to a lack of the requisite skills. Obviously, provider-owned MHOs have less ability to exercise this potential power, while those that have organized participatory structures are most likely to have both the incentive and the means to realize this potential.

2.3.5 Access

Affording access to health care requires that MHOs' premiums are not excessive in relation to the incomes of their target groups, that incentives are given to enable members to include their dependents in the coverage, and that the form of the contribution (cash or kind) is adapted to the target groups' means.

Only two case study MHOs, the Education Volunteers (Senegal [1]) and Alafia (Benin [4]) expressly exclude family members from joining the scheme or benefiting from the services. Some MHOs automatically include the members' families among the beneficiaries without asking for extra payments, in which case their premiums may be considered as family subscriptions. Table 11 shows how different case study MHOs handle family coverage.

According to table 11, a majority, 14 MHOs provide automatic cover for the dependents or family of the titular member, while one other, Côte d'Ivoire [3], covers just the spouse of the member as well. This shows that the case study MHOs are responding positively to their responsibilities in terms of expanding access to health care to families. Moreover, as noted previously, this helps minimize adverse selection.

Another aspect of accessibility can be gleaned from the relationship between the level of contributions MHOs demand from their members and the average incomes of most of their target populations. As an example, estimates for the rural MHO Lalane Diassap (Thiès region, Senegal [3]) indicate that the average income of the peasants who belong to the MHO is around FCFA 15,000 per month. The MHO dues of FCFA 150 per person per month work out at FCFA 750 per month per family of five members (the average family size), or in other words, 5 percent of the family's monthly income (see the Senegalese case study). Similarly, with the West Gonja MHO, Ghana [1], which also operates in a rural community, the current annual premium of 44,000 (US\$1.78) for new members is estimated to be equivalent to 2.4 days of wages of a person earning the minimum wage (see the Ghanaian case study).⁴³

⁴³ The minimum wage is mainly relevant to those in paid employment, but in the absence of data on the imputed income of subsistence farmers, it is a reasonable proxy for the average wage of a poor farming community. Moreover, the scheme does include paid employees, partly because it lies in a tourist area.

| Table 11. Family and Dependent Coverage by Case Study MHOs | | | |
|--|---|--|--|
| <i>Families and dependents excluded from coverage</i> | <i>Automatic family and dependent coverage</i> | <i>Family and dependent coverage allowed for extra premiums</i> | |
| | | Premiums same as for titular member | Incentives to register family |
| 2 MHOs (10 percent): Education Volunteers (Senegal [1]) Alafia (Benin [4]) | 14 MHOs (67 percent): FAGGU (Senegal [2]) MUTEC (Mali [1]) Kolokani (Mali [2]) COWAN (Nigeria [1]) Lawanson CPH (Nigeria [2]) Jas CPH (Nigeria [3]) Ibughubu (Nigeria [4]) Teachers' Funds (Ghana [2]) Dagaaba Association (Ghana [3]) MUGRACE (Cote d'Ivoire [1]) CARD (Cote d'Ivoire [2]) AMIBA group [Cote d'Ivoire [3]) Les Intimes (Cote d'Ivoire [5]) MUGEFCI (Cote d'Ivoire [6]) | 2 MHOs (10 percent): Lalane Diassap (Senegal [3]) West Gonja (Ghana [1]) | 3 MHOs (14 ⁴⁴ percent): Sirarou and Sanson UCGMs (Benin [1, 2]) Ilera (Benin [3]) |
| Note: The AMIBA group (Côte d'Ivoire [3]) has automatic coverage for only a spouse, while the situation for MC36 (Côte d'Ivoire [4]) is not known. | | | |

More information about members' income profiles of members and about the average health expenditures of peer group non-MHO members is obviously required to be able to make any confident statement about the financial accessibility impact of MHOs; however, the contributions MHOs levy do not appear to be excessive in relation to their members' incomes.

One exception among the case studies argues against the above hypothesis: the Education Volunteers MHO (Senegal [1]) collects its contributions for four years in advance, and spread over only three months of the volunteers' allowances at the beginning, when they are being trained and are not even receiving their full pay.⁴⁵ Clearly this MHO, which excludes families from the coverage, is only able to extend access to the volunteers because its membership is compulsory and the dues are deducted from source.

One financial aspect reflected in the practice of some MHOs, especially in Senegal, is to institute a long period of dues payment at the initial stages without providing corresponding benefits to members to generate sufficient start-up funds. This can sometimes take as long as two years. In addition to its possible demoralizing effect, this practice also encourages the imposition of stiff conditions for new members who, not being among the founders, did not participate in building up this start-up fund. The need to build up start-up funds in this way therefore has a potentially adverse impact on access.

Given that a significant number of MHOs are operating in rural areas with target populations among those sections of the population that do not earn cash incomes, it is somewhat surprising that not a single

⁴⁴ Note: percentages do not add up to 100 due to rounding.

⁴⁵ The total contribution for the four years is FCFA 40,000, but the volunteers receive only FCFA 15,000 per month during the three months during which it is levied.

MHO reported that it would permit, let alone encourage, contributions in kind rather than in cash.⁴⁶ The significance of this depends, however, on whether the members have the power to decide on the preferred payment system or whether this has been imposed on them.

The only MHOs that achieved a penetration rate of 100 percent among the target population are, not surprisingly, two schemes that are based on compulsory membership: Education Volunteers and the Teachers' Funds (Ghana [2]). Two others that insist on compulsory membership, COWAN (Nigeria [1]) and Kolokani (Mali [2]), have not attained 100 percent penetration because their total membership does not cover the entire target group.

Another MHO (Lalane Diassap, Senegal [3]) achieved a high penetration rate of 82 percent, but this is largely due to the small size of the target group (1,200) and the close-knit character of the communities involved. Other MHOs for which information is available achieved well below 50 percent penetration, with the exception of the Dagaaba Association, a traditional ethnic type of MHO that has achieved close to 100 percent coverage, but which has an even smaller and more closely knit target population than Lalane Diassap.

While automatic family coverage is a key feature of the design of most MHOs in the study, the evidence on the level of dues collected in relation to members' incomes is inconclusive. The practice of building up start-up funds through a fairly long period of dues collection at the beginning without the provision of corresponding benefits may adversely affect access, not only by demoralizing the pioneers, but also by encouraging the imposition of stiff financial barriers for people who wish to join the MHO subsequently. None of the MHOs studied, even those in rural areas, accepts payment of dues in kind, but whether this reflects a genuine lack of choice by members or is indeed their preference is not clear. Nevertheless, on the whole contribution levels do not appear to be excessive in relation to incomes.

Only MHOs that mandate membership of the entire target group or those whose target group was small and close-knit managed to achieve high coverage of between 50 and 100 percent. All others had low rates of penetration of the target groups, but a significant number of MHOs in the study appear to be in their young, expanding phases, for instance, 9 of the 24 MHOs found in Senegal were at their formative stages. While ascertaining reasons for the low penetration rates requires further investigation, some major causes for appear to be related to inadequate marketing, the poor quality of services, the inability to afford the premiums, and so on.

Few MHOs bother to undertake surveys to establish precisely what services the target group requires before start-up and during development (to adapt these services to demand), and no consumer satisfaction surveys were reported (see Bennett, Creese, and Monasch 1998).

2.3.6 Sustainability

Many aspects of MHOs impinge directly or indirectly on their viability as institutions and as going concerns for their members.⁴⁷ These range from issues of training and leadership, to accountability and administrative skills and practices, to financial and managerial competence. In addition, some of the aspects already discussed, especially under efficiency, quality of care, and resource mobilization, are also relevant to sustainability.

⁴⁶ MHOs in some high inflation countries like the Democratic Republic of Congo are known to permit this form of contribution, for instance, the Bwamanda Scheme and the Mutuelle ASABO in Bokoro.

⁴⁷ The available data enable us to examine mainly the sustainability of the voluntary, democratic, and nonprofit insurance organizations, that is, the *mutuelles*, although some of the principles are adaptable to near-*mutuelles* as well. An exhaustive discussion of sustainability of the latter might have called for more parameters to be examined, for instance, for savings and credit organizations, rates of interest, loan recovery rates, and savings to credit ratios. However, as no MHO in the study considered credit for health care as an economic activity like other savings and credit systems, but more as an additional form of assistance to existing benefits, such an approach would not be entirely relevant here. More relevant is how they calculate the annual savings required to cover expected demand for such soft loans (in the COWAN case, the demand clearly exceeds the savings), how to protect the value of savings from erosion by inflation, and so on.

A good indicator of sustainability would have been the rate of failure of MHOs; however, in view of the youth of this phenomenon in the subregion, such an assessment would not be apt at this stage. However, looking at the design of the MHOs to assess their impact on viability is possible. For some older MHOs, series data from a number of studies are available that can be used to make a preliminary assessment of their viability.

For simplicity, the various issues involved here are grouped into the following three main areas:

- ▲ Institutional issues: billing, entering into contracts with providers, promoting accountability and participation, maintaining relations with supporting and promoting institutions, monitoring and evaluation
- ▲ Administrative and management capacity: training, setting premium rates and collecting premiums, determining the benefits package, marketing and communication, record keeping, accounting and bookkeeping, budgeting and management of funds, assessing the appropriateness of the care provided and its pricing (dealt with in section 2.3.4)
- ▲ Financial performance indicators: technical evaluation ratios and indicators such as liquidity ratio, solvability, ratio of administration costs to income, ratio of dues owed to dues paid.

Many of the MHOs studied provide a range of services and engage in diverse activities beyond the simple provision of health care benefits. Therefore, strictly speaking, the MHOs' sustainability will depend on all these activities and their relationships to each other, for example, a deficit in one area might adversely affect other activities. Similarly, their multidimensional nature directly affects some features of their viability, such as the possibility of hiring salaried or skilled personnel, having access to equipment and other resources, and motivating members. As the research focused on the MHOs health care services and features, these other important aspects were not investigated except tangentially, and the analysis here ignores them, yet it is worth keeping this broader perspective in mind.

2.3.6.1 Institutional Issues

The MHOs in the study that pay service benefits tend to be billed directly by health care providers for care given to the MHOs' beneficiaries, usually at the end of the month. The MHOs are then required to settle the bills directly, some immediately (West Gonja), others within a particular time (Education Volunteers, two weeks).

In this regard, the studies show an important distinction between community-owned MHOs and provider-owned MHOs. The community-owned South Borgou MHOs (Benin [1, 2]) regularly vet invoices submitted by the hospital to ensure that these correspond with the sick notes issued by the MHO to its beneficiaries for that period, and pay only the vetted amounts. This is not the case with the provider-owned West Gonja (Ghana [1]), where a vetting process does not exist, illustrating that the MHO's lack of independence from the provider results in an inability to represent the interests of its members effectively. The absence of a grace period within which the West Gonja MHO can pay its bills, something the two community-owned MHOs are entitled to, further reinforces this point.

Apart from the MHOs linked to St. Jean de Dieu Hospital in Senegal and the CPH schemes in Nigeria, experience with drawing up contracts with providers is little documented among the case study MHOs. The Senegalese examples have already been touched on several times. The CPH schemes in Nigeria are based on memoranda of understanding that constitute an agreement between the health care provider and the community associations that constitute the community partners' network. The memoranda spell out the duties and obligations of each partner, including defined and measurable health improvement targets to be

attained. A similar memorandum of understanding sets out the relationship between the CPH and the foreign development partner providing technical assistance.

Data from the inventory studies provide some information about contractual and similar relationships. The majority of the MHOs, 27 (60 percent) reported that they had no formal agreements with any health providers. 14 (31 percent) had some tariff agreement with providers, while 5 (11 percent) managed a health facility.

As concerns accountability and participation, most MHOs studied have fairly standardized organizational structures for involving members in decisionmaking and demanding accounting from their leaders. These generally involve an annual general assembly, composed of all members when the MHO is a small one in a single location, or delegates when the MHO is fairly large or dispersed across a large territory. The annual general assembly elects the board of directors or management committee, which in turn appoints the officers or executive bureau. This more or less describes the situation in 16 of the 22 case study MHOs. Among those that do not have representative bodies to involve members in management is the only example of low participation or of a simple community financing scheme among the cases, West Gonja, and the MUTECH Health Centre, which has no formally organized MHO of its actual users or beneficiaries.⁴⁸

Moreover, the formal structures and implied participatory character of the MHOs are not always the same as effective participation, because ordinary members may not have the knowledge and competence to grasp many of the technical issues under discussion; meetings may be poorly attended (for an example, see box 10); and unhealthy or undemocratic practices may be perpetuated by particular individuals in leadership positions who cannot easily be replaced, or even criticized.

Box 10. Participation, Evaluation, and Accounting in the Lalane Diassap MHO

The Lalane Diassap MHO enjoys a high penetration rate: 82 percent (989 beneficiaries out of a target population of 1,200 people). This attests to the effectiveness of the campaigns carried out to raise awareness and to the confidence its members have in the MHO.

This high rate of penetration is not an indicator of active participation by members in the life of the organization. The last general assembly had to be split into three sessions in an effort to mobilize the population. Thus a general assembly was held in each of the areas: Lalane, Diassap and Medina Fall. Those in charge complain of the members' lack of interest. The confidence (or lack thereof) placed in the leaders and the proper operation of the MHO seem to be the source of this disinterest.

In contrast, those in charge are fully invested in the management of the MHO. Office and administrative council members do not receive any payment for travel to meetings. However, this issue is under review, because of the risk that the administrators will become discouraged.

The contributions recovery rate of 60 percent still needs improvement, but is not bad for a rural MHO. The proximity of neighborhood delegates is essential for collecting contributions. If payments are more than three months late, the mutual members are not excluded, but are covered in proportion to how long they have contributed.

The MHO has no auditor. The leaders interpret this situation as a sign of confidence and good operation, but this view is unfounded. Control of the financial situation should be systematic and ongoing even in the absence of major problems. Transparency is even more important, because the members seem unconcerned about how their MHO is managed.

The documents following up on beneficiaries are up-to-date and show individuals' contribution payment status. The registry of hospitalizations is a valuable statistical tool, but is not being used optimally. In the area of accounting, transactions are recorded regularly, but no balance sheet is drawn up. The MHO lacks the resources for periodic evaluation; however, this is an essential activity.

Source: Senegalese case study.

⁴⁸ However, the parent organization of the center is the teachers' MHO, MUTECH, which has overall policymaking power over the center through its organizational structures. Reportedly, the principle of a general assembly of users of the health center has been approved.

Only one MHO, FAGGU (Senegal [2]), reported undertaking periodic internal monitoring and evaluation exercises. Donors have carried out external evaluations of some other MHOs, but this would not have a major impact unless the MHOs have the internal capacity and the incentives to appreciate the importance of evaluation. Regular monitoring is necessary if MHOs are to know whether they are achieving their targets or adhering to their procedures, so that if they are not, they can take remedial action. Periodic evaluation is a more comprehensive examination of MHOs' activities whose aim is to find out whether or they have met their objectives and to what extent. Analysis of the results of such evaluation can provide lessons that MHOs can use to improve the future running of their organization.

2.3.6.2 Administrative and Managerial Capacities

(a) Training

While a number of MHOs appear to have management who have benefited from training in general administration, the studies reveal a shortage of MHO-specific skills. About 10 of the case study MHOs have competently trained leaders, but this is mainly in general areas of administration and financial management like budgeting, record keeping, general accounting, and bookkeeping. In addition, since 1997 some MHOs in countries such as Benin, Burkina Faso, Mali, and Senegal have benefited from training sessions on the establishment, organization, and administration of MHOs conducted by the WSM-ANMC/ILO-ACOPAM joint program of technical support to MHOs in the subregion, while in Benin the CIDR fulfills this role with support from the Swiss Cooperation Agency. This kind of training highlights the crucial importance to MHOs of relationships with institutions that promote and support MHOs in the subregion. Such relationships have been important in transferring much needed skills to MHO leaders; however, the assisting institutions' resources are also limited, and if MHOs continue to grow, whether such bodies can continue to meet the demand for training is uncertain. In fact, whether support levels are adequate to meet current demand is debatable.

Conspicuously absent from the WSM-ANMC/ILO-ACOPAM program are MHOs in the English-speaking countries of the subregion. Nevertheless, the MHOs in the Anglophone countries are among those with the best trained managers, but except in a few cases like West Gonja (Ghana [1]), their training is not usually specifically related to MHO skills. Here too, the role of foreign development partners has been vital. The USAID's Basic Support for Institutionalizing Child Survival Project is a source of skills transfer and training for MHOs in Nigeria, and the Catholic Church and its overseas networks, including MEMISA in Holland and some German Christian NGOs have played a similar role in Ghana.

Training in some of the critical administration and management areas is lacking. For instance, setting contribution rates and determining benefits packages requires some knowledge of how to price the health risks of the community or target group, if these are to be done realistically and in such a way as to ensure the MHO's viability. As an example, the relative success of the South African and Zimbabwean medical aid societies is related in no small measure to their highly skilled management, who have been trained to price health risks (actuarial science) fairly reliably.⁴⁹ In the WCA subregion, MHO staff generally lack this kind of knowledge. In addition, MHO staff tend to lack the specific skills needed to check the appropriateness and quality of health care provided. This is generally because such skills are expensive, and given the tight budgets of all but the largest MHOs, they cannot afford to pay for them. Yet they will need such skills if they are to negotiate with providers as equals, or at least as informed purchasers.⁵⁰ Finally, the financial skills of

⁴⁹ By contrast, one of the researchers reported that even private health insurance companies in Nigeria have met financial disaster because they did not have a good grasp of such technical skills (see the Nigerian case studies).

⁵⁰ A cheaper alternative would be for MHOs to hire consultants to assess the quality and appropriateness of care. National associations of MHOs might be able to maintain a list of competent consultants that individual MHOs could engage as needed. In addition, the maintenance of such a list would foster competition among consultants on the basis of price and quality of their services.

MHO leaders probably need strengthening as far as the management of their funds is concerned, for example, awareness of alternative investment strategies to prevent their funds from losing value.

(b) Collecting Premiums and Setting Premium Rates

Analysis of the inventory study reveals that 42 of the MHOs (93 percent) collect their dues directly from members, 5 (11 percent) deduct their dues automatically from source (salary check-off), and 1 (Senegal [24]) is an organization of street children whose dues are paid for by individual child sponsors.⁵¹ Of the five MHOs that deduct dues directly from source, three of them also permit direct payment by individuals if they so choose.

The process many of the MHOs that involve insurance or subscription contributions use to set the level of contributions is not known, even where the precise level of coverage they are providing per member is known, as in the case of all the MHOs linked formally to St. Jean de Dieu Hospital in Thiès, Senegal, where the hospital charges a fixed rate per person per day of admission and the MHOs cover a maximum number of days. The MUTECH Health Centre (Mali [1]) has established two fee schedules for each case or category of care, one schedule for health center subscribers and another for nonsubscribers (user fee payers). However, it has three subscription rates for subscribers that correspond to the group the subscriber belongs to: MUTECH members pay FCFA 12,000, other workers in the fields of education and culture who are not MUTECH members pay FCFA 15,000, and all others pay FCFA 18,000. All subscribers pay the same FCFA 200 co-payment for a consultation.

Staff of the Kolokani MHO (Mali [2]) perform actuarial calculations based on the average number of hospital references per month, which they use to calculate expected costs and apportion costs to patients (see box 8). The West Gonja MHO (Ghana [1]) accepts that rate setting is an imperfect process, partly because of the lack of reliable data, and tries to get around this by allowing itself the flexibility to raise its fees in the course of the year if cost projections show that it is heading for a deficit.

In general, this vital process of contribution rate setting is an area that needs further investigation, because MHOs' viability depends on getting this right. Annex 4 presents a simple example of how to calculate the premium rate for a hypothetical MHO.

(c) Determining the Benefits Package

The fact that the largest number of MHOs offer benefits relating to major risks—37 offer only hospital admission benefits, while 15 others provide both PHC and higher-level benefits, including hospitalization—shows that most believe that such services are the most viable ones to offer, both financially and in terms of ease of administration, even if they are not the services most in demand.⁵²

In this connection, the novel and different approach adopted by the CPH mutuals in Nigeria [1, 2] is worth noting. Here, in consultation with the communities involved, the MHOs have established a list of the top 10 priority health problems or needs, and then concentrated the MHOs' interventions on providing affordable and good quality care in those identified priority areas with a view to improving community health status as a whole. Another significant feature is that the financing mechanism has avoided the use of insurance, but relies instead on third-party subscription fees with discounted fees. This, combined with collective membership through associations instead of individual membership, with the leaders of the associations acting as gatekeepers to PHC facilities, is meant to minimize moral hazard, which is always a danger with these kinds of benefits.

⁵¹ As previously noted, this example of MHO membership by sponsorship could serve as a model for how governments could subsidize the health care of the poorest by paying their premia.

⁵² Where services have been defined in consultation with the community, sometimes, as in Nigeria [1, 2], the services offered are not always related to major risks.

(d) Marketing and Communication

In the research, only 10 MHOs reported ever undertaking surveys to establish precisely what services the target group required before start-up. Marketing usually consists mainly of distributing leaflets and running campaigns to explain the scheme's principles and benefits. Similarly, they rarely, if ever, carried out user surveys to adapt the services to demand, and no consumer satisfaction surveys were reported.⁵³

(e) Managing MHOs' Funds

Some MHOs, Ghana [1], Nigeria [1, 2, 3], Senegal [1], invest their funds in deposit accounts to earn interest. In addition, at least one of them, Nigeria [2], also engages aggressively in other fund-raising activities with development partner and community support to earn extra income for its activities. Researching available alternative investments options for MHOs in each country to increase their capacity to hedge against inflation and other adversities would seem to be a worthwhile venture. This is especially relevant for MHOs that collect their contributions on a seasonal basis, for instance, after the harvest, when they would have large cash balances, or where illnesses covered exhibit seasonality, for example, malaria.

(f) Record Keeping

MHOs do not always appreciate the importance of accurate and up-to-date record-keeping, including accounting records.⁵⁴ The Education Volunteers MHO (Senegal [1]) is among the many that reported keeping records such as minutes of meetings regularly. In addition, this MHO has a computer, but does not use it optimally as a management information system (MIS) tool to maintain individual membership and benefits utilization records or as an aid to accounting.

Most of the MHOs keep manual records, which is not a problem in most cases, as the organizations are often small, and administrative simplicity is precisely one of the attractive features and comparative advantages of such organizations. However, more care and time are needed to keep manual records safe and up-to-date. The Lalane Diassap (Senegal [3]) MHO has found that lack of premises has contributed to poor record keeping. The MUTECH MHO (Mali [1]) keeps records of subscribers, but these are reportedly not up-to-date, which illustrates another fairly common problem: when people leave, do not renew, are transferred, or die, the records often do not reflect this, because the MHOs do not give much to such exercises or lack the time and resources for such work.⁵⁵

The largest MHO in the survey in terms of numbers, MUGEF-CI (Côte d'Ivoire [6]), kept poor records until 1994, when it undertook an exercise to update its records.

Even with a computerized MIS, the quality and reliability of the data are not guaranteed. The COWAN MHO (Nigeria [1]) has computerized records, but their quality is hard to assess. The West Gonja MHO (Ghana [1]), by contrast, has one of the best computer-based MISs of any MHO, which is reasonably up-to-date, but does not yet record every pertinent item of information.

(g) Accounting and Bookkeeping

The situation with accounting and bookkeeping is similar to that of record keeping. In particular, while a number of MHOs prepare periodic income and expenditure statements, which implies some level of bookkeeping, few appear able or willing to use the major tools of financial analysis, especially profit and loss accounts and balance sheets.

⁵³ The findings are similar to those found by Bennett, Creese, and Monasch (1998) in their worldwide survey of nonformal sector insurance schemes.

⁵⁴ A separate but related issue is whether management staff actually use accounting and other data, where available, for decisionmaking; an issue that only further inquiry will resolve.

⁵⁵ A much more likely explanation is that MHOs are simply not informed about family changes because the members forget to tell them; however, MHO leaders should be responsible for finding out such details from time to time, but many probably do not devote the required attention to this task.

Possible reasons for this state of affairs include a lack of knowledge of the requisite tools and of their utility to the MHO, including erroneous views that these are tools applicable only to commercial enterprises; the lack of interest on the part of leaders and members in ensuring that such tools are used systematically; the absence of accounting systems sufficiently adapted to MHO contexts; and perhaps even a deliberate lack of transparency by leaders. Such shortcomings can affect the organization's democratic accountability; make monitoring and evaluation impossible; limit the MHO's relations with third parties; and throw into question the usefulness of MHO legislation in such a context, unless, of course, the law seeks to ameliorate the situation by requiring, for example, deposition of audited accounts.

The periodic preparation of financial statements is vital if MHOs are to be in a position to assess their financial position and progress, and thus make future plans and projections. In addition, such tools are needed to judge the performance of MHOs in accordance with the technical evaluation tools developed in the context of the WSM-ANMC/ILO-ACOPAM MHO program.

2.3.6.3 Financial Performance Indicators

Enough data to enable an accurate assessment of MHOs' performance according to the financial evaluation criteria described earlier are available for only a few MHOs (Senegal [1, 2, 3], Mali [1], Ghana [1], Benin [1, 2]). Table 12 presents the available information calculated on the basis of data supplied from the case studies. The table shows that the ratios of dues to expenditures and of dues owed to dues paid of the MUTECH Health Centre are not healthy. The two results are related, because the low rate of dues collection in relation to spending is an outcome of the small uptake of the center's mutual health scheme by users, with the vast majority (80 percent) preferring the user fee system for reasons previously discussed.

| Table 12. Financial Performance Indicators | | | |
|--|---|--|---|
| MHO and year of data | Ratio of dues to expenditures | Ratio of dues owed to dues paid | Ratio of administrative costs to income |
| Education Volunteers (Senegal [1] 1997) | 1.9 | 0 (dues deducted from source) | 11% |
| FAGGU (Senegal [2] 1997) | 1997: 1.12 1996: approx. 1.52 | 1997: 59% owing dues 1996: approx. 75% | 20% (payments to bureau members) |
| Sirarou UCGM (Benin [1] 1995/96, 1996/97) | 1995/96: 1.54 1996/97: 1.10 | Not available | 1995/96: 22% 1996/97: 19% |
| Sanson UCGM (Benin [2] 1995/96, 1996/97) | 1995/96: 0.87 1996/97: 1.24 | Not available | 1995/96: 44% 1996/97: 25% |
| Lalane Diassap (Senegal [3] 1996) | 1996: 1.78 1997: 1.46 | 40% owed | Probably very small; no office and no remuneration to staff or officers |
| MUTECH Health Center (Mali [1] 1994, 1995, 1996) | 1994: 54.6% 1995: 35.4% 1996: 15.8% | Recovery of subscription payments only about 20% until 1996 | Not available |
| West Gonja (Ghana [1] 1996) | 0.85 | 0 (anyone not renewing is automatically dropped from membership) | 27% ¹ |
| Note: ¹ This is largely due to exceptional expenses arising from recruitment campaigns in bad terrain, because the MHO is in its initial expansion phase. | | | |

Besides the exceptional cases of Senegal [1] and Ghana [1], dues payment appears to be a severe problem. No dues are owing from members of Education Volunteers (Senegal [1]), because their dues are automatically deducted from source, while the zero default in the case of West Gonja (Ghana [1]) is

misleading, because the members of the scheme are defined simply as those who have paid their dues for the current year, and anybody not renewing is automatically dropped from membership.

The Benin MHOs appear to have generally favorable dues to expenditure ratios except for the Sanson MHO in 1995/96, but their administration costs to income ratios are considerably beyond the accepted safe limit (not more than 5 percent). However, this could be partly due to the youth of the MHOs and the associated high costs of campaigning, sensitization, and membership mobilization.

As concerns the dues arrears situation of the inventory MHOs, while 34 (79 percent) are owed dues, 9 (21 percent) do not have dues arrears. In other words, approximately four-fifths of inventory MHOs for which data was available reported dues arrears of varying lengths of time and amounts. This reinforces the analysis in the discussion on resource mobilization.

What all the MHOs do about noncompliance in dues payments is not known, but of those for which information is available, the methods range from doing nothing, giving a grace period of some months, or excluding people from membership immediately (this measure usually applies with annual payments). In the case of the Lalane Diassap, for instance, members are given three months before action is taken, and the eventual action consists of letting them enjoy benefits only to the level of their previous contributions (see box 10). In the West Gonja MHO any members who do not pay their annual premiums are immediately dropped from the scheme.

Box 11 describes a case of MHO self-sufficiency that might be instructive.

Box 11. The Teachers' Welfare Funds in Ghana: A Case of Self-Sufficiency

The Ghana National Association of Teachers is the professional association that embraces all teachers in the country. Teachers, who are all automatically members of the association, number more than 150,000 nationwide and are found in nearly every town, village, and hamlet.

The Teachers' Funds (Ghana [2]) are notable for being completely self-sufficient, even though their health insurance role, which mainly complements the free health care the state provides for teachers and their families, is not yet of much significance in the overall distribution of expenditure among various welfare purposes.

The Teachers' Welfare Funds were originally set up to help members in times of hardship or to help with certain social events for which financial assistance is needed, especially funerals of members or their close relatives. The funds are totally decentralized, so that each branch of the Ghana National Association of Teachers in a district runs its own welfare fund independent of the national association. This is the real source of the system's strength, because every district branch defines its own benefits package and levies contributions through collective decisionmaking of the local association branch to cover those benefits on a sustainable basis. There is no subsidy from the national association or anywhere else. Another source of strength is, of course, the fact that all the teachers are educated to some significant level and possess skills that not only facilitate genuine participation, but also good management.

Recently, the government has started to limit the total health care bill of public sector organizations, leading to caps on expenditure per person or family and exclusion of some health care services from the free coverage. This has increasingly led some teachers to draw upon their welfare funds to help them fill the gaps, or in some cases, to obtain better quality care than is obtainable at public facilities, to which free care is limited. The level of cash benefits for health care is usually small relative to those for other social needs. The amounts involved are small, but that is partly because of the government subsidization of teachers' health care.

At the Kintampo District in the Brong Ahafo region, estimates indicate that the fund has approximately 1,000 members, all the teachers in the district plus the staff of the association's district secretariat. On admission to a hospital or herbal clinic, members or defined family beneficiaries qualify for cash assistance from the welfare fund. The exact amount was being reviewed at the time of the research. The subscription fee for membership of the Kintampo District fund is 4500 (US\$0.22) per month, which is relatively small, and certainly affordable for all categories of teachers.

Source: Ghanaian case study.

Table 13, which shows utilization rates and mean costs per type of intervention for the two South Borgou MHOs (Benin [1, 2]), indicates clearly the kind of powerful management information that regular and adequate record keeping can yield. These kinds of data enable management to analyze and compare both utilization and mean costs at different facilities to determine if there are significant differences between them. If such differences exist, as in this case, the reasons must be analyzed, and if the analysis indicates evidence of inefficiencies, action can be taken to reduce or eliminate those inefficiencies.

In the case of the two MHOs depicted in table 13, the evolution of utilization rates and average costs differ markedly. For all interventions, utilization is significantly higher in Sanson than in Sirarou. Moreover, in Sanson, more than 90 percent of interventions take place at the communal health complex level, and resort to the reference hospital for care is relatively rare. Finally, note the much higher rate of deliveries covered by the Sanson MHO.

How should these trends be interpreted? The research revealed the following. The different rates of utilization at different levels partly reflect the fact that the reference hospital for the two MHOs is located at Sirarou, as well as the availability and adequacy of health care at the PHC facilities utilized by members of the MHOs. These differences are in turn translated into differences in mean costs of interventions. At the communal health complexes, the costs are not dramatically different. However, at the reference hospital level, the cost differences are large: the costs of hospitalization at the Sanson MHO were more than 2.2 times that in Sirarou in 1996/97 and more than 1.5 times as much in 1997/98. This is due mainly to the fact that the communal health complex at Sanson has facilities for hospitalization while the communal health complex at Sirarou does not. Therefore, members of the Sirarou MHO are much more likely to be admitted to hospital even for relatively minor, hence less expensive, conditions than members of the Sanson MHO. These differences in utilization of facilities at different levels in the referral chain also explain why the mean costs of interventions in Sirarou are double the means costs of intervention in Sanson. Thus one could argue that providing some first-level hospitalization facilities to the communal health complex at Sirarou would result in efficiency gains.

The difference in delivery rates covered by the two MHOs is similarly explained. At Sanson, women MHO members who need delivery services tend to use the communal health complex because the facilities are adequate, while at Sirarou, the communal health complex is staffed only by men and the MHO members use these facilities less often.

| Table 13: Sirarou and Sanson UCGMs: Utilization Rates and Costs of Intervention | | | | | | | | | | | | |
|--|-----------------------------|--------|---------|--------|---------|--------|---|--------|---------|--------|---------|--------|
| <i>Category</i> | <i>Utilization rate (‰)</i> | | | | | | <i>Mean cost of intervention (FCFA)</i> | | | | | |
| | 1995/96 | | 1996/97 | | 1997/98 | | 1995/96 | | 1996/97 | | 1997/98 | |
| | Sirarou | Sanson | Sirarou | Sanson | Sirarou | Sanson | Sirarou | Sanson | Sirarou | Sanson | Sirarou | Sanson |
| At communal health complex: | | | | | | | | | | | | |
| Delivery | 7.5 | 125.7 | 23.7 | 49.7 | 18.1 | 50.0 | 7,863 | 3,850 | 2,872 | 4,232 | 3,375 | 4,269 |
| Minor interventions | 3.8 | | 10.2 | 7.9 | 21.9 | 19.6 | 1,090 | | 1,860 | 2,375 | 1,969 | 2,773 |
| Hospitalization | | 70.7 | | 81.5 | | 125.0 | | 1,722 | | 1,423 | | 1,270 |
| Subtotal | 11.3 | 196.3 | 33.9 | 139.1 | 40.0 | 194.6 | 5,605 | 3,084 | 2,566 | 2,481 | 2,605 | 2,197 |
| At Reference Hospital: | | | | | | | | | | | | |
| Delivery | | | 8.7 | 4.0 | 8.7 | 1.8 | | | 9,532 | 9,050 | 7,112 | 8,800 |
| Minor interventions | | | 1,6 | | 2,4 | | | | 3,000 | | 5,000 | |
| Hospitalization | 52.6 | | 54.4 | 4.0 | 58.8 | 16.1 | 6,557 | | 8,990 | 20,200 | 9,051 | 14,050 |
| Subtotal | 52.6 | | 64.6 | 7.9 | 70.0 | 17.9 | 6,557 | | 8,916 | 14,625 | 8,669 | 13,525 |
| Total | 63.9 | 196.3 | 98.5 | 147.0 | 110.0 | 212.5 | 6,389 | 3,084 | 6,732 | 3,137 | 6,462 | 3,149 |
| Average number of beneficiaries | 266 | 127 | 1,268 | 503 | 2,872 | 560 | | | | | | |
| Source: Benin case study. | | | | | | | | | | | | |

2.3.6.4 Summary on the Sustainability of MHOs

While the MHOs possess some managerial and administrative skills, these are not usually the result of MHO-specific training. Major problems remain in the areas of institutional development and skills in handling MHO-specific tasks, such as setting premium rates, determining benefits packages, marketing and communication, using an MIS, determining the appropriateness of care provided and its pricing, contracting with providers, accounting and bookkeeping, monitoring and evaluation, and collecting dues. MHOs also need to consider appropriate investment strategies for their funds to protect them against erosion due to inflation. Accountability is a particularly serious problem with provider-owned schemes where no participatory structures of any kind exist.

Some specific conclusions are that few data are available on the financial aspects of MHOs generally, which could be an indication of sensitivity regarding the release of such information, inadequate or poor accounting practices, unreliability of the available data, or a combination of these. Where such data do exist, the clear indications are that financial performance is weak to moderate. Finally, financial sustainability is open to question in the cases where analysis is possible, and arguably more so where such data are not available.

2.3.7 Democratic Governance of the Health Sector

A number of MHOs are playing strong advocacy and consultative roles on behalf of their members within the health sector as a whole, and in their relations with health care providers in particular.

Representatives of the Sirarou UCGM (Benin [1]) have met with the management of the reference hospital it is linked to to discuss improving maternity services. The same MHO, together with the Sanson UCGM (Benin [2]), has also complained to the health authorities about the problems of parallel (black market) payments and unhelpful staff attitudes at health facilities.

COWAN (Nigeria [1]) is an NGO that not only owns its own clinics on whose management the members have representation, but that plays a strong advocacy role on PHC issues in the regions where it works. The CPH schemes in Nigeria are modeled to give the community a powerful voice in improving health care quality by direct contacts between community representatives and providers. Evidence indicates that the Ibughubu Union (Nigeria [4]) also plays a significant advocacy role in the health care system of its home village.

The sheer number and relatively rapid growth of MHOs in the Thiès region of Senegal gives them potential power to influence decisionmaking in the health sector of the region; however, concerted action through MHO coordinating bodies is only just beginning, and so this potential is still to be tapped.

The foregoing are examples of a function that never existed before, that of communities directly influencing the behavior of health care providers and contributing to the governance of the sector. It is without doubt one of the most important roles that such organizations can play in the health sectors of their countries, regions, or districts, with potentially significant benefits for all: patients, providers, authorities, and communities.

3. Conclusions, Implications, and Recommendations for Key Actors

This section will first present some general observations and conclusions relating to the value added by the research in nine WCA countries, and will then present some specific conclusions related to the six criteria selected for assessing the MHOs' contributions.⁵⁶ It will conclude by highlighting the study's implications for key actors.

3.1 General Observations and Conclusions

3.1.1 General Observations

- ▲ The study is the largest quantitative and qualitative analysis of its kind that involves this many countries in this subregion of Africa. It is also the first attempt to arrive at an indication of the number of MHOs in the sub-region. Nearly 70 initiatives were studied. The MHOs in general are relatively young and not fully developed.
- ▲ The study is also the first to examine both Francophone and Anglophone MHO experiences in the subregion in one study.
- ▲ The constraints and problems brought to light by the study permit identification of the elements favorable to and/or the prerequisites for MHO success.
- ▲ The study did not analyze different strategies for supporting and promoting MHOs, thus making definite conclusions in this regard is not possible; however, some tentative recommendations regarding general principles or guidelines will be provided.

3.1.2 General Conclusions

- ▲ The MHOs identified and investigated in this study are predominantly young, in most cases less than three years old, so this movement can be described as an emergent one.
- ▲ The legal and institutional environment for the development of the MHOs is characterized mainly by self-regulation, the presence of a number of promoting institutions, government interest in their potential, and some limitations related to lack of autonomy for local health facilities that could facilitate MHO development.
- ▲ The current impact of MHOs on financing, delivery, and access to health care in the subregion is relatively limited, due in part to the small number of MHOs and MHO members, although their potential is considerable.
- ▲ The study revealed that poor people with little or no savings can mobilize their small contributions to enable them all to obtain access to health care of acceptable quality.

⁵⁶ This section does not distinguish between *mutuelles* and *near-mutuelles*, but focuses on the former.

- ▲ The multiplicity of MHO experiences and the different dynamics highlighted show that there is no magic formula or particular mode of operation for the promotion of MHOs, although the basic principles of health insurance design and sound management are broadly applicable.
- ▲ Any overall evaluations of MHOs should take into account the breadth of problems they attempt to address. Many MHOs are formed to provide a multitude of services to their members as part of a diverse strategy of the struggle against poverty. They are an instrument of social protection for people who are not beneficiaries of current (official) regimes of social security. Alternatively, they may complement such existing regimes.

3.2 Specific Conclusions Relating to Criteria of Assessment

3.2.1 Contribution to Resource Mobilization

As already noted, the main conclusion drawn with respect to resource mobilization is that current MHO contributions in this area are limited, but the potential for expansion may be substantial if the current contribution reflects the following factors: low levels of dues collection; possibly low subscription rates; low levels of membership or penetration of target groups related, among other things, to inadequacies in MHO design; inadequate marketing; collection of contributions not synchronized with income earning periods; and so on. Also, individuals are likely making substantial payments already through parallel payments for health care at public health facilities, user fees, payments to traditional healers, and payments for drugs. If the design, and perhaps other aspects, of the MHOs were improved to address most of the above factors, then presumably more of these payments could be channeled through MHOs.

3.2.2 Contribution to Efficiency

MHOs seem to have the potential to influence efficiency in the health sector significantly using a range of design tools and mechanisms that are available, but are not yet universally practiced. Some of the MHOs practice some measures to promote efficiency, although no MHO was implementing all the desired measures in its design. The main conclusions from the study were as follows:

- ▲ A number of design features and practices that are favorable to scheme success include waiting periods for new members; social control to avoid abuses; co-payments or ceilings on the amounts of coverage; and some level of obligatory membership at the family, association, or target group level, which ensures that membership is extended beyond just those who wish to join voluntarily.
- ▲ The MHOs generally lack the negotiating power and managerial skills to opt for the most efficient provider payment mechanisms, and in many cases there is not enough choice of providers to afford the possibility of bargaining.
- ▲ The MHOs could make a greater contribution to the allocational efficiency of the health sector by encouraging greater use of preventive and promotive services, combined with mandatory reference as a condition of access to their benefits.

3.2.3 Contribution to Equity

WCA MHOs enable those in the informal and rural sectors who otherwise benefit little from state-provided or subsidized health care to receive better access to health services than they would otherwise. However, within their target groups, MHOs' equity contribution is characterized by the same features that Bennett Creese, and Monasch (1998) found in their study, namely:

- ▲ They generally apply flat rate premiums, not sliding scale ones. However, this study argues that despite their regressivity, the difficulty of implementing sliding fee scales in rural and informal sector settings weighs in favor of such flat fee systems as the most efficient basis for setting dues, even if it is not the most equitable approach.
- ▲ They rarely allow exemptions for the very poor. This study maintains that the provision of health care for the very poor is more correctly viewed as a legitimate area for public policy, not MHO interventions. Moreover, by helping a portion of the population to pay for and obtain access to acceptable health care, MHOs enable the public sector to target its resources toward the truly needy.
- ▲ They do not provide for payments in kind, even in rural areas. While this is factually correct, presumably in those organizations that are democratically accountable, the members may, if they wish, opt for payment in kind.

3.2.4 Contribution to Quality Improvement

MHOs tend to be set up around a provider that offers care of acceptable quality to the MHOs' members. This quality is usually measured in terms of waiting times, staff behavior toward patients, and drug availability. The existence of good quality services is necessary for achieving better penetration of target groups, because few people would be prepared to subscribe to an MHO for health care benefits of unacceptable quality.

As concerns other criteria of the quality of care, such as the quality of prescriptions and treatments given to members, there is no evidence that MHOs in WCA currently have any impact, despite their considerable potential. Those MHOs that use service benefit payment systems enter into negotiations with providers on tariffs, but few are able to use their position as organized purchasers to negotiate on the quality of care delivered to their members. This is an indication of the relative weakness of many of these organizations, which is again perhaps related in part to their youth and small numbers. MHOs in the study also do not carry out checks on the appropriateness of care provided to members and its pricing. The reasons for the lack of negotiating power also apply here, although another important factor in this connection is the lack of appropriate skills.

Where services of good quality do not exist, MHOs may be able to help improve the quality of existing services, for instance, through making budgetary planning of health facilities easier or holding discussions with the providers as in South Borgou in Benin, or even through creating such services if other avenues for obtaining quality care are not feasible. In the latter case, which requires MHOs to consider establishing their own provider facility, maintaining separation of purchaser and provider such that the management of the two activities is kept separate would help meet efficiency objectives.

3.2.5 Contribution to Health Care Access

Only those MHOs that mandate membership of the entire target group, or those whose target group was extremely small and close-knit, managed to achieve high coverage (between 50 and 100 percent). All others had low rates of penetration of the target groups. The major causes for this appear to be related to the inadequacy of their marketing, the low quality of services, the newness of the health insurance concept in many cases, and the natural tendency of many people compelled in current economic circumstances to choose between current priorities and the risk of illness in the future to attend to their most pressing needs first.

Few MHOs ever undertake surveys to establish precisely what services the target group requires before start-up, and their marketing consists mainly of leaflets and campaigns to explain the principles and benefits of the scheme. In addition, few carried out user surveys during development to adapt these services to demand, and none reported carrying out consumer satisfaction surveys.

No MHO, even in the rural areas, allowed contributions in kind, though contribution levels appear on the whole to be reasonable in relation to incomes

3.2.6 Contribution to Sustainability

Because of the MHOs' youth and the fact that the study investigated only the health care benefits of these organizations, the findings and conclusions on sustainability need to be viewed with caution. That said, however, the investigation was still important in ascertaining some of the practices and features of MHOs that either do or do not promote their sustainability. The actual impact of these on the MHOs and the possibility of redressing constraints or shortcomings will depend ultimately on the totality of services offered by the MHOs and additional implementation experience.

While the MHOs possess some managerial and administrative skills, these are not usually the result of MHO-specific training. Nevertheless, major problems remain in the areas of institutional development and skills in handling MHO-specific tasks, such as setting premium rates, determining benefits packages, marketing and communication, using an MIS, determining the appropriateness of care provided and its pricing, contracting with providers, accounting and bookkeeping, monitoring and evaluation, and collecting dues. MHOs also need to consider appropriate investment strategies for their funds to protect them against erosion due to inflation. Accountability is a particularly serious problem with provider-owned schemes where no participatory structures of any kind exist.

3.2.7 Contribution to Democratic Governance of the Health Sector

The role a few MHOs play in contributing to democratic governance of the sector is a function that rarely or never existed before, namely, that of communities directly influencing the behavior of health care providers and authorities. It is one of the most important new benefits that such organizations can bring to the health sectors of their countries, regions, or districts, in that it helps make providers and decisionmakers more responsive to community views and needs.

3.3 Implications and Recommendations

This section highlights the implications of the study's findings for different actors involved in the promotion, organization, and development of MHOs, as well as for contractual and other partners of the MHOs. For the actors involved directly as partners in the realization of this study, the last part of this section offers specific recommendations.

3.3.1 MHOs

Although the objectives of the study precluded a detailed analysis of the social movement dynamics of the MHOs, this aspect is also important. As products of the recent democratization and flowering of civic organizations in Africa, MHOs make an important and diverse contribution to social life and civic society in their countries, and attention should be drawn to the need to constantly reinforce those contributions. In the case of provider-owned MHOs, for instance, this implies creating structures of participation by and accountability to the community in a systematic way through such means as co-management.

The other main points that stand out from the study and that the leaders and managers of MHOs may find useful are the following:

- ▲ The design features that tend to favor scheme success include robust, built-in risk management techniques, such as
 - △ Using mandatory reference (a gatekeeper system) for members seeking health care at secondary or higher levels, which minimizes moral hazard and encourages efficiency in the health sector.
 - △ Requiring compulsory participation where this is feasible to eliminate the serious danger of adverse selection.
 - △ Basing MHO membership not on individuals, but on existing associations or groupings with a tradition of solidarity to enhance the likelihood of scheme success where compulsory participation is not feasible or is unacceptable on other grounds.
 - △ Making the family rather than the individual the unit of membership where membership is entirely voluntary.
 - △ Imposing a waiting period whose duration is proportional to the risk involved for new members, especially in those schemes where new registrations take place year round.
 - △ Incorporating essential and generic drug policies into their agreements with providers in those MHOs whose benefits packages include the costs of drugs and enforcing the prescription of these as a condition for paying providers' invoices as a way to contain costs.
 - △ Using the capitation payment system. The provider payment mechanism is one of the most important tools available to MHOs both to contain costs and to promote efficiency in the health sector, and where the choice of good quality providers exists, the capitation payment system probably offers the best chance of doing this. However, even with fee-for-service arrangements, MHOs can negotiate modifications that reduce providers' incentives to drive up costs. In the long term, MHOs need to invest in learning some managed care techniques, for example, utilization review, drug formularies, retrospective review, and audits, to contain costs without sacrificing quality.
 - △ Structuring the benefits package to include or promote the use of preventive and promotive services to reduce costs and improve health sector efficiency.
- ▲ The MHOs should consider involving first-line health care staff in their organizations to reinforce or improve the accountability of providers to the community.
- ▲ The MHOs cannot contribute to quality improvement in the health sector if they do not have direct contacts with providers, especially through the payment mechanism. The service benefit payment arrangements provide the best way to influence provider behavior, and therefore the

quality of care. However, the MHOs need to include specific quality standards, for example, standards related to waiting times or staff attitudes toward patients, in their negotiations with providers, rather than confining these discussions merely to the tariffs as is the prevalent situation.

- ▲ The study found that hardly any MHO in the subregion was able to monitor the quality and appropriateness of care delivered to its members. MHOs need to develop such capacity to enhance their ability to best serve their members' interests, as well as to contribute to efficiency and to lowering of costs in health care. Only appropriately qualified medical and pharmaceutical staff can carry out such monitoring properly and discuss such issues with providers.
- ▲ The generally low rate of penetration of target groups by MHOs in the subregion is a possible cause for concern and needs further investigation to determine its causes and to seek ways to improve coverage rates. A design issue that may have some relevance here is inadequate marketing: MHOs rarely carry out user surveys to find out what beneficiaries would like before the schemes are implemented. Thus benefits packages are frequently designed without prior consultation and then "sold" or explained to the target groups.
- ▲ The analysis of the sustainability of the MHOs in the subregion shows that they need to strengthen their institutional, administrative, and managerial capacities with training; to increase accountability; to carry out regular monitoring and evaluation; to upgrade their skills in setting premium rates, costing, and determining benefits packages; to make contracts with providers; to manage their funds; and to use better accounting systems.
- ▲ The MHOs need to consider effective strategies for investing their funds to prevent them from losing value in situations of high inflation.
- ▲ The MHOs should enhance their democratic participation and accountability aspects by means of, for instance, holding regular annual general assembly meetings, which, among other things, would strengthen their negotiating powers and enable them to contribute to the democratic governance of the health sector.
- ▲ The maintenance of independence from health care providers or of a purchaser-provider split even where the MHO owns its own health facilities and the development of contractual relationships with providers can be important tools MHOs can employ to influence the quality of care and enhance health sector efficiency (see Toonen 1995 for an example from Latin America).
- ▲ The MHOs need to develop regular dialogue with their members and ensure transparency in their management, for instance, by using nontechnical language in documents and reports to meetings so that all members can understand and participate in discussions and by submitting regular and accurate financial reports.
- ▲ The MHOs need to develop contacts with other MHOs (as is beginning to happen in the Thiès region of Senegal) to share and exchange experiences and to develop levels of representation and dialogue that could improve their negotiating powers.
- ▲ The MHOs also need to improve their bookkeeping practices, maintain sound and reliable accounting systems, and analyze their financial position regularly using the tools of accounting appropriate for this type of organization.

3.3.2 Promoters

Promoters may be technical support institutions, other social movements, external cooperation agencies, governments, providers, or existing collectives of MHOs in a given area. Therefore, the points that are relevant to each particular promoter may be found under the recommendation for other actors in this subsection. That said, all the suggestions for the attention of the MHOs themselves are relevant for all their promoters too, who need to be aware of good and bad design features if their interventions are to be productive. Other recommendations for promoters are the following:

- ▲ The issues pertaining to the sustainability of MHOs will require particular attention by promoters, first, because their attainment may be largely outside the control of many MHOs without external assistance, and second, because they are prerequisites of long-term success that will equip MHOs to tackle all the preceding points. Promoters therefore need to focus much of their efforts not just in helping set up MHOs, but in equipping them with the kinds of skills listed above.
- ▲ The promoters should see the process of capacity building as a broad one that should include university courses on health economics, introduction to health care financing for health care professionals, and higher training programs at home or abroad in public health and health care financing.
- ▲ The promoters should pay particular attention to developing the democratic participation aspects of MHOs and their contribution to the development of civic society and to good governance of the health sector.
- ▲ The promoters should include hospitals at the district level, savings and credit schemes, and existing associations (unions, cooperatives, farmers' groups, and so on) as target groups for their work in connection with MHOs.
- ▲ The promoters should employ a truly participative approach to enable MHOs to take responsibility from the start, with special emphasis on organizational aspects. It is better for MHOs to acquire the capacity to resolve their own problems than for others to resolve their problems for them.
- ▲ The methodological framework for promoting MHOs on the whole still needs to be developed and disseminated. More action-oriented research, capitalization of existing experiences, and dissemination are needed. Promoters therefore need to exchange and coordinate experiences and information more, for instance, with other promoters, to analyze their practices and approaches.
- ▲ The promotion of MHOs, to be truly effective, cannot be limited simply to the promotion of the MHO institutions themselves, but must also encompass an active interest in the supply of health care, that is, promoters should also promote quality health care through interaction with providers.

3.3.3 Health Care Providers

Providers need to understand that dealing with MHOs, which are autonomous and juridical entities, requires some new skills and behavior on their part. The following recommendations assume providers at least at the level of a district hospital. They are not meant as absolute requirements for setting up MHOs, but as features that would be desirable to aim at in the course of time to facilitate the continued development of MHOs. Practically all providers can achieve the first two without much investment. The rest are more

difficult to attain given current constraints and conditions in WCA; however, they provide guidelines for those, especially decisionmakers in health, who wish to optimize their support for MHOs.

- ▲ Providers can facilitate the development of MHOs or retard it, depending on the disposition of the providers' management toward them. Providers' staff may, in some cases, need some basic orientation or sensitization on relations with MHOs.
- ▲ Providers with more forward-looking management staff could encourage regular and formal contacts with MHOs as one way to improve the quality and efficiency of their service delivery. In addition, holding regular consultations with MHOs is a way to gather useful views about the community's opinion of the services and how they might be improved to the community's and the provider's mutual benefit.
- ▲ Providers need to learn to enter into contracts with MHOs. Of course, this assumes that a provider is also a legal entity entitled to enter freely into contracts or can be accorded this power.
- ▲ Providers need marketing skills to be able to assess consumer satisfaction and provide the kinds of services their users require.
- ▲ Providers should consider adopting quality assurance principles, which could form part of their contracts with MHOs.
- ▲ Providers need to know how to price their services realistically and how to offer discounts to MHOs and similarly organized purchaser groups. In the same vein, providers need to be equipped with the skills to negotiate with informed purchaser groups about alternative payment mechanisms, including capitation, fee-for-service, case payment or fee per episode, and budget payments.
- ▲ Providers who have management autonomy, including maximum control over their own budgets and fee retention, will be the ones able to handle relationships with MHOs most satisfactorily and to benefit most from the development of the MHOs in their catchment area. However, the quality and efficiency aims of MHOs may well be the opposite of those of providers.

3.3.4 Governments, Including Ministries of Health

Governments can assist the institutional development of MHOs, in the following ways:

- ▲ Governments can develop and put in place a clear policy framework that recognizes the complementary role of MHOs in attaining national health policy goals, including appropriate legislation where necessary. The lesson of this study is, however, that the legislative process must respond to the concrete needs of the MHOs and not government fiat. It is possible to envisage circumstances where such legislation may not be helpful to MHOs, and so the best way to proceed is to allow MHOs and their promoters to play a consultative role in the design of the legislation, and before that, in articulating the need for it. This does not mean that governments have to be passive. They can play a pro-active role by initiating the consultation process designed to elicit the MHOs' views on the need for, and the possible shape and form of, appropriate legislation.
- ▲ MHOs can exist and function without necessarily obtaining legal recognition, at least in some countries, as the study demonstrated. Where governments believe that legislation is needed,

however, such legislation should give legal recognition and corporate status to MHOs, set operational guidelines for schemes, and promote accountability. The latter can be accomplished by, for instance, requiring external audits of MHOs' accounts and making available, where needed, neutral, outside facilitators to conduct orderly, free, and fair elections at MHO assemblies. The latter functions might be better organized through national or regional associations of MHOs themselves, so long as there are sufficient numbers of MHOs to make this feasible. This might also have the added advantage not only of reinforcing MHO autonomy, but also of providing a useful forum through which MHOs could provide other MHOs with technical assistance and training, possibly with the assistance of partners. It is important that governments not interfere directly in the management of MHOs.

- ▲ Ministries of health should consider the likely impact of health sector reform policies on the MHOs before these are implemented. In particular, reforms that would facilitate MHO success include strengthening the institutional and managerial capacities of local health facilities as an essential part of a package of granting autonomy to these institutions. Half-hearted reforms, or reforms that are not backed by the resources required to implement them successfully, will not contribute meaningfully to such success. The areas in which health care institutions need to improve their capacities have been highlighted in the list of recommendations for health care providers. The interests of MHOs in health sector reforms will only be guaranteed if the MHOs themselves are associated in the design of, or at least consulted on, the reforms.
- ▲ Governments should encourage, and where necessary, authorize providers to adopt quality assurance principles. This could be combined with an accreditation system whereby the ministry of health, in line with its new supervisory role in the era of decentralization, inspects facilities and grants or refuses them accreditation to supply services to MHOs and others in accordance with certain quality standards.
- ▲ Health facilities in some countries need to be better integrated to give them the incentives and ability to enforce referral mechanisms, so that patients enter the health care system at the most appropriate and cost-effective level. Hospitals are thereby relieved of much of the pressure of handling those that could be equally well treated at lower levels. Patient behavior could be altered by a system of fee waivers for patients who are properly referred, together with suitable charges to nonreferred patients to reflect the costs of by-passing the referral system, but this would not necessarily alter provider behavior. For providers, the government could use its subventions to them in a similar manner to encourage those that work with lower-level health facilities to operate effective referral systems while penalizing those that do not.
- ▲ Governments can also encourage the role of MHOs in making providers, especially those in the public sector, more quality- and cost-conscious and more efficient. They can do this by encouraging MHOs to cooperate in larger purchasing bodies, such as national and regional associations, and by encouraging providers to consult regularly with such bodies in setting prices and defining quality standards.
- ▲ MHOs could be strengthened in their purchasing role if the government were to subsidize the care of the very poor by paying the schemes to enroll them (as Bennett, Creese, and Monasch 1998 suggest). At the same time, this might be a more effective way to achieve government equity objectives than existing exemption mechanisms for the poor, which may be widely abused or difficult to implement effectively.
- ▲ Some governments in the subregion, notably in Ghana and Nigeria, are actively considering, if not starting to implement, the phasing in of national health insurance schemes. The proposal in each case is to cover the formal sector first, then other groups in the informal and rural sectors.

An obvious question in this context is to ask what role, if any, MHO schemes can play in such a scenario. The answer is perhaps suggested by the concept of phasing, and the duration of the first phase could be long, given the immense obstacles to extending national insurance to informal and rural groups. Indeed, the Ghanaian government has explicitly realized this by inviting development partners to help promote MHOs in rural districts even as the national insurance scheme is taking off in the formal sector. MHOs can be viewed as a transitional arrangement to the national health insurance scheme in the sectors that will not be provided for under the initial phase of the state scheme. Moreover, the comparative advantage of MHOs in covering such groups, especially in collecting contributions and checking identities, may be such that an eventual national health insurance scheme for those sectors will be built on the MHOs, similar to the situation in most of continental, Western Europe.⁵⁷ In this view, MHOs need not disappear when national health insurance takes effect.

- ▲ Governments have an overall role of complementing MHO contributions to the health sector by looking at their global impacts, for instance, on equity between rich and poor regions. MHOs are unlikely to do much to bridge such gaps, and may actually reinforce such divisions unless governments consider how to assist resource-poor and deprived regions or districts to ensure they are not left behind, for instance, by providing them with more and better health facilities. In the long term, and especially where MHOs are likely to develop into a major prop of the health care system, this may require such measures as cross-subsidization or risk equalization funds to help redress imbalances. In South Africa, where MHOs are a major force in the health care system, the Ministry of Health has initiated a discussion aimed at finding a way to reinforce equity within the schemes, and one of the options being considered is to set up a risk equalization fund.⁵⁸
- ▲ Governments might also consider extending fiscal advantages—such as tax exemptions, customs exemptions, or value added tax exemptions—currently available for NGOs in many countries to MHOs, provided they operate on a nonprofit basis.
- ▲ Governments' main role is to create a favorable overall context. This includes ensuring freedom of association, guaranteeing good quality of health care services, building a climate of security and trust, ensuring reliability of the banking system, and achieving an environment of sustained economic growth.

3.3.5 Cooperating Agencies and External Technical Support Institutions

Consultation and dialogue between different agencies in each country and/or in the subregion could help avoid unnecessary duplication, facilitate efficient and rational use of resources, and maximize the impact on MHO development by capitalizing on each agency's area of comparative advantage. Strengthening the managerial and institutional capacities of MHOs is probably the most cost-effective intervention that can be made. Most of the other problems of MHOs can be traced to this major shortcoming. Of course, if MHOs were to compete for members, this too might lead them to become more efficient, transparent, and beneficial to their members, but this requires putting adequate mechanisms in place to prevent cherry-picking, such as establishing risk equalization funds and requiring them to accept all those who wish to join. The specific

⁵⁷ In France the *mutuelles* offer complementary insurance for services not covered under the social security regime; in Germany the sickness funds (*krankenkassen*) are the official carriers of statutory health insurance in that they manage the officially mandated welfare benefits to their members; and in Belgium both systems are present, that is, the *mutuelles* both manage the officially mandated benefits and provide complementary insurance for services not covered under the social regime. For more about the social insurance systems of European countries see Glaser (1991).

⁵⁸ Such a fund would seek to eliminate cream-skimming and the advantages of positive risk selection (enrollment of healthier people less likely to require services and incur costs) by equalizing risks between schemes, that is, all schemes would contribute a percentage of their earnings into a fund, which would be used to compensate schemes that have a disproportionately adverse risk mix.

requirements in terms of managerial and institutional support that could be the focus of training and other interventions are as follows:

- ▲ Setting up adequate and practical MISs, and eventually specific health MISs
- ▲ Carrying out monitoring and evaluation activities
- ▲ Setting premiums
- ▲ Determining benefits packages
- ▲ Marketing and communication
- ▲ Managing funds
- ▲ Choosing and negotiating the most efficient provider payment mechanisms
- ▲ Assessing the appropriateness of care provided and its pricing
- ▲ Using managed care principles to rationalize the utilization of benefits and provider behavior.
- ▲ Ensuring that MHOs are capable of absorbing the new capacities provided in training sessions that are often removed from their own daily reality.

This is a crucial area of institutional development that often does not receive much attention in support work. Support agencies must recognize the distinction between equipping individuals with new skills and translating those new skills into productive work within the organizational setting. Particular attention needs to be devoted to the other interventions required to achieve this, and this may require specific investigation, as the current research did not touch on this area. As an example, a GTZ study of its projects in Latin America showed that the informal organizational rules and procedures that arise in the course of time were frequently more important in project success than the formal rules and procedures agreed on with donors during the design stage. The point is that support agencies must go beyond the easy assumption that training is lacking to more fundamental issues like: What is currently impeding success or better performance? What can be done with current skills and resources to raise performance and enhance success? What factors are preventing this from happening? How would training remove these factors or help do so? What complementary steps are required to enable the organization to optimize the use of the new skills?⁵⁹

In their role as promoters, the cooperation agencies and technical support institutions should consider the following additional points, which are also applicable to other promoters:

- ▲ The MHOs that are most successful financially are those that manage to mandate membership of the entire target group. When this is not practically enforceable, the study shows that other innovations can help achieve the same effect, for example, membership through other existing solidarity-based associations and groups. This could mean a whole village, for instance.
- ▲ The savings and credit cooperative movement is quite strong in many African countries, especially the Anglophone countries. However, this movement is so far conspicuous by its absence from the MHO promotion scene (unlike the history of the mutual movement in Europe). Promoters should consider how to encourage this movement to participate in MHO promotion and development, as the natural basis for setting up MHOs in an area, for instance. Other groups that could be involved in such promotion include the mutual credit and savings

⁵⁹ These questions are not specific to MHO training, but to any kind of training; however, stating them here is useful, because the potential users of the study span a wide range of people and organizations, some of whom might benefit from such restatement.

organizations, women's groups, trade unions, and self-help groups.

- ▲ The technical assistance of their partners may be needed for many of the recommendations identified for governments and providers. These include developing quality assurance standards and accreditation systems for provider institutions and reinforcing the managerial competence of providers and government agencies so that they can play their role in MHO promotion and support competently. The cooperation agencies should consider how they can best work with governments and providers to help bring about this favorable climate for MHO development.

3.4 Possible Issues for Further Investigation⁶⁰

The study did not touch on or discuss at length a number of interesting issues that could usefully be explored in other contexts and studies as a way of adding value to this work. Some suggestions for further investigation follow:

- ▲ What roles could MHOs play in the wider development of the health systems of WCA countries? The issues here include the ideal financing and financial risk-sharing arrangements in the event of the development of social health insurance schemes.
- ▲ Could MHOs serve as an intermediate step toward local, decentralized purchasing of services, such as what district health offices could eventually do through commissioning or contracting for services from all possible providers?
- ▲ What modifications, if any, would MHOs have to undergo to be able to play a role in a reform process for the whole health system?
- ▲ Could MHOs provide lessons for the rest of the system, for example, from their provider payment methods, their contractual relations with providers, and their methods of checking health care quality and prices?
- ▲ Is there any role for competition among MHOs for members? If so, what would the advantages and disadvantages be, what changes would be required to prevent cherry-picking (for instance, risk equalization mechanisms), and how feasible would these be?
- ▲ How could the development of MHOs in the subregion be further enhanced by improving their institutional and financial environment, for example, by setting up re-assurance mechanisms and elaborating monitoring and evaluation tools?

⁶⁰ I am grateful to Dr. Marty Makinen of Abt Associates Inc. (PHR Project) for these stimulating suggestions.

Annexes

Annex 1: Summary of Methodological Guidelines for Research on MHOs in West and Central Africa

| MHO Typology Matrix | | | |
|--|--|---|---|
| Type of MHO | Socio-professional base or criteria of membership | Size or Scale (membership): (small = <100; medium = 100s; large = 1000s and above) | Extent of participation by members (management, meetings & elections) |
| 1. Traditional (clan or ethnic-based social network) type | usually based around members of an ethnic group or clan, not inclusive | usually small to medium | usually very high |
| 2. Inclusive mutual health social movement or association type | can be community, professional, enterprise or social movement (e.g. trade union) based | small to large | usually high |
| 3. Community financing (or provider-managed) insurance scheme | usually around a community (catchment area of a district hospital or health center) | medium to large | very low or nil |
| 4. Co-managed (provider+community) mutual health scheme | as above for 'simple' model; but community concerned manages first level (health center) facility | large | high |
| 5. Medical Aid Societies | can be community, professional, enterprise or social movement (e.g. trade union) based - or a combination of all these | large to very large | usually low but union based ones may have reasonable level of participation |

There are some further characteristics of these types that are worth noting:

Traditional (clan or ethnic-based social network) type: The definition of the target group is very narrow (clan or ethnic), but the level of solidarity within this target group is very strong. Equity also tends to be a relatively low priority.

Inclusive mutual movement or association: These are associations or groups (community- or enterprise-based) that are organized as social movements. They are either voluntary associations of individuals coming together to advance their common interests (health or other), or are formed by existing social movements (e.g. trade union, teachers' or other professional association, etc.) to pursue similar aims for members. It is this form of organization that most closely fulfills the criteria described in the above definition of MHO. It should be noted that some trade union-based MHOs may insist on obligatory membership as a means of avoiding adverse selection.

The *community financing health insurance* type of scheme derives from the Bamako Initiative, and is usually organized by a health care provider as an insurance scheme to improve its cost recovery position and to extend health care access to more people in the provider's catchment area. This type is becoming more and more frequent.

In the *co-managed (provider+community) mutual health scheme*, the community takes charge of managing at least the first level of health care (health centers) through participatory structures. This brings the community and the health care provider together in a joint partnership to develop, manage and maintain health facilities and to attain the community's health goals.

Medical aid societies are seen mainly in Zimbabwe and South Africa. They are usually big-scale, formal health insurance organizations run by professional staff and frequently (though by no means always) with strong commercial features (such as profit-seeking behavior, incentives for the lower risk categories and/or powerful disincentives to discourage intensive use of health facilities). They are not, however, part of the private commercial health insurance sector, and many operate on principles similar to the mutual aid schemes as defined above (e.g. they have community-rated premia and other features tending to promote a community approach to solving health care problems). Though this type of MHO is not likely to be encountered in Western and Central Africa (the focus of the fieldwork), the analysis of documentation on MHOs in Eastern and Southern Africa may provide lessons for West and Central Africa.

Annex 2: Country-Specific Recommendations from the Country Case Studies

Country case studies are available in a separate report. This annex presents selected recommendations for five countries.

Benin

The MHO movement in Benin is recent, hence it suffers from a lack of skills and of knowledge of how to set up, organize, and manage MHOs. The weaknesses apparent in the Alafia and Ilera MHOs indicate a strong need for external technical support in this domain. Moreover, this input is required not only at the start-up phase, but also in the subsequent development phase if success is to be assured. Recommendations from the study indicate a need to

- ▲ Develop a policy framework to base the health system on values and principles closer to the people and allow it to support greater diversity and adaptability to local circumstances, to reinforce the ability of the population to take charge of their own health, and to place the mutualization of health risks within the general strategies of the fight against poverty.
- ▲ Evaluate the support provided by the Centre International de Développement et de Recherche in South Borgou and other alternative strategies to draw lessons relevant to the elaboration of a flexible policy of technical assistance toward setting up MHOs in the country.
- ▲ Develop demonstration projects for setting up MHOs in several regions to enlarge the basis of MHO experience and to support the elaboration of the strategy of mutualization of health risks.
- ▲ Put in place a flexible legal framework that allows MHOs to be legal (corporate) entities and guarantees the autonomy of such organizations.
- ▲ Reinforce the coordination and synergy of cooperation agencies in the field of MHO development.

Ghana

The recommendations from the case study indicated a need for the following:

- ▲ Coordination between development partners and other interested parties to determine unmet needs and to match available resources to the areas of greatest priority.
- ▲ Training programs in the principles of nonprofit mutual health insurance for the personnel of existing MHOs and for those considering setting up such schemes.
- ▲ Concentration on those sectors of the population—the informal sector and rural communities—that will not be covered, at least initially, by the proposed national health insurance scheme 4. Technical assistance to existing MHOs to equip them to manage their schemes better, for example, with the skills to carry out monitoring and evaluation.

- ▲ As concerns technical assistance and MHO promotion, it may be useful to bear in mind one of the principal findings of the case study from Nigeria, namely, that the high participation (complex) model of community financing appears better attuned to communities' health care needs and the country's health sector goals than either the low participation (simple) model or the traditional social network scheme. Schemes based on social movements, such as the Teachers' Welfare Funds, also have great potential.
- ▲ Targeted technical assistance, a need highlighted by the weaknesses of the low participation model, for instance, the West Gonja and Nkoranza schemes. The areas where such support might be useful would be to help address the lack of independence from the provider, the lack of negotiating power, the needs in connection with marketing, the need for quality control mechanisms, the need for a drug policy, and the lack of preventive and promotive services.
- ▲ Legislation to enable MHOs to acquire legal or corporate status through registration, to offer protection for members who subscribe and pay dues, to regulate financial management and administration, along with model rules and regulations drawn up in consultation with existing MHOs that new organizations can adopt or adapt to their own needs.
- ▲ Stakeholder participation. While the government is actively pursuing policies to implement a national health insurance program for the formal sector, little or no consultation with all possible stakeholders has taken place. In addition, plans to inform the public about the scheme only propose to explain to the general public what it all means to them through leaflets and media campaigns so as to win public support for the scheme. Policymakers do not appreciate the need to include stakeholders in consultation exercises prior to designing such schemes, and this is an area in which technical support and cooperation agencies could offer assistance and advice. Also, the marketing of such a scheme must go beyond merely explaining to the public what has been decided, but should include earlier consultation and studies to determine user preferences and the way these are likely to evolve in the future.

Mali

The following recommendations may be made from the case study.

- ▲ In the informal and rural sectors, MHOs should be developed. In addition, a serious problem that should be tackled is that of irregular contributions, a crucial issue for all voluntary schemes.
- ▲ As far as the rural sector is concerned, pilots should be launched in priority cash crop zones, namely, the cotton zone.
- ▲ The Association de santé communautaires should be part of the strategy to launch hospitalization insurance MHOs.

Nigeria

Areas of intervention that the study has highlighted and that will add some value to MHOs in Nigeria include the following:

- ▲ Coordination between development partners and other interested parties would be useful to determine unmet needs and to match available resources to the areas of greatest priority. In Nigeria, the U.S. Agency for International Development, the United Nation's Children's Fund, and the World Health Organization could help establish the nucleus of such a network.

- ▲ Specific training is required for managers in administrative and accounting procedures, record keeping, and funds management, as demonstrated by analysis of the Community Partners for Health (CPH) experience.
- ▲ Concentration on the those sectors of the population—the informal sector and rural communities—that will not be covered, at least initially, by the proposed national health insurance scheme.
- ▲ Technical assistance to existing MHOs to equip them to manage their schemes better, for example, with the skills to carry out monitoring and evaluation and to run an insurance scheme. The Nigerian schemes would also benefit from targeted training in the need for independence from the provider (CPHs), use of negotiating power, marketing, quality control mechanisms, and drug policy.
- ▲ As concerns technical assistance and MHO promotion, it may be useful to bear in mind one of the principal findings of the case study from Nigeria, namely, that the high participation (complex) model of community financing appears better attuned to communities' health care needs and the country's health sector goals than either the low participation (simple) model or the traditional social network scheme. It is no coincidence that both types of community financing schemes share broadly similar features in so far as participation by the insured or their representatives in management is concerned. These participatory features may be the real key to their relative success or potential for success, but one further advantage of the participatory community financing or CPH type is that it is directly linked to the providers, and therefore can potentially negotiate terms and influence quality and efficiency of provider care. COWAN cannot do this because it has no links with providers except its own clinics.
- ▲ Legislation to enable MHOs to acquire legal or corporate status through registration, to offer protection for members who subscribe and pay dues, to regulate financial management and administration, along with model rules and regulations drawn up in consultation with existing MHOs that new organizations can adopt or adapt to their own needs. The policy framework for NGOs the Nigerian government has proposed has the potential to harm the interests of such organizations and does not address adequately the specific needs of MHOs.
- ▲ Focus on the shortcomings of the proposed national health insurance scheme, in particular, the way it appears to ignore the interests of important stakeholders and the lack of public debate or discussion of the key design features. These shortcomings need to be addressed to ensure that an inappropriate, and perhaps unworkable, scheme is not imposed on the country.

Senegal

The authorities are currently considering a law on MHOs, but this study concludes that this is not a priority for Senegalese MHOs. However, this does not mean that MHOs would not benefit from a clear policy framework that spells out national health goals for the foreseeable future and the role that private initiatives might play. Some areas identified for technical assistance were as follows:

- ▲ A need to upgrade skills in accounting procedures, including making budget projections. Some MHOs require institutional and technical support to undertake certain reforms. For example, Lalane Diassap needs help to set up monitoring and evaluation tools and the Education Volunteers would like to extend coverage to include families and other benefits, but would like assistance to evaluate the likely impact on costs before proceeding.

- ▲ A specific analysis to determine whether the ceiling of 15 days admission coverage is justified or not for MHOs in the Thiès area linked contractually to St. Jean de Dieu Hospital, given that the average duration of hospital stay is 6.5 days.
- ▲ The practice of some MHOs such as Lalane Diassap in advancing the money for costs beyond the 15 days coverage has the potential to bankrupt the organization and requires close study and evaluation.
- ▲ The provision of material support, such as office equipment, for some MHOs to maintain their offices and perform their work adequately. Some that have computers need training to be able to use these optimally in their organizations.
- ▲ The experience of the FAGGU MHO, which covers pensioners with complementary insurance, could be publicized as an example of relative success.
- ▲ The provision of help to some MHOs that seek aid to establish beneficial contacts with mutual organizations in the industrial countries.

Annex 3: List of Inventory and Case Study MHOs Investigated by Country

To facilitate the reading of the paper, this annex provides a complete list of the MHOs in this study, coded for easy reference. Coding is by country and number, for instance, Mali [3] refers to MEUMA; Senegal [3, 21] refers to Lalane Diassap and Bok Jef.

Benin

Sirarou UCGM (l'Union communale des groupements mutualistes de Sirarou (UCGM Sirarou))
Sanson UCGM (l'Union communale des groupements mutualistes de Sanson (UCGM Sanson))
Ilera MHO (Mutuelle Ilera de Porto Novo–Mutuelle du cabinet médical St Sébastien)
Alafia MHO (Mutuelle Alafia de Gbaffo)

Burkina Faso

Dakwena MHO (Mutuelle Dakwena)
Famille Tounouma (Mutuelle pharmaceutique de la sainte famille Tounouma)
MUATB (Mutuelle des agents du Trésor du Burkina)

Cameroon

AFFERAZY (Association des filles et femmes ressortissantes de l'arrondissement de Zoétélé à Yaoundé)
Babouantou (Caisse de solidarité Babouantou de Yaoundé)
BACUDA (Batibo Cultural and Development Association)
MNE (Mutuelle nationale de l'éducation)
MPOUAKONE
MUPEHOPROMA
Les Amis (Association des amis clan d'âge no. 13)
NSO-NGON
POOMA (Yaoundé)
SAWA (Association des ressortissants SAWA de Yaoundé)

Côte d'Ivoire

MUGRACE. (La Mutuelle générale des résidents d'Abobo centre–commune d'Abobo)
CARD (Le Cercle des amis de la rue de dimbokro–commune de Marcory)
AMIBA (L'Amicale de la Bagoué–Commune de Koumassi)
MC 36 (L'Amicale des mamans du Canal 36 (Commune de Youpougon)
Les Intimes (Les Intimes du nouveau quartier)
MUGEF-CI (La Mutuelle générale des fonctionnaires et agents de l'état)

Ghana

West Gonja (Community Financing Scheme for Admissions, West Gonja)
Teachers' Funds (Teachers' Welfare Funds)
Dagaaba Association (Duayaw Nkwanta Dagaaba Association)

Mali

MUTEC Health Centre (Centre de santé de la MUTEC)
Kolokani (Centre de santé de référence du cercle de Kolokani, that is, Reference Health Center of the Kolokani circle or zone)
MEUMA (Mutuelle des étudiants et universitaires du Mali)
MUTAS (Mutuelle des travailleurs de l'action sociale et de la santé)

Nigeria

COWAN (Country Women's Association of Nigeria Health Development Fund)
Lawanson CPH (Lawanson Community Partners for Health)
Jas CPH (Jas Community Partners for Health)
Ibughubu Union (Ibughubu Improvement Union)

Senegal

Education Volunteers (Mutuelle des volontaires de l'éducation)
FAGGU (Mutuelle FAGGU)
Lalane Diassap (Mutuelle de Lalane Diassap)
Dimeli Yoff
Multi Assistance de l'Éducation
Mutuelle Sococim Entreprise
Fandene
FISSEL
KOUDIADIENE
Menagères de Grand Thiès
Mont Rolland
Ngaye Ngaye
Saint Jean Baptiste
Sanghe
Darou Salam
Mboro
Pamdienou Lehar
Thially
Nimzatt-Kaolack
RJOK (Regroupement de jeunes ouvriers de Kaolack)
Bok Jef
Keur Maloum
Koundam
Mutuelles des enfants de la rue

Togo

ACB (Association des couturières de BE)
 Sages Femmes (Association des sages femmes du Togo)
 Djagbagba
 GMC (Groupement mutuel des cadres)
 Mutuelle OTP (Office Togolais des phosphates)
 Affaires Sociales USYNCO (Union syndicale des coiffeuses de style du Togo)
 MUCOTASGA (Mutuelle des conducteurs de taxi motos de la station Gaitou)
 MUSAD (Mutuelle de santé ADIDOADE)
 MUSA–CSTT (Mutuelle de santé–Confédération syndicale des travailleurs Togolais)

| Countries in the Study | |
|---|--|
| Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Mali, Nigeria, Senegal, Togo | |
| Case Study MHOs | |
| <ol style="list-style-type: none"> 1. Sirarou UCGM (l'Union communale des groupements mutualistes de Sirarou (UCGM Sirarou)) 2. Sanson UCGM (l'Union communale des groupements mutualistes de Sanson (UCGM Sanson)) 3. Ilera MHO (Mutuelle Ilera de Porto Novo–Mutuelle du cabinet médical St Sébastien) 4. Alafia MHO (Mutuelle Alafia de Gbaffo) 5. MUGRACE. (La Mutuelle générale des résidents d'Abobo centre–Commune d'Abobo) 6. CARD (Le Cercle des Amis de la rue de Dimbokro–Commune de Marcory) 7. AMIBA (L'Amicale de la Bagoué–Commune de Koumassi) 8. MC 36 (L'Amicale des mamans du Canal 36 (Commune de Youpougon) 9. Les Intimes (Les Intimes du nouveau quartier) 10. MUGEF-CI (La Mutuelle générale des fonctionnaires et agents de l'état) 11. West Gonja (Community Financing Scheme for Admissions, West Gonja) 12. Teachers' Funds (Teachers' Welfare Funds) 13. Dagaaba Association (Duayaw Nkwanta Dagaaba Association) 14. MUTECH Health Centre (Centre de santé de la MUTECH) 15. Kolokani (Centre de santé de référence du cercle de Kolokani i.e. Reference Health Centre of the Kolokani circle or zone) 16. COWAN (Country Women's Association of Nigeria Health Development Fund) 17. Lawanson CPH (Lawanson Community Partners for Health) 18. Jas CPH (Jas Community Partners for Health) 19. Ibughubu Union (Ibughubu Improvement Union) 20. Education Volunteers (Mutuelle des volontaires de l'éducation) 21. FAGGU (Mutuelle FAGGU) 22. Lalane Diassap (Mutuelle de Lalane Diassap) | |
| Inventory MHOs | |
| <ol style="list-style-type: none"> 1. Ilera MHO (Mutuelle Ilera de Porto Novo–Mutuelle du cabinet médical St Sébastien) 2. Dakwena MHO (Mutuelle Dakwena) 3. Famille Tounouma (Mutuelle pharmaceutique de la sainte famille Tounouma) 4. MUATB (Mutuelle des agents du trésor du Burkina) 5. AFFERAZI (Association des filles et femmes ressortissantes de l'arrondissement de Zoétélé à Yaoundé) | |

6. Babouantou (Caisse de solidarité Babouantou de Yaoundé)
7. BACUDA (Batibo Cultural and Development Association)
8. MNE (Mutuelle nationale de l'éducation)
9. MPOUAKONE
10. MUPEHOPROMA
11. Les Amis (Association des amis clan d'âge no. 13)
12. NSO-NGON
13. POOMA (Yaoundé)
14. SAWA (Association des ressortissants SAWA de Yaoundé)
15. MUTECH Health centre (Centre de santé de la MUTECH)
16. MEUMA (Mutuelle des étudiants et universitaires du Mali)
17. MUTAS (Mutuelle des travailleurs de l'action sociale et de la santé)
18. Education Volunteers (Mutuelle des volontaires de l'éducation)
19. FAGGU (Mutuelle FAGGU)
20. Lalane Diassap (Mutuelle de Lalane Diassap)
21. Dimeli Yoff
22. Multi assistance de l'éducation
23. Mutuelle Sococim entreprise
24. Fandene
25. FISSEL
26. KOUDIADIENE
27. Menagères de Grand Thiès
28. Mont Rolland
29. Ngaye Ngaye
30. Saint Jean Baptiste
31. Sanghe
32. Darou Salam
33. Mboro
34. Pamdienou Lehar
35. Thially
36. Nimzatt-Kaolack
37. RJOK (Regroupement de jeunes ouvriers de Kaolack)
38. Bok Jef
39. Keur Maloum
40. Koundam
41. Mutuelles des enfants de la rue
42. ACB (Association des couturières de BE)
43. Sages Femmes (Association des sages femmes du Togo)
44. Djagbagba
45. GMC (Groupement mutuel des cadres)
46. Mutuelle OTP (Office Togolais des phosphates)
47. Affaires Sociales USYNOCOSTO (Union syndicale des coiffeuses de style du Togo)
48. MUCOTASGA (Mutuelle des conducteurs de taxi motos de la station Gaitou)
49. MUSAD (Mutuelle de santé ADIDOADE)
50. MUSA-CSTT (Mutuelle de santé-Confédération syndicale des travailleurs Togolais)

Annex 4: Estimating Premium Rates for an MHO

This method of estimating premium rates requires some estimated figures for annual number of hospital admissions, deliveries, and outpatient visits per 100 members. These numbers are multiplied by the prices agreed on with the providers, then divided by the number of members. This example also illustrates how monitoring utilization rates can help MHO management keep track of the MHO's financial status and any need for contribution rate adjustments.

Example:

Data:

Annual hospital days/100 members: 41

Annual deliveries/100 members: 4.3

Annual outpatient visits/100 members: 258

Agreed prices:

Hospital day: FCFA 40,000

Delivery: FCFA 50,000

Outpatient visit: FCFA 5,000

MHO's costs:

Monthly administration, transport, and miscellaneous costs: FCFA 405,200

Annual training costs: FCFA 2,183,600

Membership:

Number of members: 2,347

Average dues collection rate: 90 percent

Contribution schedule:

Every 4 months

Calculations

Expected annual costs for 2,347 people

Training: FCFA 2,186,600

Annual Administration, Transportation, and Miscellaneous: FCFA 4,826,400

Hospitalizations: $41 * 40,000 * 2,347/100 = \text{FCFA } 38,490,800$

Deliveries: $4.3 * 50,000 * 2,347/100 = \text{FCFA } 5,046,050$

Outpatient visits: $258 * 5,000 * 2,347/100 = \text{FCFA } 30,276,300$

Total: FCFA 80,859,150

Scenario 1: Where those who have not paid their dues are immediately excluded from enjoying the services:

Contribution required per member every 4 months: $80,859,150/2,347/3 = \text{FCFA } 11,484.04$

Scenario 2: Where no strict policy of immediately excluding noncompliant members is in force:

Given that the dues recovery rate is 90 percent, the contribution every 4 months per member, for sustainability, is $11,484.04 * 1.1 = \text{FCFA } 12,632.45$.

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