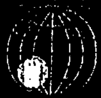

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after each individual measure taken. Even if at a given time it would appear, that the mix of measures to enhance resource mobilisation as well as to improve budget utilisation is close to the optimum, changing habits of clients, the arrival of competing providers, economic and political changes will require the mix to be reviewed and adapted frequently to keep abreast of such developments. If not, either the institutional viability will suffer or the utilisation and healthcare outcome will be affected.

In view of these latter findings the following points might be raised and worthwhile to discuss in greater detail:

1) Without proper (but even so appropriate) analytical bookkeeping and reporting, achieving viability or sustainability of health services and healthcare institutions will remain an illusive goal.

2) In the absence of a transparent financial report and a clear plan of operations, recurrent expenditure support should not be granted.

3) It is an urgent matter to review the guidelines for annual hospital reports and to edit and publish as a separate document the guidelines for making a plan of operations for monitoring recurrent expenditure and for reporting and analysis of the data reported.

4) It is essential for healthcare institutions to have access to health economist advice regularly to optimise their cost-effectiveness.

5) Consumers are so much aware of cost of health care provision, that there can be found a close correlation between perceived cost-effectiveness and:

A effective utilisation
B. willingness to pay a share in the cost directly and in particular indirectly via prepayment schemes or local insurance schemes.

6) The contractual approach (whether contracting in or contracting out) makes greater attention to analytical bookkeeping and cost-effectiveness analysis all the more necessary.

7) Decentralisation of health service administration and budgets will lead to survival of the fittest i.e. in this context not necessarily the providers with the best medical results but with the clearest reporting.

8) Given the fact, that training for heath institution administration and for health economist is hard to come by in developing countries the creation of such courses should be facilitated in all possible ways (OPEN FOR DEBATE).

Types of mutual aid arrangements in sub-Saharan Africa: what place for health insurance?

by Dr. Bart Criel

Free health care... an illusion
There is no such thing as free health care - the equation is straightforward : households pay for everything !
... but the implication for the household (i.e. the "burden") differs considerably according to the way of payment !

Introduction

In recent years there has been an increasing interest in the development of health insurance systems in sub-Saharan Africa. The financial crisis haunting African public health care systems certainly contributed to this evolution. Initially, in the sixties, free health care was a constitutional right and public health care systems were supposed to be entirely tax-financed. This rapidly proved an illusion. The international economic crisis in the seventies had dramatic effects on the government budgets allocated to health. 'Free care' became a myth: at the end of the day patients were forced to purchase (expensive) drugs in the private sector because drugs were scarce in the public sector. Patients also had to come up with under-the-table fees for underpaid (and sometimes unpaid) health care personal.

A pragmatic response to this situation was the introduction in the 1970's and 1980's of direct 'out-of-pocket' payments by the patient at the time and point of use. Today, this policy of 'out-of-pocket' payments - i.e. user fees - has become a fact of life in the whole of Africa. This policy has been legitimised through the Bamako Initiative of the World Health Organisation and UNICEF and has lead to successes where fees were used to improve the quality of public health care, for instance to assure the availability of essential drugs. This has been extensively documented in the case of West African countries like Guinea and Benin (Levy-Bruhl et al. 1997).

Nevertheless, the disadvantages of user fees are clear, certainly when they are comparatively very high - which is the case in many African countries. They decrease the access to health care for poor population groups and they can even lead to total exclusion in situations where the family income is seasonal as in many rural African communities. Insurance systems are therefore a technically interesting option that can also contribute to the solidarity within the community.

- **People spend a lot of their (meagre) financial resources on health care**
  -public sector
  -private non-for-profit sector
  -private-for-profit sector : including self-medication
  -traditional health care sector
- **They often get poor value for money**
- **Existing mechanisms for the financing of health care are highly regres sive**

In this paper I will attempt to clarify the health insurance debate in Africa which might at the same time improve the insight into European health insurance systems, which are too often taken for granted. First I would like to introduce a typology of collective arrangements for mutual aid with a focus on those systems based on insurance and where solidarity is an important underlying value. I will than proceed with a discussion of the current dynamic of locally developed, voluntary health insurance systems.

Types of mutual aid mechanisms

In developing countries in general and in sub-Saharan Africa in particular, a number of collective mechanisms designed to face individual risks have been developed. These risks are related to life cycle events like birth, death but also illness. In this discussion we shall focus on the latter. A distinction can be made in this variety of mutual aid arrangements depending on the presence or not of insurance (see table 1).

The International Labour Office (ILO) defines insurance as: "the reduction or elimination of the uncertain risk of loss for the individual or household, by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member" (ILO, 1996). Insurance implies the possibility of a discrepancy between the initial investment (i.e. the costs for the insured) and the eventual result (i.e. the personal return) of this investment for the subscriber. This frequently occurs in practice. From a financial point of view this means that there will always be winners and losers: everybody pays in to compensate the damage suffered by some. Hence, the insurance principle differs from the reciprocity principle where inputs and expected outputs are more or less equivalent.

Insurance can be paired to varying degrees of solidarity. Solidarity can be defined as follows: "the awareness of unity and a willingness to bear its consequences" (Dunning, 1992). In the case of insurance this means the (implicit) acceptance that the size of the personal return may not match the initial investment. In the case of mandatory insurance systems, as they exist

in many European countries, this unequal relationship is imposed on people by law. Solidarity is then institutionalised, but is nevertheless reversible. Whether it is reversed or not depends on the political and social choice society makes.

Table . Mutual aid mechanisms for individual health risks

without insurance	without insurance
❑ Systems of family and clan solidarity: moral obligation to help ❑ Informal systems of mutual aid (endogenous associative movements, tontines or ROSCA's): expectation of reciprocity ❑ Systems based on an act of prepayment without sharing of risks with others	❑ Mandatory health insurance systems managed by the State (the Bismarck model): insurance and solidarity ❑ Voluntary health insurance systems: ❑ with a private finality: insurance without solidarity ❑ with a pubic finality: insurance and solidarity

Mutual aid mechanisms without insurance

Family and clan solidarity is based on the moral obligation—informal, but nevertheless codified—to help family members[1].

. These systems of mutual aid are selective since those who do not belong to the family, clan or ethnic group cannot benefit from the aid. This help can be, and indeed is, mobilised for a range of events that is not, and does not have to be, explicitly defined. The 'coverage' definitely goes beyond troublesome events like illnesses or accidents, and includes happy events like births and feasts.

Next to traditional family solidarity systems, there exist in Africa a rapidly growing lot of endogenous associative movements, which play an important role in the domain of mutual aid. These associations may gather people beyond kinship relations, they intervene in a wide range of (positive and negative) events, and they contribute to the creation and reinforcement of social networks. These associative movements can be classified according to the social features of the people that have joined the association, or according to the nature of the services the association provides (Romainville 1999; Romainville & Ioveva 1999).

[1] J.P.Olivier de Sardan (1999, p.40) writes '...[the solidarity networks] provide each person with a capital of social relations far exceeding that of other continents [than the African], they also include an almost general obligation of mutual assistance. One cannot refuse a service, a favour, a bit of string-pulling or compliance to a relative, neighbour, party comrade or friend. Nor ought one to refuse the same to someone who is 'sent' by any of the above. The circle of individuals to whom one feels obliged is thus astonishingly wide.'

Many of these endogenous mutual aid systems have a strong focus on decease and funeral (which sometimes encounters disapproval from young people who question the emphasis on the death rather than on the living). Few of these associations, however, intervene substantially in the case of illness. According to Sylla Moussa (personal communication) this precisely constitutes a justification for the introduction of exogenous insurance-based mutual aid systems that fill that gap by selectively covering expenses in the domain of health care.

The tontine[2] is one type of associative movement that constitutes a widespread aid arrangement in the whole of Africa. In the English literature tontines are called Rotating Savings and Credit Associations (ROSCAs). These arrangements are not insurance systems[3], but rather informal (yet not illegal) savings systems. Usually a tontine consists of a limited group of people who have something in common (like for instance a same profession) or who are acquainted in one or the other way. Each participant makes regular payments to a common pool (the 'pot') which is then in turn allotted to each one of the participants[4]. The investment, usually financial, is in principle in balance with the eventual individual benefit. Tontines are usually created in order to generate a small capital that is invested in a small business, or that is used to purchase a particular costly good. The functioning of tontine is such that the members' expectation of reciprocity, characteristic for many of these endogenous associative movements, is fulfilled. Tontines are rarely mobilised to cover health care expenses, since these are difficult to determine and plan ahead.

In the case of prepayment systems (sometimes called abonnement in the French health insurance jargon, see Galland et al. 1997), a certain payment, sometimes on an individual basis but usually on family basis, is made in advance to a health care provider or health care institution. At every consultation of the health care provider, this prepaid amount is gradually debited -according to the consultation fees charged - until the total amount is consumed. This system is actually quite rare and is usually organised to prefinance the costs of fairly predictable health care costs, like antenatal or under-five consultations. Prepayment is, nevertheless, an interesting option because it allows purchasing health care at a time when money is indeed

[2]The origin of the denomination tontine comes from a kind of savings association developed by the Italian banker Lorenzo Tonti in Naples in 1653. Today, tontines clearly correspond to an endogenous, ancestral and specific phenomenon (Jacquier C. 1999).
[3]This is, however, not always the case. In some instances ROSCA's may also have an insurance function—even if it is not their primary purpose—when the sequence or order of allotting the 'pot' is altered in the favour of a member facing an acute need like for instance a disease (de Swaan 1996; Abraham & Plateau 1995).
[4]A nice example of the functioning of ROSCAs, and the social ambience in which they evolve, is found in Bähre's (1999) description of South African ROSCAs.

available in the household. The impact of prepayment, however, is limited by the fact that expensive events, like a hospital admission, are more diffi cult to pre-finance. Moreover, in such systems the risk is generally shared amongst a relatively small group of people (a family for instance).

Health care and 'uncertainty'

- **Uncertainty concerning the duration and the severity of illness : how much will it cost ?**
- **Poor predictability of the time at which health care is needed : when will it happen ?**

Mutual aid mechanisms with insurance

In this section I would like to elaborate on aid arrangements based upon insurance. As shown in table 1 there is a distinction to be made between on the one hand the model of mandatory health insurance, especially the Bismarck-model[5] as it exists in different European countries[6], and voluntary health care systems on the other.

Systems of mandatory or compulsory health insurance do exist in most African countries. In most of cases they were established in the last years of the colonial rule or in the first years following the independence of the young African states. This Bismarckian health insurance model is in fact an imported (European) model, introduced in countries with a totally different social and political background. In reality these systems have proved to reach only a fragment of the population, particularly civil servants. This population group consists of a small minority, rarely making up more than a few percent of the total population, and often already relatively privileged when compared to rural households living from subsistence agriculture. It seems unlikely, in short or even middle term, that the range of such systems will show a significant boost. Many African countries are now engaged, under pressure from the World Bank, in structural adlustment programmes, where one of the main elements is to reduce the number of civil servants.

A possible extension of these health insurance systems to the rural population, or to people employed in the informal sector, requires efficient and effective administrative and managerial capacity at the governmental level. Today, such a capacity is unfortunately not readily available in most of the sub-Saharan African countries. Moreover, it is highly questionable whether the average African government enjoys sufficient popular credibi-

[5] The first system of mandatory health insurance was introduced (for workers) in Germany in 1883 under chancellor Otto von Bismarck.
[6] These systems are commonly called social health insurance (Norman & Weber 1996).

lity for the organisation and management of a nation-wide social health insurance system. Hence there is a generally recognised necessity to develop and test new models of health insurance that focus on reaching the unsalaried population (Gruat 1990; Dror & Jacquier 1999).

Within the category of voluntary health insurance systems a distinction can be made between systems driven by a public or private rationale respectively. In the latter case, insurance premiums are usually linked to the magnitude of the individual health risk and are independent of the family income - which affects the equity of these payments. A majority of the African population would therefore, de facto, be excluded from participation in such private health insurance initiatives. For a more detailed discussion of the distinction between public and private rationale in health care delivery in general, we would like to refer to work done by Giusti & colleagues[7](1997). From hereon, we shall further focus on voluntary systems pursuing a public finality[8]

First of all, it is useful to point to the important distinction between health insurance as a function, and health insurance as an institutional set-up (Kutzin, 1998). Kutzin attributes two functions to health insurance. The first one consists of ensuring accessibility to the health care delivery system. The second consists of protecting the family capital - savings and/or other goods - in case of high-cost health care: in other words avoiding a family from being thrown into poverty because of health care expenditure. Health insurance as a function is an end in itself; this is not the case for health insurance as an institutional arrangement. From this perspective a British citizen would be as 'insured' as a German citizen, although the health care in the United Kingdom is mainly tax-financed and health care in Germany is financed through earmarked social security contributions paid by both employees and employers.

Voluntary health insurance pursuing a public objective

There is great need to structure the great variety of locally developed voluntary health insurance schemes. Creese and Bennett (1997) recently made a very interesting attempt to do so. Their classification of voluntary insurance schemes mainly focuses on schemes developed in rural areas. The authors handle two variables: first, the identity of the systems' management (e.g. the care provider, the community, a co-operative society, a non-governmental organisation, the government, etc.); second, the nature of the risks being covered: on the one hand, rare high-cost events, on the other frequent but low-cost events. On the basis of these two variables two insurance types can be distinguished. A first type where there is coverage of 'high' risks (e.g. a hospital admission) and where the hospital owns and/or runs the scheme. A second type is one that especially covers 'low' risk events (e.g. first line consultations) and that usually is run by a community-based structure.

[7]Giusti et al. propose 5 criteria for a public finality or rationale: 1) a social perspective, 2) no discrimination, 3) responsibility for and accountability to a well-defined population, 4) respect of compliance with national health policy, and 5) non-lucrative goals.

[8]In that case, the premium is usually a flat rate and thus independent from the risk-status of the subscriber. In the insurance literature this is labelled community rating (Mills, 1983).

The relevance of these two variables is beyond doubt, but they do not suffice to structure the heterogeneous lot of voluntary insurance schemes. Other variables that seem useful are the following:

i) The scale of the target population. This variable matters for at least two reasons. First, the size of the population tends to be inversely related to the potential for the community to participate in the scheme's management. Second, a larger population allows for economies of scale, hence contributing to the scheme's efficiency and effectiveness.

ii) The degree of overlap of the population targeted by the insurance scheme and the population covered by existing functional entities of health care providers (e.g. a health district). Health care financing then may constitute a lever to rationalise the pattern of health care delivery organisation in that very functional entity (for instance rationalising the referral system).

iii) The existence (or not) of an intermediary institution in between the source of funding (i.e. the households) and the eventual destination of the funds (i.e. the care provider). This institution or organisation can play a more or less active role—beyond merely channelling funds. In the Anglo-Saxon literature this is called active purchasing, referring to the fact that the purchaser (or insurer or buyer) deliberately uses his financial power to obtain efficient and high-quality health care (Kutzin 1998). The expression 'from payer to player' is an adequate expression of this situation.

If one combines these different variables, one can distinguish two poles of voluntary health insurance systems: on the one hand the 'mutualistic' or participatory model, on the other a care the 'provider-driven' or technocratic model. The major features of these two models are summed up in table 2.

[9]This concept is similar to the concept of *area-based* insurance arrangement Jain uses in her analysis of social insurance in India (Jain 1998).

[10] The label *direct* insurance is also used when there is no intermediary structure, and indirect insurance when there is (Mills 1983).

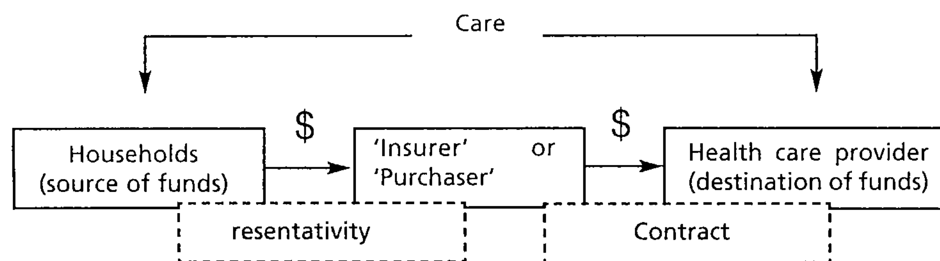
Insurance

- saveguard access to health care when needed
- protect household's income and assets from the financial cost of expensive medical care

The mutualistic model

In the mutualistic model a members association (a 'Mutual Health Organisation' or MHO[11]) functions as an intermediary structure between the source and the destination of funds (see figure 1).

Figure . The mutualistic model: a purchaser between payer and provider.



The *raison d'être* of the insurer (or purchaser) lies in the defence of the interests of the members it represents. The mutualistic model is often part of a larger social dynamic where solidarity and self-governance are important concerns. The insurer and the care providers confer with each other and negotiate the terms of the care that will be offered to the insured and define the financing modalities of the package of benefits. These are then recorded in a contract. Evrard & Bationo (1999) write that the difference between more 'traditional' associations of mutual aid and MHOs precisely lies in this contract established with the members. In traditional systems, there is obligation to mobilise means but no obligation to achieve results. In MHOs, however, there is a commitment (often explicit) to achieve results, i.e. to offer certain types and amounts of care at an agreed price.

The operation of such an intermediary structure obviously accounts for additional expenses to the system as a whole (transaction costs), but

[11]Attemps to translate the french term 'mutuelle de santé' into English have always been dogged by the lack of any clear recognisable equivalent, perhaps illustrating the fact that the mutuals' reality is different in English speaking African countries. The term Mutual Health Organisation, however, has recently come to be used in the discourse to describe organisations of this kind (Atim 1998).

through this structure an improvement in quality and efficiency can—at least in theory—be obtained from the health care providers. Such a structure can serve as a kind of "counter-force"[12] to the health care services. Whether or not this potential is indeed achieved, mainly depends on the objectives pursued and on the managerial capacity of the purchaser.

Recent research indicated that a dynamic of mutual insurance systems exists in Africa, especially in the French-speaking part (Centre National de l'Enfance 1997), even though this "movement" is still recent and poorly structured (Brouillet 1997, Atim et al. 1998). Sometimes one distinguishes between corporative and non-corporative mutualistic associations (Criel 1999). The first one is targeting individuals and their relatives, who share a same professional identity: e.g. the MUTEC in Mali (MUTEC stands for *Mutuelle des Travailleurs de l'Education et de la Culture*) which covers more than 10,000 people. The non-corporative type is aimed at a more mixed and heterogeneous population regarding professional activity, but which as a group shares other characteristics[13]: for instance people who live in the same neighbourhood or who are member of the same club/association or social movement. The corporative system usually has many more members than the non-corporative system as the latter often remains small-scaled, at most a few hundred people [14]. This obviously will influence the financial sustainability of the latter.

Today, this mutualistic dynamic enjoys important technical and institutional support[15]. Many mutualistic initiatives, however, (still) struggle with problems in the institutional design and management of the system. The financial viability of African mutualistic associations remains on the whole limited due to a lack of economies of scale. The underlying social dynamic that (supposedly) marks most African mutualistic associations has until now rarely been studied in a systematic way (Atim, 1999).

The provider-driven or technocratic model

This is also a voluntary health care insurance system without however an intermediary structure between the payer of funds and the health care provider (see figure 2): in other words the care provider is also the insurer.

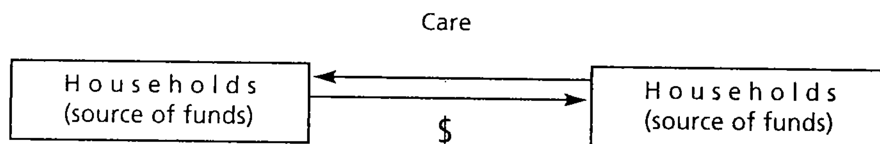
[12]In French *contre-pouvoir*.

[13]Galland refers to the *principe d'identification* (Galland *et al* 1997). These common features enhance group cohesion, but may also lead to a concentration of similar (high) risks. Evrard & Bationo (1999) argue that the creation of multiple small MHO's, each one of them based on a strong feeling of belonging to a defined social group may lead to a worsening of existing social inequalities rather than the reverse.

[14]A recent study carried out in Burkina Faso (Fonteneau B 1999) confirmed this.

[15]See for instance the (excellent) practical guide designed by the (Belgian) National Alliance of Christian Mutualities in collaboration with the International Labour Organisation (ILO) and the Belgian NGO *Wereldsolidariteit* (1996).

Figure . The technocratic model: the care provider is the insurer.



Such an institutional construction bears a resemblance to the HMO model (HMO stands for Health Maintenance Organisation[16]) that is widespread in the United States. In Africa this model is found in situations where the District Management Team is responsible for the organisation and the management of an insurance system. The target population is then the population for which the district is explicitly responsible for. It can be the population of the whole district or the population living in the 'area' of a health centre. Generally, the insured patients are then required to consult a well-defined care provider. The health care provider is then the financial risk-bearer.

This model can substantially increase access to health care when the district team is lead by a public finality[18] and when it possesses the necessary managerial capacity. The insurance system for hospital care developed in 1986 in the Bwamanda district in the Democratic Republic of Congo (Criel & Kegels, 1997) is a well-documented example of this model. An important limitation of this model, however, is a lack of a 'counter-force' to the health services. The risk that the health professionals actually dominate the decision-making process is real indeed. This was clearly illustrated in the case of the Bwamanda scheme.

Table . The major features of both models.

Mutualistic or participatory model	Provider-driven or technocratic model
❑ Generally small scaled	❑ Usually larger scale
❑ Social selectivity of target population	❑ Less social selectivity
❑ Predominance of bottom-up planning	❑ Predominance of top-down planning
❑ Management by member organisation	❑ Management by health professionals
❑ Rarely overlap with functional entity of health care delivery	❑ Usually overlap with functional entity of health care delivery
❑ Intermediary structure between payer and provider	❑ Provider is insurer
❑ Provider is insurer	
❑ Mutual Health Organisation is financial risk-bearer	❑ Health care provider is financial risk-bearer

[16]Luft (1981) has defined a Health Maintenance Organisation as follows: 1) a contractual responsibility to offer a well-established package of care, 2) this package is offered to a well-defined population, 3) a voluntary subscription, 4) the payment of a fixed premium at regular intervals, and 5) the HMO itself is the financial risk-bearer in case of deficits.
[17] n a more prosaic way, the risk-bearer notion comes down to the question of 'who goes to jail in case of bankruptcy'.
[18]See again Giusti et al. (1997).

The way ahead :
two priorities

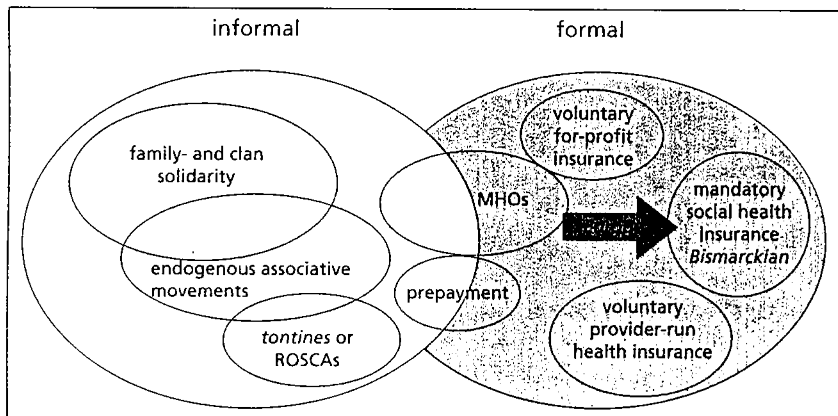
- **Improve quality of care:**
- more 'responsiveness' to consumers demands (cfr WHO report 2000)
- develop holistic care

- **Implement more progressive mechanisms of health care financing**
- tax reforms
- Out Of Pocket: from fee for service to flat rates and eventually to healt insurance contributions

Conclusion

The different arrangements discussed cover a range going from very informal systems to very formal ones (see figure 3). This overview, however, has a major limitation. It presents a cross-section—i.e. a prevalence—of what is there today in Africa. It actually positions these different systems in a non-historical, and thus static perspective. Figure 3 indeed mentions mutual health organisations as well as centrally managed and mandatory social health insurance systems. Both systems co-exist in Africa, although they are independent of each other. This is not the case when one considers European social history. The dynamic of European mutual health organisations gradually evolved, over a period of several decades and with increasing government support, into nation-wide, state-controlled, mandatory health insurance systems[19]. Hence the arrow in figure 3. One system consequently is the historical outcome of the other. It is important indeed to be aware of these differences in history.

Figure .3. Health care arrangements from an informal-formal point of view[20].



Note: MHO stands for Mutual Health Organisation

[19]Guillaume (1995, p.468) in his synthesis of the mutualistic movement throughout the world writes: *lorsqu'elle survit, la mutualité est présentée, non sans raison, comme coupée de son inspiration initiale, comme intégrée dans les rouages de l'État-providence au sein duquel elle a largement perdu ses vocations associatives, festives et éducatives. Gérant les différentes formes d'assurance obligatoire et le produit de prélèvements à la source sur les salaires ou autres formes de revenu, elle ne génère plus de militantisme et l'on est mutualiste comme on est assuré social, sans le vouloir.*

[20]This scheme is adapted from a figure originally designed by Lis & Vanthemsche (1995). Note: overlaps among the different informal mutual aid arrangements are intentional. They point to the fact that the boarders between these systems are sometimes blurred.

Obviously there are intermediate forms between the two above-mentioned models of voluntary health insurance. Such an intermediary model is not only possible, it is perhaps even desirable. It would indeed reconcile the transparency and participatory potential of the mutualistic model with the effectiveness and efficiency of the more large-scale provider-driven technocratic model. In this way a better synthesis between people's priorities on the one hand and the technical know-how of health professionals on the other could be achieved. This is only possible if there is a continuous dialogue between both partners.

This intermediary model seems coherent with the philosophy of Primary Health Care as formulated more than 20 years ago by the World Health Organisation in Alma Ata (WHO 1978). The philosophy of Primary Health Care indeed advocated consumer participation in the management process of the health system as well as the pursuit of an optimal accessibility of the health services.