

Editorial: Community health insurance (CHI) in sub-Saharan Africa: researching the context

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Community Health Insurance (CHI) is a general term for voluntary health insurance schemes organized at community level, that are alternatively known as mutual health organizations (or *mutuelles de santé* in French) (Atim 1999), medical aid societies (Atim 1999), medical aid schemes (van den Heever 1997) or micro-insurance schemes (Dror & Jacquier 1999). The common characteristics are that they are run on a non-profit basis and they apply the basic principle of risk-sharing. The last two decades have seen an apparent boom in CHI in sub-Saharan Africa, in terms of the sheer number of such initiatives and the increasing attention that some policy makers and development partners are paying to these ventures.¹

The rationale for the current wave of promotion of CHI in Africa is based on two main factors. First, the recognition that for African households, financial accessibility to quality health care is a strongly felt need. Second, the success of the Western European experience social health insurance, initiated through small CHI schemes at the end of the 19th and beginning of the 20th century (Bärnighausen & Sauerborn 2002), suggesting that the financing of health care based on pooling of resources and risk-sharing may constitute a relevant policy option for African health care systems.

These considerations, however, contrast with two pieces of empirical evidence. Participation of African households in CHI remains limited (Waelkens & Criel 2004) notwithstanding a few isolated successes. The question of why coverage rates of the target population are so low cannot be ignored. CHI is, at least in theory, an effective solution for the financial accessibility problem people experience. Why, then, is there this apparent contradiction? What is going wrong? Why do so few people join?

What are the obstacles? CHI initiatives that are similar in terms of design and implementation sometimes lead to different results in terms of people's interest and participation. This raises a second question: what causes this difference? In this editorial we argue the central importance of context for the harmonious development of African CHI and discuss the different contextual dimensions that, in our view, matter most for CHI development.

Without minimizing the importance of an appropriate design for the intervention – in this case the introduction of a CHI scheme – we suggest that the success or lack of it, of CHI in Africa cannot be dissociated from the context in which they are developed. The nature of the interaction between the intervention and the context might explain the divergent results yielded by similar CHI schemes.

The concept of the 'Context–Mechanism–Outcome' complex, developed by Pawson and Tilley (1997) in their work on the *Realistic Evaluation*, provides an interesting basis for the study of the relationship between an intervention dynamic and a context. It represents a methodological approach that is worth exploring further. The framework of the Realistic Evaluation challenges the existence of a linear relationship between intervention and outcome in complex social interventions – as is the case with CHI. The key question is not *what* works, but rather *why*, *for whom* and *in what circumstances* mechanisms or interventions that do work, succeed. The answer to this question will not be expressed in terms of 'that particular intervention is the most effective and thus needs to be replicated' (i.e. a sort of 'best buy'), but rather in terms of 'intervention I leads to outcome O in context C, but a same intervention I is likely to lead to a different outcome in another context'. The study of the intervention in a variety of contexts could then generate and fine-tune a theory that explains how the intervention really works.

We can briefly illustrate the issue with two well-documented cases of CHI schemes the authors are familiar with: a scheme launched in the mid-1980s in the

¹ See the biannual inventory of CHI in West and Central Africa carried out by the *Concertation* – a forum for CHI promoters and partners for the sub-region – and published on the forum's web site <http://www.concertation.org>.

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Bwamanda district in the north west of the Democratic Republic of Congo, which produced impressive results in terms of coverage and impact (Moens 1990; Criel *et al.* 1999). From its inception, the scheme attracted more than 60 000 people each year. The other is the *Maliando* CHI scheme created in the mid-1990s in the context of an action research project in the West-African country Guinea-Conakry (Criel *et al.* 2002). Despite careful and lengthy preparations, and despite the close involvement of community and health care providers in the design and operation of the scheme, its results were disappointing (Criel & Waelkens 2003). A similar intervention, i.e. the creation of a CHI scheme at district level in rural settings where access to health care is problematic, can thus yield totally different results.

Once we accept the key role played by the context in an intervention dynamic, we still need a thorough analysis of its precise meaning. In other words, we need to know what is important when describing and differentiating contexts within the framework of the development of CHI. We have identified five key dimensions.

The political dimension

Is the development of solidarity-driven arrangements for health care financing really a political concern and a priority in the longer term? Do public authorities at local and central level have the political will to subsidize CHI,² and eventually to institutionalize the transfer of funds from richer to poorer population groups? Are they willing to go beyond lip service in that respect?

The economic dimension

Is there a sufficient level of purchasing power for people to pay a financial contribution to CHI that covers, albeit only partially, the health care expenditure of the insured group? Or is the household income level so critically low that the pre-payment of funds for possible future health care is not yet, or no longer, a realistic option in the light of the numerous other basic needs people have to address?

² See the case of the matching grant in the Community Health Fund experience in Tanzania where the government, with the financial assistance of the World Bank, tops up the revenues of the Fund by allocating subsidies equivalent to the members' contributions (Chee *et al.* 2002). The case of China also is illustrative. In the frame of the recently launched 'New Medical Cooperative System', the central and local government will each pay 10 RMB Yuan in the insurance fund, in addition to the 10 RMB Yuan to be paid by the beneficiary (United Nations Theme Group for Health – Partners 2003).

The social dimension

Solidarity implies a certain level of shared identity and common interests; hence the need for a sufficiently strong social fabric. Is that the case? And is there enough trust in local leaders and institutions? Or is the collective experience with previously implemented financial arrangements to fund the costs of health care (or other basic needs for that matter) such that the necessary trust in such operations is jeopardized?

The technical dimension

Is the (perceived) quality of care offered in the health services sufficient to motivate people to purchase health insurance? And if this is not so, which, alas, is often the case in African health care delivery systems (Jaffré & Olivier de Sardan 2003), is there at least a concern among the providers that the quality of their services may not be satisfactory and is there a willingness to improve it? How far will health professionals be ready to view CHI as an opportunity for their own professional development?

The managerial dimension

Is there sufficient knowledge and skill among promoters of CHI, and at the same time sufficient room for manoeuvre given the organizational culture of local health systems, to experiment in an intelligent way with innovative but complex modalities of health care financing, as is the case with CHI? Or does the bureaucracy of local health systems hamper, or even oppose attempts to introduce well thought-out strategies for change?

In the case of the two examples of insurance schemes mentioned above – the Congo and the Guinea schemes – an initial assessment immediately identifies some major differences in terms of context, but a more detailed analysis of the nature of and interaction between the different contextual dimensions would be useful. The Bwamanda scheme was launched in a setting where people basically trusted the management of the scheme, where subscription premiums for participating households were subsidized, where the quality of health care supplied was of a relatively high standard and where the District Medical Team had the freedom, willingness and skill to test change (Criel & Kegels 1997; Criel *et al.* 1998). The Guinea environment was quite different: people generally distrusted initiatives taken by public authorities, the quality of care was reputed to be poor (Haddad *et al.* 1998), premiums were not subsidized and large households had problems with paying them (Criel

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& Waelkens 2003), and attempts to introduce change were viewed by the managers heading the *Direction Préfectorale de la Santé* as a burden, or even a threat.

The usefulness of the study of individual cases of CHI, be they successful or not, is obviously not in question: its real potential, however, lies in the very scrutiny of the context in which they thrived so as to reveal the reasons for success or failure. For instance, the widely perceived differences in CHI experience between West Africa (seen as relatively more successful) and East Africa (seen as relatively less successful) immediately underline the importance of further elucidation of the respective contexts (Waelkens & Criel 2004). There is thus a need to conceptualize and systematize the analysis framework of the environmental dimensions, and their interactions, in the few schemes that are successful, and in the many others that fail to yield the expected results. We believe that such inductive research, carried out in a variety of settings, could lead to a level of knowledge that would be helpful to managers in their decision-making process. A detailed outline of 'Context–Intervention–Outcome' pattern configurations could guide them in deciding whether, where, when, with whom and how to promote the creation of CHI.

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