2.5. Social health insurance in French-speaking sub-Saharan Africa: situation and current reform

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Introduction

In Africa, since independence, we have seen a multitude of reforms, strategies and alternative systems to guarantee some access to more quality health care for the populations of our developing countries. But we have also seen too many failures, for which we can legitimately ask the questions: have we learned our lessons? In fact, since the failure of free health care and the introduction of cost recovery mechanisms – with its corollary of exclusion and inequity – access to quality health care remains a remote mirage for most of our populations. In Mali, curative utilisation stagnated at 0.23 new contacts per person per year (Audibert, Martine/de Roodenbeke 2005). What about all the sick people? Where are they heading for? Where do they end up?

The role of ill health in the creation of poverty at community level has been documented for years now (ILO 2003; OECD 2003; Schultz/Tansel 1997; Whitehead et al. 2001). During our many missions in African villages, how many heads of households told us that they had to sell oxen and the crops of the year to come, just to face the sickness of a family member, and at what price? Most of the time, the money was not even sufficient or came too late, as, for example, in the case of an urgent caesarean section to be performed hundreds of kilometres away with no efficient or adequate transport at hand.

Faced with this setback, social health insurance is seen as a means to alleviate the suffering of our populations (Waelkens et al. 2005). Social health insurance – be it voluntary like Community Health Insurance (CHI), compulsory and/or universal – is now high on the political agenda. What has been realised? What are the current reforms? What can we expect in the near future? We try to find an answer to these questions based on information from the following sources:

- Country reports from 13 out of 14 countries (Benin, Burkina Faso, Burundi, Chad, Gabon, Guinea, Ivory Coast, Mali, Mauritania, Niger, Rwanda, Senegal and Togo, but not Comoros), presented at the symposium *L'amélioration de l'accès aux services de santé en Afrique francophone: le rôle de l'assurance* (Improving access of health services in French-speaking Africa: the role of health insurance), organised by the World Bank Institute and the Institut Multilatéral d'Afrique in Paris, from 26 till 30 April 2004;
- Reports from the Coordination Network *La Concertation entre les acteurs du développement des mutuelles de santé en Afrique*, commonly referred to as *La Concertation*, in particular of the inventories made and of the forums held;
- Our own investigations in several sub-Saharan countries;
- The existing literature.

Diagnosis

With independence, the French-speaking sub-Saharan African countries inherited a system of free health care at the point of use. For this reason and since the 1960s, their emerging social protection policies barely took in account health insurance. Most social security documents of the time touched only minimal measures regarding health, such as occupational health, with the establishment of infirmary posts, company health centres and inter-company health centres (*Centre Médical Inter Entreprise*, CMIE). Gradually, laws have been adopted to allow free health care for privileged population groups such as civil servants, the military and students.

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Very soon the young African states faced their first and massive financial problems. Hospitals and other health care structures ran short of all basic requirements: drugs, medical consumables and surgical items. Thus, the populations' direct financial contribution to access health care became a fact, first informally, then more formally. In 1987, the Bamako initiative generalised the concept of cost recovery.

In order to enable a more equitable access to health care, several mechanisms were explored to reduce unwanted financial barriers. These mechanisms can be grouped in three main categories: prepayment systems, community and other voluntary health insurance schemes, and compulsory and/or universal health insurance.

Community and other voluntary health insurance schemes

Set up as a response to failing health care access, community health insurance schemes (CHIs) first appeared in Africa in the mid eighties. Health care providers from faith-based organisations initiated the first two initiatives. These were the CHI scheme of CDI Bwamanda (Moens 1990) in the Democratic Republic of the Congo (DRC, then Zaire) and the Fandène scheme in the Thiés region of Senegal.

The Congolese Bwamanda scheme – despite the political and military problems of the DRC – remains statistically the most important one of French-speaking sub-Saharan Africa, with over 114,000 members in 2004 (47,000 in 2002, at the height of the war). The Senegalese Fandène scheme was unable to manage its own growth: it refused membership to a neighbouring village (Ouattara/Colas 2003) and has now about 3,050 beneficiaries.

Back in 2003, the Coordination Network *La Concertation* provided a third inventory of West African CHIs. The inventory included different kinds of health insurance schemes (HIs), both CHIs, strictly speaking, as well as solidarity funds. The inventory was presented at the 2004 Forum of the Coordination Network *La Concertation* at Bamako:

Table 2.7.1: Health Insurance Coverage in West Africa

Country	All HIs	Functional HIs	Functional / all HIs in this country	HIs in this country/ HIs in the region
Benin	54	43	79.6 %	8.7 %
Burkina Faso	92	36	39.1 %	14.8 %
Cameroon	38	22	57.7 %	6.1 %
Chad	7	7	100 %	1.1 %
Guinea	11	55	49.5 %	17.8 %
Ivory Coast	40	36	90.0 %	6.4 %
Mali	80	56	70.0 %	12.9 %
Mauritania	7	3	42.9 %	1.1 %
Niger	19	12	63.2 %	3.1 %
Senegal	149	87	58.4 %	24.0 %
Togo	25	9	36.0 %	4.0 %
All countries	**622**	**366**	**58.8 %**	**100 %**

Source: Letourmy 2004, slide 3-4

In total, 622 Health Insurance schemes were recorded, among which 58.8 % were operational at the time (2003). Among these health insurance schemes, only 10 % were solidarity funds. The remaining vast majority were community health insurance schemes. What are the features of these CHIs?

Generally speaking, the setting up of the CHIs did not respond to a national vision: only in recent years have African countries started to integrate CHI development in their social and health development plans and programmes. Most CHIs are new organisations, only 12 % were set up before 1996. Most CHIs are small-size organisations as 72 % have less than 1,000 beneficiaries (median: 678 beneficiaries). The typical benefit package prioritises drugs, small risks and pregnancy. Most CHIs formalise the relationship with their health care providers in a convention, whereby fee-for-service reimbursement is the standard, fee-for-episode reimbursement is applied in only 18 % of the schemes. Membership seems to be affordable and in 60 % of the cases it is about 500 FCFA (less than € 0.80) per family and per month. In three out of four schemes (76 %), the end-user has to make a co-payment, which is usually around 30 % of the benefit cost. In nearly one out of five schemes (18 %), contributors cross-subsidise the membership of (poorer) non-contributors.

Compulsory and/or universal health insurance

In French-speaking sub-Saharan Africa, very few compulsory and/or universal health insurance systems have been developed. Instead, waivers were established for the privileged such as civil servants, the military and salaried employees, but also for vulnerable groups like the very poor. The limitations of these waiver policies have nowadays become obvious: all public health care providers expected to deliver these free services have serious financial problems. This is one more reason why health insurance reforms are appearing on the national agendas.

Moving away from the waiver policy, some French-speaking sub-Saharan African countries have been developing compulsory health insurance schemes. Such is the case in Senegal (*Institutions de Prévoyance Maladie*), in Rwanda (*Rwandaise d'Assurance Maladie*), in Ivory Coast (various occupation-based compulsory schemes), in Guinea and in Gabon. As most of these schemes deal with the formal sector only (or even a part of it), they are still far from universal and might increase inequity.

Current reforms and prospects

The ongoing health sector financing reforms in French-speaking African can be grouped in two main categories. On the one hand, the followers of universality (mainly Gabon and Ivory Coast) aim to reach coverage for the whole population. Gabon does so by integrating a health care division in both of the existing social security schemes (one for the private sector, another one for the rest of the population). Ivory Coast works towards the creation of two central schemes, under the umbrella of a National Fund for Health Insurance.

On the other hand, the strategy in the other countries includes different approaches for specific population groups: the creation of a compulsory scheme for the formal sector (in the Senegalese variant, this might implicate the merging or reinsuring of the existing health insurance institutions in one national insurance scheme); the creation of CHIs for the informal sector and the artisans; and the implementation of assistance funds for the very poor.

Taking into account the vivid dynamics of these ongoing reforms, the situation in French-speaking sub-Saharan Africa looks promising. In our opinion, however, none of these reforms will solve the continent-wide problem of access to health care without a series of additional urgent collateral efforts. These include targeted support for the demand side of health care – in particular for the development of social health insurance – in French-speaking sub-Saharan Africa, to counterbalance the support for the supply side that for years was unable to bring about the expected results. Secondly, long-term support for the development of social health insurance in French-speaking sub-Saharan Africa is needed in order to overcome the thousands of short-term small projects that created more problems than solutions. Thirdly, the creation of a human resources training programme for the French-speaking sub-Saharan social health insurance sector is a felt need since a skilled health financing work force is absent at present. Lastly, sufficient guarantees for the financial and managerial autonomy of national and community health insurance schemes, independent from the highly

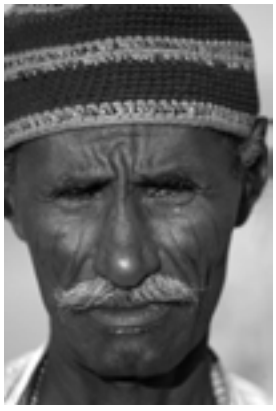
Table 2.7.2: Overview of health insurance mechanisms in francophone sub-Saharan Africa

Country	Public sector	Private sector	Other sectors	Ongoing reforms
Benin	Non-contributory scheme, related to the Code of Civil Service	Contributory scheme according to the Labour Code. Covers work-related injuries and illnesses, maternity and daily allowances	CHIs and private-for-profit insurance companies	
Burkina Faso	Non-contributory scheme, related to the Code of Civil Service	Contributory scheme according to the Labour Code. Covers work-related injuries and illnesses, maternity and daily allowances	CHIs and private-for-profit insurance companies	Creation of a compulsory health insurance scheme for the formal sector
Burundi	Compulsory contributory scheme (*Mutuelle de la Fonction Publique*), since 1980, in theory for 600,000 beneficiaries, in practice only 10 %.	Compulsory scheme created in 2000, but not functional. Application presently dependent on the goodwill of the employers	Medical Assistance Card for independents and farmers. Should cover 20% of the population but faces major operational difficulties	
Chad	Contributory compulsory scheme. Covers 75% of ambulatory care, hospitalisation and referral	Contributory scheme according to the Social Security Code. Covers work-related injuries and illnesses, maternity and daily allowances. Some non-occupational schemes exist	CHIs and private-for-profit insurance companies	Planning of the creation of a broader compulsory scheme, a pilot committee has been installed
Gabon	Non-contributory scheme, about 160,000 beneficiaries. Ambulatory care is fully covered, 10% co-payment applies for hospitalisation, 20% for referral	Health care division of the National Social Security Fund, based on a 4.1 % salary contribution of the employers only. Ambulatory care is fully covered, co-payment applies for hospitalisation and referral	National Fund of Social Guarantee for government contractors, independents and the very poor; based on a budgetary contribution, about 300,000 beneficiaries. Supplementary private insurance scheme, 65,000 beneficiaries	Creation of universal health insurance, provided by a sovereign Gabonese public institution: contributory and compulsory for all workers, non-contributory for the very poor
Guinea	Non-contributory scheme, related to the Code of Civil Service	Health care division of the National Social Security Fund since 1994, based on third party payment + 30% co-payment on behalf of the insured	CHIs, MURIGA (*Mutuele pour la prise en charge des Risques associés à la Grossesse et aux Accouchements*) for obstetrical risks and private-for-profit insurance companies	
Ivory Coast	Semi-contributory compulsory scheme (*Mutuelle Générale des Fonctionnaires et Agents de l´État*). Civil servants have the option to withdraw from the scheme	Well developed occupational medicine, with insurance contracts in some cases	CHIs and private-for-profit insurance companies	Creation of universal health insurance (*Fonds National*), based on two schemes (*Caisse Sociale Agricole* and *Caisse Nationale d'Assurance Maladie*)
Mali	Non-contributory scheme, related to the Code of Civil Service. Similar schemes for the elderly and war orphans.	Contributory scheme according to the Labour Code. Covers work-related injuries and illnesses, maternity and daily allowances	CHIs, emergency obstetrical funds and private-for-profit insurance companies	Creation of a compulsory health insurance scheme for the formal sector and of a medical assistance fund for the very poor
Mauritania	Non-contributory scheme, related to the Code of Civil Service. Similar schemes for the military, students	Contributory scheme according to the Labour Code. Covers work-related injuries and illnesses, maternity and daily allowances	CHIs, obstetrical fund, private-for-profit insurance companies, fund for the very poor	

Country	Public sector	Private sector	Other sectors	Ongoing reforms
	and the very poor			
Niger	Non-contributory scheme, related to the Code of Civil Service. Similar schemes for the military, students and the very poor	Contributory scheme according to the Labour Code. Covers work-related injuries and illnesses, maternity and daily allowances	CHIs and private-for-profit insurance companies	Creation of an overall HIs for the civil servants
Rwanda	Contributory scheme of the *Rwandaise d'Assurance Maladie*, based on third-party payment + 15% co-payment on behalf of the insured	Contributory compulsory schemes, diverse benefit packages and service level coverage according to the different employers	National fund for genocide victims (*Fonds National pour l'Assistance aux Victimes les plus nécessiteuses du Génocide et des Massacres*), about 283,000 beneficiaries CHIs, 7,388,647 beneficiaries: probably the biggest African CHI network	Restructuring of the different schemes, with extension of the benefit package
Senegal	Non-contributory scheme related to the Code of Civil Service. Similar schemes for the military, students and the very poor	Contributory compulsory schemes of the Health Insurance Institutions (*Institutions de Prévoyance Maladie*) with defined benefit packages, co-payment percentage according to the different schemes Compulsory scheme of the Social Insurance Institute (*Institut de Prévoyance Social*) for the retired	CHIs and private-for-profit insurance companies	Planning of the creation of a National HIs for the civil servants Planning of the creation of a Agricultural Social Scheme, in the framework of the existing agricultural laws Reinforcement of the legal framework for CHIs and for the National Solidarity Fund
Togo	Coverage for civil servants should be assured in the newly established Lomé hospital. Government shares the medical costs of expatriate civil servants. Government assumes the medical costs of the military.	Contributory scheme according to the Social Security Code. Covers work-related injuries and illnesses and maternity	CHIs and private.for-profit insurance companies	Planning of the creation of a compulsory scheme

Source: World Bank Institute/Institut Multilatéral d'Afrique 2004.

indebted social security institutions in our failing states, is vital for implementing sustainable health insurance mechanisms. Only if these conditions can be satisfied will social health insurance in French-speaking sub-Saharan Africa be able to improve access to health care as expected and also to boost the quality of the care offered by giving a voice to our suffering populations.



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2.6. The Inclusion of the Poor in a Social Health Insurance Framework: The Strategies Applied in Viet Nam

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Background

By shifting from a centrally planned to a market economy since 1986, Viet Nam has been undergoing a dramatic economic and social transformation. In the last two decades, the 'doi moi' (renovation) process led to considerable improvements in overall well being, with more than 7 % GDP per capita annual growth rate. The transition of the health care system contributes positively to the health status of the population. Despite being a low-income country, vital health indicators of Viet Nam are comparable to those of middle-income countries. In terms of life expectancy adjusted for years lost to disabilities, Viet Nam ranks 116 among 191 members of the World Health Organization (WHO) - not very different from much wealthier countries such as Greece and Brazil (World Bank 2004).

Although Viet Nam has recently been considered as one of the most successful countries in poverty reduction, there is still 24 % of its population living under the poverty line (at the end of 2004), many people still live just above the poverty line[31] and the risk of falling back into poverty remains high. In addition to the Hunger Eradication and Poverty Reduction program and program 135[32], a number of measures have been applied to ensure health care for the poor. Equity, efficiency and development are the objectives that have been identified by the Party and the Government for the health care system in the strategies of health care of the population into 2010.

Viet Nam – Basic data of 2005

- Population: 83 million
- Estimated growth rate: 8.4%
- Estimated GDP/capita: 620 US$, PPP: 3000 US$/capita
- Total GDP: 51 billion US$
- Life expectancy: 71 years
- Maternal mortality ratio to below 70/ 100 000live births
- IMR <25/1000 live births
- Under-five MR <32/1000 live births

Reforms in financing health care have been considered as the backbone policy to achieve equity in access to health care. Social Health Insurance (SHI) implementation has been the most important policy among the health financing reforms. Other notable health sector reforms are the introduction of user charges, the public-private mix of provision and the opening up of the pharmaceutical market. There is broad consensus in the country that achievement of universal SHI coverage appears to be the best way towards equity, efficiency and development. But how can SHI cover the poor and the near poor in a developing country like Viet Nam? Why did Viet Nam shift from other protection mechanisms to SHI policy for the poor? What are complementary health policies to health insurance for the poor? Is SHI appropriate for the poor in every condition? Those issues will be presented in this paper.

Development of SHI in Viet Nam

SHI was introduced quite early in the renovation process in Viet Nam. Being aware of the importance of accessibility to health care services for those who cannot afford to pay user fees at health facilities, the Government has piloted social health insurance schemes since 1989. The first Decree on SHI regulation was promulgated 3 years later, in 1992. At the end of 2004, more than 18 million people were covered by SHI schemes, including 3.9 million

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[31] Using in both cases the Viet Nam poverty line, which is different for the WB poverty line.

[32] The national program HEPR was launched in 1998, providing poor households with a range of benefits, including exemption of school fees, health care cards, access to subsidised credit, exemption from compulsory public work, exemption from agriculture tax and other contributions and food provision between harvest seasons. Program 135 provided poor communes with a resource allocation that they most often use to invest in a local infrastructure project, including roads, health centres, schools, irrigation systems, water supply systems, etc.