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Technical Note on Health Mutuelles in Madagascar

Local Health System Sustainability Project
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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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ACRONYMS

ACMU	*Agency Couverture Maladie Universelle* (Universal Health Coverage Agency) (Senegal)
CA-CSU	Cellule d'appui pour la mise en œuvre de la Couverture Santé Universelle (Universal Health Coverage Implementation Support Unit)
CBHI	Community-Based Health Insurance
CSB	*Centre de Santé de Base* (Basic Health Center)
DECAM	Decentralization of Health Insurance (program)
EHIA	Ethiopian Health Insurance Agency
LHSS	Local Health System Strengthening (project)
MSANP	*Ministère de la Santé Publique* (Ministry of Public Health)
NGO	Non-Governmental Organization
OPASS	*Organe Public d'Assurance Santé et Solidarité* (Public Health Insurance and Solidarity Unit)
SHOPS Plus	Sustaining Health Outcomes through the Private Sector Plus
SN-CSU	*Stratégie nationale pour la couverture sanitaire universelle* (National Strategy for Universal Health Coverage)
SNFS	*Stratégie nationale de financement de la santé* (National Health Financing Strategy)
UEMOA	*Union économique ouest-africaine* (West African Economic Union)
UHC	Universal Health Coverage

1. BACKGROUND

The Government of Madagascar has outlined its commitment to achieving Universal Health Coverage (UHC) through the 2015 National Strategy for UHC (*Stratégie nationale pour la couverture sanitaire universelle,* SN-CSU). The SN-CSU provides for improved health financing and particularly financial protection for users, which is reflected in the National Health Financing Strategy (*Stratégie nationale de financement de la santé,* SNFS), which is awaiting validation by the Minister of Health at the time of drafting this note. Other documents, such as the 2018 Implementation Plan, support the SN-CSU.

In May 2022, the government, through the Ministry of Public Health (*Ministère de la Santé Publique*, MSANP), took a new direction in health financing to develop Community-Based Health Insurance (CBHI) schemes (*mutuelles)*, adapted to the Malagasy population's needs. In response to this new priority, the UHC Implementation Support Unit (CA-CSU) that is attached to the General Secretariat of the MSANP, with the support of the Local Health System Sustainability (LHSS) project, conducted a document review and internal reflection and discussion sessions. The CA-CSU and LHSS held a workshop in July 2022 to deliberate on the lessons learned from the Malagasy and international experiences and to define the key elements of the model that will be recommended to the government.

The workshop was also an opportunity to increase CA-CSU's knowledge to better understand the technical and strategic discussions on CBHI, to share information and apply the lessons learned when considering existing health financing mechanisms in Madagascar (insurance, CBHI, cooperatives, etc.). According to the CA-CSU, this is the first phase of a long-term process that should lead to the merger of health insurance schemes. It is important to note that the various aspects of CBHI discussed in this note were chosen by the CA-CSU team.

After the workshop, LHSS was asked to prepare a technical note to support the government, in particular the CA-CSU, when it considers the key features to take into account in developing a CBHI scheme that is adapted to Madagascar's needs and that will contribute to the implementation of the SNFS, in particular the pooling of risk under one health insurance agency (Public Health Insurance and Solidarity Unit (*Organe public d'assurance santé et solidarité,* OPASS)).

This technical note will be updated based on the decisions and progress made in implementing CBHI or other health financing mechanisms, other governmental decisions, and the capacity of the CA-CSU and other actors in implementing the SNFS. Through the LHSS project, USAID Madagascar expects the key features presented in this note to be incorporated into other sustainable health financing mechanisms as per the World Health Organization's recommendations on CBHI to serve as a springboard toward risk pooling and not as an end in itself.

2. SUMMARY OF THE CONSENSUS OF THE CA-CSU TEAM ON CBHI

The Government's Proposed Vision for CBHI

All Malagasies have access to quality health care and services through CBHI schemes set up by the State to guarantee and protect all its population.

- **Presentation of the CBHI mechanism**: The CBHI will be supported by the State with the involvement of the decentralized local authorities, the decentralized technical units, and the community. A CBHI scheme will be established in each commune. Each scheme will have the legal status of an association and be governed by Order 60-133 of October 18, 1960. A decree issued by a government council will regulate the creation and the operation of these CBHI schemes and all other CBHI schemes. The CBHI schemes will be established with a view to networking the schemes. A quality assurance approach will be introduced in the health facilities through the CBHI schemes.
- **Management body**: For the association's management, each CBHI scheme will be managed by a General Assembly, a Board of Directors (in which will be non-voting decentralized local authorities and decentralized technical units, and representatives of the enrolled members), an Executive Board, and a Supervisory Commission.
- **Supervisory body**: Each CBHI scheme will appoint an account committee. Each CBHI may decide whether it will be additionally subject to inspection by a state body. Once the association has the status of a Public Utility Association (*Association Reconnue d'Utilité Publique*) or receives a subsidy from the State, state financial control will be automatic.
- **Membership**: CBHI membership will be family-based. For large families, an additional fee, proportionate to family size, will be applied. Each CBHI will define the documents required for membership.
- **Health care package offered**: The health care services and care that CBHI schemes will reimburse will be defined and provided by the Basic Health Centers (*Centres de santé de base*, CSBs) of the commune where the CBHI schemes are located, as will hospital care at referral hospital centers, subject to the members' ability to contribute.
- **Modalities for providing care to members**: Access to health services and care is subject to the presentation of a valid card and possibly a certificate of coverage. Providers will be reimbursed subject to pre-payment monitoring and verification in a PhaGCom account for the Basic Health Center.
- **Introduction of a quality assurance approach in health care facilities through CBHIs**: Improving the quality of care provided to members is necessary for member retention and satisfaction. This quality improvement innovation takes into account both clinical care and the performance of the CBHI scheme and is one of the fundamental pillars of the CBHI implementation approach in Madagascar.

3. KEY FEATURES TO CONSIDER IN DEVELOPING CBHI SCHEMES SUPPORTED BY THE GOVERNMENT OF MADAGASCAR

3.1 COMMUNITY-BASED HEALTH INSURANCE SCHEMES

As defined by the CBHI Federation of MIARA-MIAHY, recognized at the time of its establishment and governed by Law No. 2020-005 on insurance, a CBHI scheme is "a non-profit group of individuals, endowed with the legal personality of private law and which, essentially by means of its members' contributions, proposes to carry out in the interest of its members and their dependents, an action of foresight, mutual aid and solidarity, with a view to taking charge of preventive and curative health care, as well as social protection" (Repoblikan'i Madagasikara 2020).

This definition is recognized nationally when the CBHI scheme has characteristics of private law and whose promotion and development will be supported by public and private actors wishing to contribute to the government's policy on health financing and in particular financial protection.

Universally recognized foundations of CBHI schemes include:

- MUTUAL AID AND SOLIDARITY: Malagasy culture (*Fihavanana*) and the traditional practices in certain regions of Madagascar already incorporate the spirit of mutual aid and solidarity, which has facilitated the creation and scale-up of CBHI schemes that are adapted to specific targets but are aligned with the UHC vision.
- NON-PROFIT: Profit sharing is incompatible with the culture of mutual aid between communities. Revenue must be reinvested in the CBHI scheme for other social actions aimed at benefitting scheme members.
- DEFENSE OF COMMON PROPERTY AND INTERESTS: Members of CBHIs adhere to a social movement that aims to protect common property and interests for the development of the community.
- Self-management and joint decision-making are other principles that arise from this.

In Madagascar, the existing CBHI schemes are non-profit entities, sharing the same objective: to promote access to quality and affordable health care to alleviate the difficulties of families facing financial risks related to illness. They are heterogeneous, with each scheme having its own geographical area of coverage; conditions of membership related, or not, to membership in an institution such as a company or other group; and management of the financial flow for the security of funds. These CBHI schemes have evolved over the past several years in order to better meet the needs of their targeted populations.

With the adoption of the Insurance Act, it became necessary to clearly distinguish the activities of microinsurance and community-based insurance from those of CBHI to comply with regulations. The concepts used could create confusion because it has become customary to refer to internationally recognized practices although the local context is different. For example, it would be more appropriate to use the term "mutual health insurance" instead of "community-based health insurance" to avoid confusing CBHI with microinsurance schemes, which are private for-profit entities.

3.2 THE DEVELOPMENT OF CBHI SCHEMES IN RELATION TO NATIONAL PUBLIC HEALTH POLICIES IN MADAGASCAR

The Health Sector Development Plan 2020-2024 provides for the development of CBHI networks under the Plan's prevention activities (Strategic Guideline 1.1: Health promotion – Outcome 1.1.4.7); financing of community health (Strategic Guideline 2.2: Strengthening of interventions related to community health development – Outcome 2.2.3.4); and the establishment by health districts of at least two financial protection mechanisms that make access to care available to their population (Strategic Guideline 3.3: Strengthening the efficient management of the health system's financial resources – Outcome 3.3.5).

In the SN-CSU, the added value of CBHI is demonstrated at the level of fundraising and mobilization of the population. The need to develop CBHI schemes so that they can become delegated management organizations for other insurance companies is clearly indicated (Sustaining Health Outcomes through the Private Sector (SHOPS) Plus 2019).

The reforms proposed by the SNFS in its April 2022 version are to promote the development of voluntary health insurance, particularly CBHI. In addition to its primary mission, OPASS will pool CBHI funds for risk sharing among schemes.

3.3 LEGAL ACTS

During the July 2022 workshop, it was agreed that all CBHIs be governed by the same text, a decree issued by the government council.

There is no specific law on mutual benefit insurance system in Madagascar. Law No. 2020-005 on insurance (recasting Law No. 99-013 on August 2, 1999, on insurance) in its article 2 – section 3 lists the entities not subject to this law, including CBHI schemes. It assigns the Ministry of Finance the task of determining by decree the conditions for exercising CBHI activity and the criteria applicable to these entities and publishing them on its website. With the support of the USAID-funded SHOPS Plus project, a draft decree on CBHI was drawn up in 2021 at the request of the MIARA-MIAHY CBHI Federation to clarify the mutualist principles governing the schemes, the conditions for exercising and controlling their activities, as well as the protection of members and beneficiaries. With the support of the World Bank, the CA-CSU developed a draft Law on the Financial Protection of Health Services Users that would take into account the decree on CBHI. The process of adopting this law is still underway.

To establish a legal framework that respects the hierarchy of Malagasy legislation, it was proposed to the MSANP to set up a technical committee in collaboration with the CBHI Federation to review the legal framework for CBHI schemes, including the draft decree and its orientation in relation to the Law on the Financial Protection of Health Services Users. A review of the legal framework conducted by SHOPS Plus in 2019 suggests that:

- The draft order on CBHI schemes should not be subject to the very strict supervisory measures governing companies or mutual insurance companies, because the financial stakes are not the same. On the contrary, incentives should be provided to encourage the setting up and development of CBHI schemes, given their social rather than economic role.
- The ministries involved in the supervision of CBHI schemes should be better organized, for example methods for verifying the rules governing the contribution amounts, and monitoring compliance with mutualist principles in order to protect the population from possible abuse, especially when the diversity of activities of CBHIs go beyond the health insurance framework.

3.4 LEGAL FORM OR STATUS OF CBHIS: ASSOCIATION

The Insurance Act clearly indicates the entities that can carry out mutual assistance and solidarity activities in the form of an association and a non-governmental organization (NGO). Local experience has shown that only the status of association is adapted to the CBHI culture. Of the eight schemes that are members of the CBHI Federation, only one has adopted the form of an NGO to allow technical and financial partners to sit as observers in the various meetings. All CBHI schemes set up under the SANTENET1 and 2 projects (2004-2008, 2009-2013) are governed by the Associations Act in Madagascar.

An association is governed by order n°60-133 of October 3, 1960, and its enforcement decree 1960-383 of October 5, 1960, which specify the creation and dissolution, the management and administrative bodies, and the general functioning of an association. The legal model of an association is available at the Ministry of the Interior and its decentralized services. The statutes authorize the creation of three bodies: deliberative (General Assembly and Board of Directors), executive (Bureau, Council, or Executive Secretariat), and supervisory (Supervisory Board).

At their establishment, most existing CBHI schemes adopted a simplified mode of governance consisting of a General Assembly and Board of Directors, with provision for the recruitment of paid staff once resources permit (the members of the administrative bodies are volunteers). Under this format, the founders of the CBHI scheme are in charge of scheme management, are fully involved in scheme activities, and are able to learn from experience and lessons. Management by an external resource may detrimentally affect the viability and sustainability of a CBHI.

However, Association statutes are limited with regard to the development of CBHI schemes and the achievement of UHC. To maintain their viability, the majority of existing CBHI schemes are forced to collaborate with other partners to combine a technical and financial partnership with a distribution network and a sufficient membership base; or to create income-generating activities to boost the community's capacity to pay contributions. Other strategies should also be developed to make membership automatic, as is done by CBHI schemes that are attached to an entity. For example, all loan beneficiaries could automatically get a CBHI scheme membership card. The major challenge for voluntary CBHI schemes is that some people cannot contribute, or can contribute but do not want to. This issue should be taken into account by the state CBHI schemes and be discussed among stakeholders in order to choose the most appropriate status.

3.5 CONNECTING CBHIS TO A COMMUNE

The MSANP has proposed a CBHI model that sets up a scheme in each commune.

The model that has already worked in the country is the Community Mutual Health Fund integrated into the Kaominina Mendrika Salama model supported by the USAID/SANTENET1 project (2004-2008). Its targets are limited to residents of a commune, or even to a sector of the CSB level 2. The USAID-funded Mahefa Miaraka project (2017-2021) set up community groups similar to community savings and credit banks with health funds dedicated to paying members' health expenses. These models would not have been able to incorporate all the criteria needed to ensure the viability of a CBHI scheme. In contrast, multiple CBHI schemes linked to the same decentralized entity can develop with a risk-pooling network based in the central entity. For example, a CBHI network can expand as the agricultural cooperative to which it is linked when the cooperative creates branches in other regions.

To expand this model, it is necessary to consider scaling up CBHI schemes at the district, regional, and national levels, and integrating into OPASS, which is indicated in the SNFS. According to the experience of SANTENET1, the CBHI membership rate is quite low, which jeopardizes the sustainability of the "communal" system. When they were launched, most CBHI schemes had a membership rate of around 20 percent of their target population, and some schemes attained a rate of 50 to 70 percent. However, over the years and with the withdrawal of SANTENET's support, this rate decreased—even the most successful schemes enrolled only 10 to 15 percent (SANTENET2 2010). However, four districts, Vatomandry, Ambohimahasoa, Ambalavao, and Ambositra, have scaled up CBHI schemes at the district level and their experience can provide lessons learned.

Furthermore, a discussion should be held on the role of communes and in particular the mayor in the management, administration, or supervision of CBHI schemes, and the role of the chief medical officer of the CSB level 2, and finally the role of the Communal Committee for Social Development, which automatically includes mayors and CSB leaders. The role of the mayor could become more political and the promotion of CBHI is a means of accountability.

Finally, if the "communal" model is chosen as the government's strategy, the State should encourage existing CBHI schemes and other health financing actors to adapt or transition existing mechanisms.

3.6 MANAGEMENT BODIES

The CBHI proposes to include other individuals with public authority (elected and/or appointed without voting rights) in CBHI management bodies.

The number, type, and membership of management bodies are specified in the laws governing associations and NGOs. Membership often depends on the objectives of the founders, the promoters, and sometimes the external partners who support the establishment of the CBHI schemes. In the case of CBHI schemes linked to a commune, a "technical and strategic" review should be undertaken to identify the management bodies and their members to avoid the use of the schemes for political or personal purposes; this requires a clear decision on the role of the Communal Committee for Social Development, the mayor, and other state services decentralized to the local level. One of the risks mentioned by the CBHI Federation is the involvement of partners in decision-making, which could create dependence, particularly financial dependence, for a CBHI scheme. Although financial support for CBHI schemes is inevitable when they are first established, there should be safeguards to avoid political influence.

Consequently, it is necessary to carefully consider the composition of CBHI schemes' management bodies, the role of members and partners, and the voting principles to be specified in the statutes or internal regulations of the scheme as an association.

3.7 TARGETS/MEMBERS

The target population for the communal CBHI model is all residents of the commune.

The populations classified as extremely poor will be identified using the criteria defined by the local CBHI scheme. The State will cover some of the costs of these vulnerable groups. To focus the targeting effort, the criteria could be the geographical area (rural, landlocked), the sector of activity (informal, agriculture, etc.), or other parameters that will allow the scheme to reach a large number of potential members and that will facilitate automatic membership. To finance

coverage of these groups, for example, a portion of municipal taxes collected could be paid directly into the CBHI account on behalf of taxpayers and their families. Lessons can also be learned from the implementation of equity funds and the National Solidarity Fund for Health in targeting the vulnerable population. The Malagasy Vocational Training Fund model could be used to cover members with low contribution capacity. In addition, the financial support of the most deprived should be discussed again and clarified because it requires funding.

3.8 PAYMENT OF CONTRIBUTION FEES

To facilitate the enrollment of the population, each commune will decide the payment method for collecting contribution fees.

It is important that each CBHI scheme analyze the financial cycle of its target population and conduct a feasibility study of the proposed payment method and how it will affect scheme membership, management, and operations, as well as the continuity of member coverage. For example, allowing people to pay in several installments adds to the scheme's promotion and management costs, and missing a payment will interrupt a member's coverage.

A communal membership/contribution model has already shown limitations, because in some communes, coverage periods are often limited to the inter-harvest "lean" season, which lasts six to eight months. During this time, the vast majority of the rural population does not have sufficient resources to pay for CBHI membership, making their coverage discontinuous. If premiums were collected during the harvest period, it would be easier to set up a single annual payment system. However, this schedule might exclude those who are undecided about membership during this period and, as a result, will not increase membership.

The waiting period between the contribution payment and actual coverage (one to three months in other countries) should also be considered to combat adverse selection. A short period may attract families with a sick person looking for short-term reimbursement, rather than motivating the entire population to seek long-term membership.

3.9 MEMBERSHIP TERMS AND CONDITIONS

Family membership is most often adopted by CBHI schemes as a strategy to avoid adverse selection, with a variable number of one to six people per family. An individual is considered a one-person family. However, the family must be distinguished from the household because a household may comprise extended family members. The calculation method most often used is the flat-rate contribution per family per period, especially for CBHI linked to an entity, with a fairly high amount (25,000 Ar to 80,000 Ar per year per family). This system helps to mitigate the risks associated with adverse selection. Some CBHI schemes calculate the family contribution by setting an individual amount multiplied by the number of people per family. But this may exclude large, low-income families, who are the primary targets of this model. The model should also allow for group membership, for example, students in a school or employees of a company and their families. Having multiple membership modalities encourages a heterogeneous population to join the health mutual.

3.10 CARE PACKAGES COVERED

Communal CBHI schemes often limit benefit packages to outpatient consultations and deliveries. The objective would be to add preventive services and health promotion and to standardize the care package at the commune level. Some CBHI schemes established under the SANTENET1 program set a fixed price (constant value) for referrals or medical evacuations

to district or regional hospitals. This had an impact on the membership rate because some community members could afford primary care, but not the fee for hospital coverage.

During the scaling up of CBHI schemes at the district level, SANTENET2 found that it was possible to add coverage of hospital care in different forms: a variable rate of coverage, a complementary package that covered some hospital services, or a lump sum for comprehensive care. However, coverage of hospital care would have tripled the amount of the contribution (contribution calculation for CBHI schemes at the SANTENET2 district level). CBHI schemes linked to an institution or with automatic membership can often apply a fairly high rate of reimbursement for hospital care, ranging from 30 percent to 100 percent, reimbursement of emergency transport ranging from 0 percent to 100 percent, or a flat rate or a cap on the cost of health care services (administrative services at the hospital, resettlement at home) according to the MIARA-MIAHY Federation.

Calculation of the contribution fee should consider all clinical, economic, and public health parameters in order to estimate a fee amount that meets the needs of the population and the specificities of the commune.

3.11 PROCEDURES FOR PROVIDING CARE TO MEMBERS

A precise beneficiary pathway should be well defined to facilitate access to care by members of CBHI schemes. The presentation of a valid membership card should be enough, but some CBHI schemes require a certificate of coverage for specific services (inpatient care) or for costly care (dental care, ophthalmology).

3.12 CONTROL (ADMINISTRATIVE, TECHNICAL, FINANCIAL)

The statutes governing associations' activities provide for the establishment of a Supervisory Committee and financial control by an auditor, and by the State once it becomes a Public Utility Association. For this CBHI, it is fundamental to ensure the coordination of the technical and financial responsibilities of the state supervisory authorities and of any partners in regard to the CBHI activities. Each member should receive information on the level of management provided by the administrators they have effectively elected within their association.

3.13 INTRODUCTION OF A QUALITY ASSURANCE APPROACH IN HEALTH CARE INSTITUTIONS THROUGH CBHIS

Improving the quality of care delivered to CBHI members is necessary to secure their loyalty and satisfaction. Therefore, a process for quality improvement has been implemented, through the collaborative model.

This quality improvement innovation takes into account the clinical aspects of care and the performance of CBHI schemes. The approach consists of analyzing, after a few months of operation, the causes of any inadequate care or poor performance of the CBHI plans, organizing learning sessions, and then forming a team of the key actors—health care providers, members, and other important actors—in each commune, to define the package of changes, implement them, and monitor quality improvements.

3.14 NETWORKING OF CBHI SCHEMES

Networking is an approach increasingly advocated by many actors and informed observers in the field, to promote the viability of CBHI schemes. Communal CBHI schemes located in the

same district or region will be networked in an umbrella structure, with the following main objectives:

- ✓ Pool the health risk, relative to the provision of higher level of care, of scheme members throughout the commune
- ✓ Ensure the pooled management of certain functions such as:
    a. Contractual relationships with the higher-level hospital
    b. Creation of a database of CBHI schemes in the commune
    c. Supervision of CBHI schemes
    d. Training of CBHI scheme managers
    e. Organization and implementation of inter-CBHI support
    f. Creation of a guarantee fund for the communal CBHI schemes of the commune, etc.

The networking of CBHI schemes will be done in phases so that the network can gradually assume management of the functions delegated to it by the general assemblies of the district's (or region's) communal CBHIs. This pooling of functions will undoubtedly facilitate economies of scale that can contribute to the economic viability of newly created schemes.

3.15 CHALLENGES TO THE IMPLEMENTATION OF CBHI SCHEMES

According to the CBHI Federation of MIARA-MIAHY, although CBHIs operate in heterogeneous and diversified contexts, all face challenges common to social protection programs. Listed below are some of the prerequisites they must fulfill to avoid the challenges:

- A broad membership base to pool risks and give them the financial capacity to reimburse claims
- Visibility and understanding of the CBHI structure (benefit package, user pathway, provider pathway) to ensure the use of services, membership renewal, and provider investment
- A network of local, large, and quality providers to build user loyalty and facilitate access to care
- Fluid and robust "back-office" management to ensure quality of services, including timely reimbursement of providers so they are willing to provide services to scheme members
- A well-defined legal framework to facilitate the protection of resources and individuals, and allow for the development of CBHI schemes.

To reach their current development stage, CBHI schemes have experimented in part or entirely with the following four stages, which may need to take place over a decade:

- Feasibility study
- Implementation of a pilot project on a category of beneficiary and/or a restricted area
- Geographical extension and/or opening to other categories of beneficiaries
- Stabilization of activities and structuring with a view to financial, operational, and institutional autonomy

4. INTERNATIONAL EXPERIENCE

4.1 ETHIOPIA

SUMMARY

In 1998, as part of a comprehensive reform of the public health system, the Ethiopian government validated a health financing policy. This policy has proven successful, but utilization of services remains low; a main cause is the direct cost of services to households, which remains a financial barrier. In 2011, with support from USAID and Senegalese experts, the government decided to pilot the CBHI approach. The pilot produced good results, and this motivated the government to scale up the CBHI program. By 2022, 911 of 1,116 *woredas* (districts) had implemented a CBHI. Seventy-nine percent (720) of the 911 schemes were functional, and 9.5 million households with 44 million beneficiaries were covered out of a population of 105 million Ethiopians. An additional 1.75 million poor households (8.1 million beneficiaries) were covered, equivalent to 33 percent of the target population (living below the poverty line). Implementation challenges include: poor quality of care, inadequate coverage of the population and the poor (lack of funding for subsidies), fragmentation, poor management of CBHI schemes, lack of data, and an increase in the number of loss-making CBHIs, which threatens the sustainability of the scheme.

STRATEGY AND SUPPORT ENTITIES

The introduction of CBHIs schemes was implemented as part of the Health Financing Strategy (1998), and was defined by the 2008 Health Insurance Strategy. This led to the setting up of the Ethiopian Health Insurance Agency (EHIA), which is now a department of the Federal Ministry of Health. The EHIA was made responsible for establishing two schemes: social insurance for formal sector workers and CBHI for the informal sector. The EHIA has worked closely with health authorities at different levels (region, zone, woreda, and *kebele* (commune)) during the pilot phases and later with the scaling up. It plays the role of promotor, while implementation is carried out by the local entities, particularly the woreda and kebele. Scheme administration is the responsibility of the woreda.

POOLING OF FUNDS AND RISK SHARING

CBHI schemes are autonomous despite the subsidies they receive (see next paragraph). To date, there has been no risk sharing, let alone pooling of funds among schemes. This means that some schemes have run deficits or have simply gone bankrupt. The trend is toward pooling at the level of zones and regions, and possibly in the future toward pooling at the national level.

SUBSIDIES

From the conceptualization of the pilot phases and based on experiences with CBHI in Rwanda and West Africa, CBHIs in Ethiopia have benefitted from subsidies at different levels: the EHIA is funded by the federal government, and used to subsidize membership fees at 25 percent before the rate was reduced to 10 percent. Discussions are underway to see if this subsidy can be returned to its original 25 percent. It should be noted that the amount of the subsidy is set at the local (woreda) level. Woredas also cover the salaries of schemes' permanent staff: a manager, an accountant, and a communication (mobilization) officer. The woredas are also

responsible for funding premiums for the needy, who must make up at least 10 percent of ASBC members. The amount of money provided for this subsidy is often insufficient.

4.2 MALI

SUMMARY

The story of the CBHI system in Mali includes three main periods: the development of corporate CBHI schemes; the development of CBHI schemes for workers in the formal sector; and the development of alternative health financing mechanisms through CBHI. This last phase of the Malian CBHI system was marked by a political commitment that public authorities made in various documents (Declaration of National Social Protection Policy *(Déclaration de Politique Nationale de Protection Sociale)* and the Social Protection Extension Plan (*Plan d'Extension de la Protection Sociale*)). This demonstrated commitment in the 1990s included the definition of a legal framework resulting in the adoption in 1996 of the law governing the CBHI system in the Republic of Mali and four texts implementing this law. Two decrees were Decree No. 96-136 / P-RM of May 2, 1996, which set the conditions for the investment and deposit of CBHI funds and Decree No. 96-137 / P-RM of May 2, 1996, which established the standard statutes for CBHI schemes, unions, and federations of schemes. Two additional decrees were signed including one that is inter-ministerial: Inter-ministerial decree N° 97-0477 MSSPA / MATS-SG of April 2, 1997, determined the procedures for approval of CBHI schemes; decree N° 02-1742 / MDSSPA-SG of August 19, 2002, addressed the administrative and financial control mechanism of mutual and mutualist organizations. In accordance with Regulation N°07/2009/CM/UEMOA on the regulation of CBHIs within the West African Economic Union (UEMOA) and the experience of extending UHC through CBHI, restructuring of the CBHI movement has begun.

STRATEGY AND SUPPORT ENTITIES

Social protection is a right guaranteed by international agreements and enshrined in the Constitution of Mali on February 25, 1992, in its Article 17. Within the UHC framework, on February 9, 2011, Mali adopted the National Strategy for the Extension of Health Coverage through CBHI and its Five-Year Program. The basic administrative unit of this strategy is "one commune, one CBHI." It began functioning in 2012 through a three-year pilot phase covering the regions of Sikasso, Ségou, and Mopti.

Evaluation of the implementation of this phase took place in May 2015 and enabled this team to assess the results and identify the strengths, weaknesses, and obstacles of the process with regard to the various intervention areas. Based on lessons from the implementation of this phase and from the experiences of other health and social development support programs, the new National Strategy for the Extension of Health Coverage to the Agricultural and Informal Sectors through CBHI and its 2021-2025 action plan was built on a larger administrative unit, "one circle, one CBHI with branches in the communes."

In addition, the institutional reform that resulted in the creation of the *Direction Nationale de la Protection Sociale et de l'Économie Solidaire* (National Directorate of Social Protection and Solidary Economy) gave new impetus to the development of a CBHI system with a better-organized supervisory body and to the creation of a service that will build the capacity of actors in the development of mutuality through the *Centre National d'Appui à la Promotion de l'Economie Sociale et Solidaire* (National Center for the Promotion of the Social and Solidary Economy). The creation of the Malian Agency for Social Mutuality (*Agence Malienne de la*

Mutualité Sociale), in accordance with Regulation N°07/2009/CM/UEMOA on the regulation of the CBHI system within the West African Economic Monetary Union (WAEMU), resulted in the redefinition of the missions of the National Directorate of Social Protection and Economic Solidary and the designation of the Technical Union of CBHI as the Delegated Management Body of the UHC scheme.

POOLING OF FUNDS AND RISK SHARING

According to the National Strategy for the Extension of Health Coverage, the risks covered by CBHI schemes in Mali ensure that beneficiaries receive services throughout the health pyramid. The institutional architecture adopted provides for the networking of CBHI schemes according to territorial division with the delegation of a set of services. Thus, at the national level, the National Federation of CBHI Schemes will be set up. It will be the umbrella organization and will bring together all the CBHI schemes in regional unions. A plan articulating the mutualist movement with the supply of health services has been adopted.

SUBSIDIES

The CBHI schemes have three main financing sources: member contributions, the government subsidy, and funding from technical partners. The government subsidy is based on the level of collection of contributions (i.e., 50 percent of the total amount collected during the previous year). This contribution has allowed the survival of many CBHI schemes because their benefit package is quite broad. The contribution levels of community CBHI schemes varied from 1,500 to 2,000 CFA francs/person/month, depending on the scheme, although the cost of a UHC service package is 8,650 FCFA/person/year. An experiment in sharing the contribution between different actors was carried out within the framework of the Support Program for Health and Social Development Phase II (*Programme d'appui au développement sanitaire et social phase II*), Mopti II. This distribution is shown below:

- Member contribution 20 percent (1,730 FCFA/person/year)
- Malian Government 50 percent (4,325 FCFA/person/year)
- French Development Agency (AFD) 30 percent (2,595 FCFA/person/year).

4.3 SENEGAL

SUMMARY

CBHI has a long history in Senegal. The first CBHI schemes were established in the 1980s and expanded in the 1990s. They are either socio-professional CBHI schemes involving professional activities or faith-based organizations, or community schemes. The latter are the most widespread. But after 30 years of operation and support from various technical and financial partners, it was clear that the coverage of the population by CBHI had not achieved the expected results. Following the election of President Macky Sall in 2012, the Ministry of Health and Social Action adopted in 2013 the Strategic Plan for the Development of Universal Health Care in Senegal 2013-2017. This strategic plan emphasizes the adoption of community health organizations as one of the national strategies for achieving universal coverage, with the objective of making operational at least one community CBHI per commune.

STRATEGY AND SUPPORT ENTITIES

The support unit for CBHI schemes, health insurance institutions, and health committees was created within the Ministry of Health in 1998. Following this, a strategic plan for the development of CBHI schemes in Senegal was developed in 2004. In early 2012, the Decentralization of Health Insurance (DECAM) program was implemented with the support of USAID. The goal of DECAM was to set up one CBHI per local community. The implementation of the UHC policy has been coordinated since 2015 by the Agency for Universal Health Coverage, which was transferred in 2019 from the Ministry of Health to the Ministry of Local Development. Since DECAM, the CBHIs have relied on a technical assistance unit at the departmental level and are grouped into departmental unions, regional unions, and a national union, each with a number of specific missions assigned to it.

POOLING OF FUNDS AND RISK SHARING

To address the challenges and improve the management as well as the operation of the CBHI program, since 2018 the government has developed and partially implemented two major reforms. The first reform consists of a series of institutional reorganizations aimed at increasing the level of pooling of funds in order to improve the level of risk pooling. Risk pooling and part of the management of individual CBHIs have been transferred to the departmental unions; the operation and financial responsibility of the free health insurance initiatives for the vulnerable population has been transferred to the CBHI schemes. Thus, while schemes are in charge of primary and secondary care, the remaining funds are pooled at the departmental union level for health services and medicines that are provided or prescribed by referral hospitals (tertiary health care). Thus, at least for tertiary care, larger financial risks can be pooled by a larger group of people than individual CBHI schemes. The second reform is the introduction of an integrated management information system for better data management and effective and efficient operation of the scheme (Kestemont, Clouvain, and Paul, 2020).

SUBSIDIES

In 2017, the Agency for Universal Health Coverage decided to pay the salary of one manager per CBHI for one year and, for two years, to take charge of a technical management unit at the departmental level, including an administrative and financial manager and a monitoring officer. In addition to this institutional architecture, the DECAM initiative put in place an equally complex financing system. The Senegalese government has committed to subsidizing half of the premiums of beneficiaries who enroll in a CBHI scheme. Furthermore, it created specific mechanisms to subsidize the inclusion of target groups such as students (who pay 1,000 FCFA, or 1.52 EUR, per capita per year) and households benefiting from a family security grant *(bourse de securité familiale*) or a social assistance program for the poorest. As a result of these subsidization policies, CBHI schemes now have two kinds of beneficiaries: traditional beneficiaries who have to pay an annual premium of 3,500 FCFA (5.34 EUR) per capita per year, and beneficiaries who are partially subsidized (students) or fully subsidized (family security grant). At the end of 2016, of the 2.2 million CBHI beneficiaries, one-third had paid into the program and the rest were fully subsidized by the government (Daff et al. 2019; Ridde, Bossyns, and Ladrière 2018; Verbrugge, Ajuaye, and Van Ongevalle 2018).

4.4 RWANDA

SUMMARY

Rwanda has been recognized as having the most successful CBHI in sub-Saharan Africa and, indeed, one of the most successful in the world. Within a few years, the country went from having 7 percent of the population in the informal sector covered to 74 percent in 2013. The country has developed a system based on a strong partnership between the government and the communities, which are very involved in monitoring. There are different levels of shared risk pools, subsidization of poor populations to minimize adverse selection, huge efforts to establish and maintain good financial and management systems, and a commitment to sustainability. The Rwandan scheme is best described as a national CBHI program (Kalisa et al. 2015). The insurance law (N°48/2015 of 23/11/2015 Act on the organization, operation, and management of health insurance schemes in Rwanda) codifies the integration of CBHI schemes into Rwanda's social protection scheme managed by the Social Security Council of Rwanda.

STRATEGY AND SUPPORT ENTITIES

During the initial phase (pilot) of the CBHI schemes (1999-2003), the Ministry of Health set up a steering committee. For the following phase (scale-up, 2004-2010), the CBHI Scheme Support Unit was created within the Ministry of Health. In 2004, the CBHI Development Policy was created. Subsequently, CBHI schemes were supported by the General Directorate of Planning, Health Financing and Information Systems before being placed under the supervision of the Rwanda Social Security Board in 2014.

POOLING OF FUNDS AND RISK SHARING

In 2004, the Ministry of Health adopted three decrees that changed the nature of district CBHI schemes without risk sharing to a scheme with risk sharing at all levels: 1) a decree creating the National Solidarity Fund for Health and the Solidarity Fund for Health Districts (risk sharing), 2) a decree determining the responsibilities of the administrative procedures of CBHI schemes in Rwanda, and 3) a decree on the management of funds provided by the Ensuring Access to Quality Care project (financed by the Global Fund) for vulnerable people. The decision to entrust the management of CBHI schemes to the Social Security Board in 2014 effectively integrated CBHI schemes into the National Social Protection Fund.

SUBSIDIES

In 2006, the policy of subsidizing the expansion of the service package in district and national referral hospitals through risk-pooling mechanisms (National Solidarity Fund, district solidarity funds, the Global Fund-supported government subsidy policy for the very poor and other vulnerable) was implemented (Kalisa et al. 2015). In 2006, the Global Fund was subsidizing 11 percent of the population. Later, funding was provided by other development partners, such as USAID, the German Cooperation, the Belgian Cooperation, the International Labor Organization, the Swiss Cooperation, the European Union, the World Bank, World Health Organization, UNICEF, CARITAS, Compassion International, and local NGOs.

As a result, a new policy on the promotion of CBHI schemes was drafted in 2010 and implemented in July 2011 with the sole purpose of providing the population with universal and equitable access to quality health services. The policy aimed to increase equity by having wealthier members pay higher premiums than poorer members (as opposed to previous premiums that were the same for everyone) and also to generate more revenue for the plan,

which was heavily subsidized (Kalisa et al. 2015). The new policy established a new fee structure with three groups: the third group (the poorest) is fully subsidized by the government and technical and financial partners and pays no user fees. The other categories pay different amounts for their contributions.

5. INTERNATIONAL EXPERIENCE ANALYSIS AND FINDINGS

5.1 ADMINISTRATIVE ENTITY AND PROMOTION STRATEGY

In all four countries, an entity dedicated to the promotion of CBHI schemes has been set up within the Ministry of Health. In Rwanda and Senegal, it is a ministry unit; in Ethiopia, the EHIA; and in Mali, the Malian Agency for Social Mutuality. It is noteworthy that Ethiopia's approach is coherent: a reform of the health system gave rise to a health financing policy, which in turn gave rise to a health insurance policy, and finally the EHIA, which supports and guides the development of the ASBCs. For Rwanda and Senegal, the support entities evolved as a result of the needs that were identified, leading to a national social protection organization for Rwanda, and the Ministry of Local Development for Senegal.

Conclusion: The cases mentioned and the international experience advocate for a targeted promotion strategy for CBHI schemes within a broader framework of health reform or financing, supported by an administrative body dedicated to their promotion, which mainly plays a facilitating role.

5.2 POOLING OF FUNDS AND RISK SHARING

Only Rwanda developed risk-sharing mechanisms fairly early in the evolution of CBHI: funds were pooled at the communal, regional, and national levels, and eventually were housed in a national fund managed by the Social Security Board of Rwanda as part of a social protection policy. Since 2018, Senegal has been exploring the approach to pool funds. Ethiopia is at the conceptualization level of pooling, although the need has been identified. In Mali, there is already pooling through the "voluntary health insurance" product, which is distributed by a network of nearly 150 CBHI schemes.

Conclusion: The experience in the four countries and internationally supports the need for CBHI schemes to pool their resources to address challenges and risks. This process can be evolutionary, but it is best to establish funds in the early stages. The ultimate goal is the creation of a national fund.

5.3 SUBSIDIES

The government of all four countries subsidize the CBHI organizations. The most explicit is Ethiopia, which, from the conceptualization of the CBHI approach, subsidizes management (three administrative posts by the woredas and regions) and contributions (25 percent and then 10 percent by the federal government, and the most disadvantaged by the woredas). The same scenario applies to Rwanda, where the contributions of the poor and the targeted groups have been covered by the government and technical and financial partners from the pilot phase onward. Moreover, certain administrative costs were borne, explicitly or not, by the local authorities. In Senegal, the situation has evolved over time to subsidize administrative costs and cover the contributions of the needy; these subsidies now make up the majority of CBHI schemes' funding (Daff et al. 2019; Ridde, Bossyns, and Ladrière 2018; Verbrugge, Ajuaye, and Van Ongevalle 2018). The political will in relation to subsidizing contributions is clearly displayed in Mali. In this context, an experiment in subsidizing contributions was conducted with CBHI schemes in the Mopti region. The results of this experiment are being leveraged for scale-up.

Conclusion: To achieve adequate coverage and contribute to UHC, CBHIs must receive subsidies from the government to cover their management costs (the professionalization of management no longer needs debating) and the contributions of the poor and needy and even "ordinary" members (as in Ethiopia and Rwanda). Without subsidies, CBHI schemes will fail to meet the expectations of the government and the population.

6. IMPLICATIONS FOR THE DETERMINATION OF THE CBHI SCHEME

The CA-CSU, in collaboration with the various stakeholders, has begun discussions on the conceptualization of an institutional structure for CBHI in Madagascar. The validation of this scheme by the Ministry of Health will be followed by the implementation of a pilot phase. This institutional structure for CBHI will be refined by monitoring the results of this phase before scaling up. Although CA-CSU has streamlined the process by introducing a risk management concept for each element of the scheme, it is very important to verify the impact of prior decisions to maximize the chances of success for the CBHI initiative. In this respect, the feasibility study constitutes a critical step in the process of setting up CBHIs.

The discussion on the CBHI management bodies gave rise to a rich debate that evoked the risk that funds are used for political or personal purposes, requiring a clear decision on the role of the Communal Committee for Social Development, the mayor, and other decentralized government services. However, the schemes will function smoothly if each actor involved play their role in a professional manner. The optimal technical function of the CBHI schemes requires, on the one hand, the fluidity of relations between the CBHIs and the different levels of the referral and counter-referral system of the health pyramid and, on the other hand, the elimination of avoidable barriers such as the requirement of a certificate at the lowest level of the health pyramid.

The need for digitizating clinical data and management seems unavoidable, not only for local management, but above all for overall strategic decision-making, and coordination and monitoring of activities at the central level (e.g. CA-CSU). International experience shows that the management of members, data, and grants requires some level of digitalization. This digital approach is achievable even in very remote areas and can facilitate the financial management and provision of management and marketing information. The German Cooperation team in Madagascar has extensive experience in this area and an exchange with the M-TOMADY project is strongly recommended for benchmarking purposes. The information system component should be discussed with the Directorate of Studies, Planning and Information System because changing the monthly activity report is a delicate matter.

The cost of CSB benefits can be mitigated by improving preventive care and quality of care. Although most of the population would like to see this, CBHI schemes that pay for health care at both the CSB and hospital levels need to be carefully considered. Decisions on the package of care with referral and counter-referral measures can be instituted to alleviate the financial burden at the hospital level. The coordination actions of CA-CSU should focus not only on the functioning of the CBHI but also on the provision of quality care to meet the needs of the population that belongs to a CBHI scheme.

Ideally, all CBHIs should adopt annual collection of contributions. However, given the nature of the income of the populations involved, each CBHI scheme is advised to analyze the financial cycle of the population in the commune where it is located in order to match the period for collecting contributions with the period of availability of people’s financial resources.

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