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The Alternative to the Medical Scheme Model for Africa

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In Africa, wage-based social insurance and private health insurance have had very limited impact because they failed to cover informal sector workers and the rural self-employed who constitute the majority of African populations.

In South Africa, there has recently been talk of 'low cost' health coverage. However, what is truly 'low cost' for the poorest? What does appropriate coverage look like in a completely different socio-economical (and maybe even geographical) environment?

The role of health care coverage in reducing poverty levels and boosting economic growth is clear. However, the spread of formal health care coverage has often been limited as a result of affordability.

South Africa has often considered itself the exception to the woes of Africa, and in many respects, it has managed to break the mold. However, the poverty we know of in Africa is in actual fact not too different from what South Africa experiences in its dark, less-spoken-of corners and where some find themselves heading as the financial tides in South Africa turn with rising costs of living and unemployment.

Health care coverage is on every nation's agenda. Next to education, it is the obligation of any democratically elected government to its people. A nation's economic progress is also inextricably linked to the health status of the population, which explains why the medical scheme industry has received ever increasing attention, and ever more so in South Africa with the delay of National Health Insurance.

The medical scheme model is based on health insurance which encompasses risk-sharing and is supposed to reduce unforeseeable or even unaffordable health care costs (in the case of illness) to calculable, regularly paid premiums. However, this mainly caters for those in the formal sector—leaving out those in the informal sector and rural areas.

The medical scheme model has been the preferred mode of providing health care coverage to South Africans. This serves as a more formal model than what is often witnessed in other African countries, where medical schemes are often found in the formal, private market or for government employees. However, less formal models are implemented in other sectors based on the needs of the communities.

Several nations across the continent saw the rise of user fees in the 1980s on the backbone of reduced funding for health care from some development organisations. However, these did not compensate for the rising bad debts experienced by health care providers. This remains a challenge even today for both patients and health care providers.

This leaves us with a multi-faceted health care coverage challenge: poor social security, negative side-effects of user fees, and persistent problems with health care financing. This has resulted in more innovative and custom-made solutions to the health care financing problem.

The challenges facing health care coverage have resulted in the emergence of health insurance schemes in Africa which have taken the form of local initiatives of rather small sizes that are community-based with voluntary membership. They are often initiated by health facilities, NGOs, local communities, or cooperatives. These are more common in West Africa than in Central, East and Southern Africa.

The geographical coverage varies considerably between and within countries. In Tanzania and Cote d'Ivoire, these are predominant in urban areas whereas in Uganda, Ghana and Benin they are more common in rural areas. The development of these schemes began in the 1980s. This model set off in the DRC in the 1980s as the government significantly reduced funding for health care opening a gap for alternatives. The same applies for Guinea-Bissau. The spread of CBHI schemes picked up in pace in the 1990s to Ghana, Benin, Mali, and Kenya.

The size of these schemes varies from less than 100 to a million participants. As with formal insurance schemes, the size has a contributing role to the sustainability of the schemes with some of the smaller schemes often closing down and others having been in operation for decades.

Given the slightly 'socialistic' mandate of health care financing for low income earners, mainly two questions reign supreme when it comes to assessing their efficacy:

1. Has the scheme improved access to health care and thereby contributed to better health outcomes?

2. Has the scheme stabilised incomes and helped to preserve assets?

This requires that the scheme is viable and sustainable in its given setting, both from an institutional and financial point of view.

The three key success factors are:

- Scheme design and management
- Behaviour of health care providers
- Household and community characteristics

The X-factor for health care financing for the low income earners and for less formal environment is the last success factor above—households and communities. Community participation is a concept which has not been largely witnessed in South Africa but has been instrumental in Community Based Healthcare Insurance (CBHI) schemes.

The degree of community participation in the design and running of the CBHI can vary widely and is usually greater if funds are owned and managed by the members themselves than if schemes are run by health facilities. If members can identify themselves with "their" schemes because they control the funds and have decision-making power, they are less likely to misuse health care services. Do ordinary members actually feel empowered to change the direction of decisions made by their medical aid schemes and do they have a sense of ownership? Or do they feel that they are part of a health system which is working collaboratively with a national health agenda in mind?

Furthermore, strong community participation can facilitate health education and sensitisation of members in order to promote healthy behaviour and the use of preventive services, as the members share a common interest in keeping the costs of health care low. For example, the members of a self-governed CBHI comprising several villages in Benin realised that many cases of sickness and a considerable amount of health care costs reimbursed by the scheme originated from one distinct village. In consequence, CBHI members of that village and the local nurse organised sensitisation sessions on water hygiene and vaccination.

The demand for health insurance is a crucial factor if the benefits expected from CBHI are to be realised. The demand of households for health insurance depends not only on the quality of care offered by the health care provider, on the premium and benefit package, but also on socio-economic and cultural characteristics of households and communities.

Given the unique ethnic, lingual and cultural diversity within African nations, the CBHI approach may be particularly promising for this continent because it allows adaptation to local conditions. Management capacity seems to be the key lacking factor. The actual implementation of CBHI schemes has had mixed results so far, with success and viability largely depending on design and management of the scheme, community participation, regulations at the level of the health care provider, quality of services and on the socioeconomic and cultural context. ■

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