11 African triage

Assessing alternatives to health care privatisation south of the Sahara

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Health plays a central role in human development. In recognition of this fact, the United Nations adopted the Millennium Declaration, with eight Millennium Development Goals (MDGs), three of which are directly health related. Primary health care (PHC) is the cornerstone of the health systems of many countries in Africa and elsewhere. The nature of services provided through PHC, in accordance with the WHO and UNICEF definition, is:

> Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-determination. (1978, Article VI)

PHC is an approach to health care that is not only primary (first contact) or curative but also comprehensive (WHO 2008). The PHC approach to health care is especially relevant in the sub-Saharan African (SSA) context given the high burden of disease, much of which is attributable to infectious diseases that can be controlled through improvements in education, the economy, the physical environment, agriculture, and general and social development – all of which are encompassed by PHC. It is estimated that about 65% of deaths in SSA result from communicable diseases, including malaria, tuberculosis and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), perinatal and maternal, and nutritional disorders (Wurthwein et al., 2001).

The subregion has poor health indicators, with high maternal mortality ratios (MMR), high infant mortality rates (IMR), and high under-five mortality rates. Life expectancy in the region varies from 74 years in Seychelles and Mauritius to 39 years in Zimbabwe (WHOSIS 2009). There is a high prevalence of HIV/AIDS in many SSA countries – with Swaziland (38.8%), Lesotho (28.9%), and Zimbabwe (24.6%) being the hardest hit – and AIDS is among the main causes of death (UNGASS and UNAIDS 2008).

There is also increasing concern about the rising morbidity and mortality due to non-communicable diseases (NCDs) such as diabetes mellitus, hypertension, cancer, endocrine disorders, and cardiovascular disorders following urbanisation and the adoption of a Western lifestyle by many in the region (Turshen 1977, Unwin et al., 2001, BeLue et al., 2009). Indeed, there is evidence that NCDs are responsible for 15%–25% of annual deaths in Tanzania for the 15–59 age groups and that the prevalence rate of diabetes mellitus in urban areas in Tanzania and townships in South Africa is 5–8%, while the prevalence rate for hypertension is 20%–33%.

In many developed countries with far fewer disease burdens than SSA, health expenditure is more than 15% of the total state budget. Africa spends about 5% of its GDP on health as against the global average of 8.69%, and relative to other regions, a higher fraction of SSA's total health expenditure (10.7%) is accounted for by external assistance. SSA's average per capita health expenditure ($111) is far below the global average ($790). Similarly, the average government contribution to the health system per capita is $52, which, though higher than Southeast Asia ($28), falls much lower than the global average ($455). A large number of SSA countries included in this study spend less than $50 per capita as compared to $6,719 in the US, or even the $315 and $355 achieved by Algeria and Tunisia, respectively (WHO 2008).

Various studies have estimated that the informal health sector, despite its many shortcomings in terms of quality of service, provides treatment for 15%–83% of childhood illnesses in Africa (Snow et al., 1992, Molyneux et al., 1999, Goodman et al., 2007). But as Mackintosh (2003, 2006) observed, the uncontrolled expansion of the informal sector is a striking aspect of privatisation and commercialisation of the health sector.

The above characteristics – high disease burden, poor macroeconomic environment, expansive and deepening household poverty, and the development of a large informal health market in the region – are critical for considering viable alternatives to privatisation and commercialisation in the subregion because they determine the nature and texture of possible alternatives to conventional public provision of health services. Following the economic crises of the 1980s, many SSA countries experienced social and economic upheavals, and the public health systems of most countries of the subregion started to wobble very badly.

DEFINING "ALTERNATIVES" IN THE SUB-SAHARAN AFRICAN CONTEXT

We refer to "alternatives" in this study as health systems which are neither privatised nor commercialised. The former refers to all forms of private sector participation in service delivery. Commercialisation, on the other hand, can refer to public service entities that operate much like private providers,

characterised by increased provision of health services through market relations and based on ability to pay even if such service is provided by or operated by the state; investment in the production of health services for the purpose of making profit; and expansion of health care financing based on individual payment or private insurance (Mackintosh 2003).

Hence, the critical elements of both commercialisation and privatisation of health services are market-oriented, profit-motivated financing and provision of health services whether by individual entrepreneurs or state corporations. In particular, privatisation involves the devolution of health care responsibilities of the state to statutory quasi-autonomous non-governmental organisations (QUANGOs) or authorities, which then control and manage health services on behalf of the state as a corporation. Thus, state ownership does not necessarily mean non-market or non-profit; and private ownership or control does not necessarily imply the opposite.

The most obvious models of "alternative" health care provision are therefore the non-corporatised state and non-state not-for-profit health care providers. Thus, alternatives considered here assume non-corporatised, non-commercialised state-provided health services and different variations of it as the bedrock of the health system, while other non-state alternatives are considered supplementary to this.

The private sector is wide and varied in terms of both its typology and the range of activities. Private health providers include traditional healers, community-managed health facilities, faith-based and other non-governmental organisations (NGOs) owned or managed health facilities, and private for-profit and not-for-profit facilities. Any institution or organisation that provides an alternative model to market-oriented provision of services, private sector investment, or private financing of health services will be considered, *prima facie,* to qualify as an alternative. Its viability and sustainability as an alternative will be assessed using a set of specified parameters, including equity, efficiency, quality, sustainability, participation, and accountability (see Chapter 2, this volume, for details on research methodology). Approaches that address the substantive business of health service provision, provide non-market-oriented investment options, or provide non-private financing of health care are therefore considered alternatives to privatisation and commercialisation.

THE SCOPE OF THE RESEARCH AND METHOD

This study is periscopic in intent as it does not aim to provide in-depth details about identified alternatives but rather to cover as many alternatives as possible within SSA, irrespective of the country where found. Since examples of alternatives are difficult to come by, or are not located in every country in SSA, the focus is on those countries that offer feasible alternatives.

Our review made use of secondary data generated through a thorough search of relevant databases for SSA as well as interviews and literature reviews as follows:

- The identification of key informants in different parts of SSA, particularly those engaged in health-related professional activities either as researchers, professional caregivers, or implementers of health policies.
- Questionnaire interviews: a number of individuals and institutions identified in different countries in the subregion were interviewed through e-mail. The e-mail interview enabled us to identify possible alternatives to commercialisation and privatisation in the different countries.
- Colleagues at different academic conferences and meetings were solicited for information on alternatives to privatisation and commercialisation in the health sector in their regions and countries.
- A search for regional and country-specific initiatives was undertaken for documentation related to new initiatives in health provision, health financing, and methods of provider remunerations that are new and that offer viable alternatives to privatisation and commercialisation in the region.
- Internet search (including WHO database, United Nations Development Programme [UNDP] database, World Bank database, Google, and Google Scholar search engines), using different combinations of search terms such as health insurance, mutual health organisations, mission hospitals, faith-based organisations, and community-based health insurance (CBHI) schemes. We also searched for information specific to all SSA countries, through ministries of health websites.
- Journal articles on the subject matter relating to SSA were reviewed.
- Official reports, such as those commissioned by Partners for Health Reform Plus and the United States Agency for International Development (USAID), were also reviewed.

Every effort was made to ensure that comprehensive information was obtained and analysed about all the viable alternatives that are available in the region. We are mindful of the fact, however, that some initiatives have been undocumented and are therefore inaccessible, and we may have missed others. Nonetheless, we believe that this report represents a good coverage of such initiatives within the SSA region.

IDENTIFIED ALTERNATIVES

In this study, three types of alternatives to privatisation and commercialisation were identified:

- CBHI, also known as mutual health organisations (MHOs);
- national health insurance schemes (NHISs), and regional ones;
- faith- or church-based health organisations (FBOs).

CBHI and NHIS are to some degree directed at addressing challenges of health financing from both the supply and demand sides and tend to have as one of their aims equitable health care financing and/or financial risk protection for the poor, though there is an increasing number of CBHI schemes that also provide health services (Ndiaye et al., 2007). FBOs, on the other hand, generally focus on health delivery although they have also, in some instances, motivated community-based financing for systems affiliated to them (Atim 1998). These alternatives are discussed, in turn, with examples and brief evaluations of their pros and cons.

COMMUNITY-BASED HEALTH INSURANCE

CBHI, also referred to as MHOs or *mutuelles de santé* (*mutuelles*), aims to extend the benefits of insurance to populations that have been excluded from traditional social protection schemes, which in most cases means rural populations and those working in the urban informal sector (Atim 2009). Atim defines the MHO as a "voluntary, non-profit insurance scheme, formed on the basis of an ethic of mutual aid, solidarity and collective pooling of risks, in which the members participate effectively in its management and functioning".

The potential benefits of CBHI schemes include resource mobilisation for health, financial protection from catastrophic health costs, and negotiation for quality gains in health services for their members (Ekman 2004, Atim 2009). According to the African Union, CBHI schemes have tended to grow where user fees are high, good quality health care is available, solidarity networks or bonds are strong, and a tradition of self-help and organisation exists (African Union 2009).

Atim (1998) identified the main types of MHOs as including:

- traditional social solidarity networks which tend to bring urban migrants of the same ethnic and cultural origins together to foster their welfare through solidarities in times of sickness, burials, births, marriages, and other significant events;
- MHO solidarity movements – based on rural or urban communities, trade unions, religious associations, professional organisations;
- community-financed health insurance or low community-participation model of community health financing which is usually motivated, organised and managed by the health facility with minimum participation of the community in the management of the scheme;

- co-managed or high-participation community model that is usually motivated and managed by the community but with a negotiated arrangement with the facility that provides health services;
- medical aid associations – the most advanced form of MHOs based on formal insurance principles and regulations.

MHOs have become a common feature of health care arrangements in many SSA countries. They are also identified with decentralised health care systems, following the inability of governments in the region to adequately fund health services and given the relative success of community-based microfinance systems in many SSA countries.

Table 11.1 illustrates the number of schemes and population covered in some countries of West Africa, but MHOs are not limited to West African countries, as the selected case studies will reveal. Table 11.1 also shows that only very small percentages of the population in each country have been covered. However, as case studies of the Rwanda *Mutuelles de santé* and the Ghana Community Health Planning (CHP) models indicate, community-based schemes can easily be leveraged into national health programmes through appropriate national policies and financial support. In fact, it has been suggested that the MHOs can serve as a learning model for fund administrators and social solidarity (Bärnighausen and Sauerborn 2002). The Ugandan and Tanzanian models illustrate the motivations and the facilitation roles of ministries of health and donor agencies in the emergence of some of the schemes. They also illustrate the many problems these schemes face.

The typology of CBHI/MHO schemes using the framework developed for this research is single non-profit sector (SiNP), though some could be classified as non-profit/non-profit partnerships (NPNPP). An example of the latter is provider-based MHOs, which are driven by the need for cost recovery

Table 11.1 Coverage of MHOs in West Africa

Country	*No. of schemes*	*Population covered*	*% Population covered*
Mali	80	198 006	1.46
Côte d'Ivoire	40	235 280	1.30
Senegal	149	119 300	1.02
Niger	19	48 700	0.35
Ghana	45	61 600	0.28
Togo	25	16 325	0.27
Guinea	111	23 844	0.25

Source: Vialle-Valentin et al. (2008).

by the service provider (Derriennic et al., 2005). As is the case for Rwanda, there is also a partnership between government and the MHOs, and so the arrangement is that of a public/non-profit partnership (PuNPP).

Example 1 – *Mutuelles de santé* in Rwanda

Rwanda presents one of the most dramatic recent experiences of CBHI in sub-Saharan Africa, with wide population coverage. From the 1960s, health care was provided for free in Rwanda, with public subsidies through infrastructure, equipment, personnel, drugs, and other supplies. The economic problems of the 1980s and 1990s led to a dilapidated system, with poor quality of care. In 1992, the government introduced community participation for financing and management of health care, based on the Bamako Initiative (Sekabaraga 2008). By October 2007, the schemes had reportedly covered 6 702 391 beneficiaries or 75% of the population of the country, while by 2009 Rwanda boasted of being the only country in Africa with an 85% participation rate in MHOs.

To support the growth of the schemes, the government has created a special solidarity or risk-pooling fund, into which transfers from the Ministry of Finance via the Ministry of Health (MOH) are made to cover the costs of indigents and people living with HIV/AIDS. The Global Fund is providing financial support for five years to cover the government subsidy.

The MHOs are backed by government policy, which sets out the scope and regulation of MHOs. According to the official policy document: "The general objective of the policy is to assist grassroots communities and Districts to establish health insurance systems that will promote improvement of their financial accessibility to health care, protection of households against financial risks associated with diseases and strengthening of social inclusion in health" (MOH, Rwanda 2004, 10).

The scheme covers a Minimum Package of Activities, including prenatal consultation, post-natal consultation, vaccination, family planning, nutritional service, curative consultations, hospitalisation, simple childbirth, essential and generic drugs, laboratory analyses, minor surgical operations, health education, and transportation of the patient to the district hospital. The hospitals offer a Complementary Package of Activities, which covers, *inter alia*, consultation by a doctor, hospitalisation, Caesarean operations, minor and major surgical operation, referred serious malaria, all diseases of children from 0to 5 years, medical imaging, and laboratory analyses.

The *mutuelles* are, however, confronted with challenges that are organisational, technical, and operational. At the organisational level:

- The voluntary nature of subscription to mutual insurance leads to low levels of subscription. People who frequently fall sick are more likely to subscribe to *mutuelles*, resulting in an adverse selection that threatens financial sustainability.

- *Mutuelles* do not cover major risks like surgery.
- Premiums are fixed, not according to the real costs of care, but rather to the contributing capacity of the population.
- There is a lack of a specific legal framework guaranteeing their moral and legal status, and their independence and autonomy.

At the technical and operational level the problems are:

- over-utilisation of the services by subscribers who hastily solicit health care services;
- non-coverage of health care costs by partner health facilities due, on the one hand, to the low level of contributions and inadequate number of subscribers, and, on the other hand, the low level of risk sharing between sick people and healthy people;
- abusive prescription of drugs by some health facilities;
- poor quality of the care provided in some health facilities;
- over-invoicing of mutual health insurance by some health facilities;
- low management capacities of some mutual health committees;
- benevolent nature of membership of mutual health committees;
- lack of grants to mutual health insurance, in general, and, particularly, for bearing the cost of treatment in hospitals.

Example 2 – Community Health Fund (CHF) initiative in Tanzania

The CHF was conceived by the government of Tanzania in collaboration with the World Bank's International Development Association and other donors as an approach to improve the financial sustainability in the health sector and to increase access to health services. CHF is a prepayment insurance scheme for rural people, based on the concept of risk sharing and empowering communities in health care decisions, while also promoting cost sharing through local participation (Baraldes and Carreras 2003).

CHF was piloted in 1996 in one district (Igunga) and later expanded to other areas with the intention of covering the whole country. By the end of 2006, CHF was operating in 69 of the 92 councils (Mtei and Mulligan 2007). The scheme aimed to grant access to basic health care services to poor and vulnerable populations in the rural areas and the informal sector in the country, rather than to raise additional funds.

The Community Health Fund Act of 2001 sets the objectives of the CHF as following:

- mobilise financial resources from the community in order to provide health care services for members;
- provide quality and affordable health care services through sustainable financial mechanisms;

- improve health care services management in the communities through decentralisation by empowering the communities in making decisions and by contributing on matters affecting their health (CHF 2001).

CHF membership contributions are decided at the council level, and each household contributes the same amount of fee, which varies between councils from Tshs5 000 (about US$4) to Tshs10 000 per year (MOH, Tanzania 2005). For that contribution, households receive access to care for the whole year, while households that do not participate in CHF are required to pay a user fee at the health facilities.

Revenues from members' contributions are matched by a 100% grant from the government (commonly known as *tele kwa tele*). The CHF Act provides for user fees paid at public health centres and dispensaries to be used as a source of funding to the CHF (CHF 2001). Other sources of funds include grants from councils, organisations, and donors. CHF contribution to Tanzanian health sector financing is rather modest, accounting for about 15% of total revenue, while user fees at primary facilities account for 85% (MOHSW 2006, Mtei et al., 2007).

CHF faces the challenge of low enrolment rates and early drop-outs in membership; in many schemes, enrolment has dropped where it was once relatively high (Chee et al., 2002, Shaw 2002, Msuya et al., 2004, Musau 2004, Mhina 2005). Chee et al. (2002), in their assessment of the CHF in Hanang district, found that membership reached a peak of 23% in 1999, then dropped in 2001 to around 3% of total households, and this fell further to 2.2% in 2003 (Musau 2004).

Shaw (2002) argues that one of the reasons for low enrolment rates could be the small user fees set in public facilities because they give little incentive for community members to join an alternative financing system like the CHF. User fees in some councils are set at Tshs1 000 per visit at health-centre level, and many community members are more willing to pay the user fee rather than pay the higher CHF premium (Mhina 2005). Similarly, high CHF membership fees set by some councils are also likely to be a barrier to enrolment (Mtei et al., 2007).

The barriers to higher enrolment in the scheme are summarised in Table 11.2. Notwithstanding these limitations, CHF has improved access to health facilities for the poor. Being a CHF member improved the chance of seeking health care from formal health care providers, compared to non-members, and CHF membership also reduced the use of alternative medical care such as self-medication and traditional healers especially for the poor (Msuya et al., 2004). Moreover, membership in the CHF reduces the risk of households selling their assets for the sake of getting money for treatment during a disease outbreak.

Whereas CHF schemes have great potential to improve access for poorer groups, by removing payment at the point of use and allowing members to

Table 11.2 Reasons for low enrolment in CHF, Tanzania

Reason for low enrolment	*Source*
Low public sector user fees vs. higher CHF premiums	Shaw 2002, Mhina 2005
High CHF membership fees	Mtei et al., 2007
Inability of the poor to pay membership contributions	Kamuzora and Gilson 2007
Poor quality of care, lack of trust in CHF manager	Bonu et al., 2003, Kamuzora and Gilson 2007
Lack of trust in CHF managers (average and wealthy community members)	Kamuzora and Gilson 2007
No need to protect against risk of illness (average and wealthy community members)	Kamuzora and Gilson 2007
Poor sensitisation, lack of information	Msuya et al., 2004
Lack of information on CHF from district managers	Kamuzora and Gilson 2007
Top-down approach to CHF	Mtei et al., 2007
Low income and income unreliability among community members	Msuya et al., 2004
Introduction of NHIS, which removed the public servants	Mwendo 2001, Mhina 2005
Non-coverage of referral care	Mwendo 2001, Mhina 2005
Poor staff attitudes	Mwendo 2001, Mhina 2005
Broad exemption policies, which leave a limited number of people contributing to CHF	Mhina 2005, MOH, Tanzania 2006

pay when they can afford to (flexibility in contribution), in practice even relatively small contributions may be too high for the poorest to pay (Bennett et al., 2004). The MOH itself is concerned about weaknesses in management and accountability. There may not be the required financial and management capacity to handle the fund, in addition to delivering services to patients (MOH, Tanzania 2006). Districts are not clear on CHF management rules and procedures, and there reportedly was mismanagement of CHF funds in about 27% of CHF implementers. In other instances, CHF funds were not utilised and hence remained idle at the district level. An assessment by the MOH showed that not all councils conducted regular audits or reported to community members (MOH, Tanzania 2003, Mtei et al., 2007).

Example 3 – Community-based health planning and services initiative in Ghana

Another CBHI scheme that has been used effectively to foster health care utilisation and overcome barriers posed by scarce resources is the community-based health planning and service (CHPS) initiative developed at the Navrongo Research Centre in Ghana in the 1990s. This is a public-community partnership. The development of this project is documented by Binka et al. (1995) and Nyonator et al. (2005), among others.

This initiative aims to reduce barriers to geographical access to health services encountered by large populations in SSA, using the social structures of community organisation. Some of these structures are lineage and kinship networks, the chieftaincy institution that is a central pillar in African community organisation and social solidarity. The second dimension of CHPS is the community health nurse who is introduced into the community to improve service accessibility. A critical part of the CHPS is that instead of a community health worker that visits the community from a designated district health centre, the health worker lives within the community.

Community involvement in the scheme includes the donation of land, materials, labour, and other resources required to make operational a "community health compound" constructed from local materials and resources. A committee is established to oversee the functioning of the community scheme, the requisite operational resources (including motorcycle and logistics) are provided by the district health management teams, and the community health officer is introduced into the community. Thus, the introduction of CHPS into a community involves extensive planning and community dialogue (Nyonator et al., 2005).

The community health officer visits households to provide primary health services including immunisation, family planning, antenatal care, supervision of delivery, postnatal services, treatment of minor ailments, and health education. On average, a community officer oversees a catchment area of about 3 000 individuals. The community health officers are supported by community volunteers in the mobilisation and registration of community participants.

CHPS enhances access to PHC services for communities. Evaluation reports to date indicate that the programme has cut down child and maternal mortalities by 33% in communities where it has been adopted and has therefore become a national health policy in Ghana (Nyonator et al., 2005). The rating of this alternative as "successful" is based largely on its empirical success in Ghana, where it was designed and implemented. It subsequently became an electioneering and political instrument for national election campaigns as communities demanded of political parties the establishment of CHPS in their communities in return for their votes.

Evaluation of CBHI initiatives

Equity: A strong point of CBHI/MHO models as alternatives to privatisation is their promotion of equity through cross-subsidisation and equal access. As with formal health insurance, the theoretical expectation is that the wealthy would subsidise the poor, the employed subsidise the unemployed, the young subsidise the old, and so on. However, in many cases the full potential of cross-subsidisation is often not realised as those in higher socio-economic status often exclude themselves, which leaves the schemes prone to adverse selection. The very poor are also often excluded because they cannot afford the premiums required for coverage as the preceding case studies in Uganda and Tanzania clearly demonstrate.

The equity dimension of these schemes is that benefits are not usually related to how much the beneficiary contributed to the scheme and that the poor are protected against impoverishment and catastrophic effects of financing health care out-of-pocket, and thus it also reduces the tendency to dispose of valuable assets to finance health needs.

The geographic equity gains from MHOs are clearly illustrated with the CHPS in Ghana, where the rural communities are the key drivers of the scheme, and in Rwanda, where the *mutuelles* originally targeted rural communities. The presence of community health workers in Ghana, for example, removes the access barrier, which is very critical in SSA countries. Furthermore, CHPS exemplifies a strong case of emphasis on PHC, which is known to have more equitable effects than curative care (WHO 2008).

There are potential vertical equity gains from MHO schemes that are not fully realised due to their tendency to rely on flat contributions rather than calibrated contributions that consider the socio-economic status of the members. Although it may be expected that income-dependent contribution would be easy to operationalise in the context of community-based schemes since the communities are usually small, and that it would be easy to identify the socio-economic status of members within such contexts (Hargreaves et al., 2007, Rew et al., 2007), this is not the case in most instances because it is difficult to establish income levels or because of lack of consciousness of equity in the design of the schemes.

Democratic participation: The CBHI/MHO schemes improve democratic participation and social solidarity, and this is one of their underlying social benefits. However, even this important quality of the schemes is often compromised. Franco et al. (2006), for example, report that participation was quite extensive across the MHOs in Senegal, although they also observed that several of them had difficulties convening general assembly meetings, which are a key mechanism for social participation. The Tanzanian case study also made the point that lack of participation was a major threat to the sustainability of the schemes. De Allegri et al. (2006) observed that

MHOs often fail to attain their full potential because of inadequate participation. In the Rwandan example, however, democratic participation by the community is built in, and may partly explain the success of the *mutuelles* in that country.

Efficiency: The efficiency of the schemes is best assessed by their organisational efficiency, including administrative and cost-effectiveness in collecting premiums. Cost-effectiveness is usually enhanced for people in the formal sector where deduction is made at source, but this is more difficult for people in the informal sector. The lack of formal income implies that the transaction costs of collecting premiums are high through searching for information about and locating points of payment, transportation, and logistics of paying the designated individuals or institutions and the additional secretarial administrative work. This may be particularly significant for small, frequent premiums.

Furthermore, the realisation of the goal of efficiency varies among MHOs, depending on how the scheme is designed. For example, if the benefit package encourages more intensive use of PHC relative to the more expensive secondary care as evident from the Tanzanian case study, then the MHOs contribute to efficient use and conservation of national health resources. Several reports show that MHOs contribute to improved technical and allocative efficiency of health systems through proper negotiation and cost reductions by the providers (Atim 1998). Some of the MHOs are able to reduce moral hazard through social control and some others through imposing co-payments and deductibles (Sekabaraga 2008).

Sustainability: This is a key issue with MHOs. There are indications of dwindling membership due to low income and poor quality of service by selected facilities (Criel and Waelkens 2003). For instance, one of the challenges in the Tanzanian scheme was falling membership after the pilot phase of the community-based scheme (Mtei and Mulligan, 2007). And yet MHOs have had strong impacts on improving health care utilisation among the poor and represent strong coping mechanisms in low-income countries (Ndiaye et al., 2007). According to Tabor (2005), MHOs should be regarded as a complement to, not as a substitute for, strong government involvement in health care financing and risk management related to the cost of illness. Government, and its development partners, can support the growth of CBHI by ensuring that there is a satisfactory supply of appropriate health services, by subsidising start-up costs and the premium costs of the poor, by assisting CBHI to build technical and managerial competence, by helping to foster development of CBHI networks, and by assisting CBHI in establishing and strengthening links with formal financial institutions and health care providers to better manage covariate shocks and catastrophic health risks.

Quality: While in some cases MHOs have been able to control certain aspects of quality of care such as long waiting times, lack of drugs, and

discourteous staff attitude towards their patients, a majority of MHOs lack the capacity to deal with critical quality issues such as drug prescription by doctors (Atim 1998). However, the schemes provide a framework for demanding improvements in quality of care.

Accountability: Accountability is the means by which individuals and organisations are externally answerable for their actions and through which they are internally responsible for shaping the goal and aspirations of the organisation (Ebrahim 2003). Atim (1998) notes that most MHOs have standardised organisational structures for involving members in decision making and demanding accountability from their leaders. This is often accomplished through annual general meetings, which also generally elect the board members periodically.

Integration into health systems: The MHOs are easily integrated with the national health systems. The Rwanda, Tanzania, and Ghana case studies clearly demonstrate that these schemes can easily transmute into national policies. In Ghana, for example, the Navrongo experiment was scaled up to a national policy. Similarly, the Rwanda scheme transmuted into a bottom-up approach to national health insurance. Facility-based schemes in Uganda were designed as part of the facilities at which they operated, though such integration is then limited to participating facilities. However, if autonomy becomes the overriding consideration for the MHOs, it could pose a problem towards their integration into national health policy.

NATIONAL HEALTH INSURANCE SCHEMES (NHISs)

NHISs have been operating in industrialised countries for over a century but are now emerging as an important public health financing option in policy discussions in SSA. A number of countries, including Ghana, Nigeria, Kenya, and South Africa, either have started or are planning to start NHISs.

NHISs are more formal than community-based schemes, usually backed by legislative acts. The core concept is based on the pooling of risks using a particular group of people drawing on epidemiological and actuarial trends. In this manner, people that do not fall ill pay for those that are ill, and those who are ill and those who are not ill will change over time (McIntyre and van den Heever 2007). While they are usually supported by government budgetary subsidies, the main source of funding for NHISs is mandatory contributions from members and employers. The objective of these schemes is to pool risks of ill health and facilitate cross-subsidisation among large national or regional populations that are covered by the scheme.

The NHIS tends to generate a lot of political interest through building national consensus and fundamental shifts in the way resources are mobilised and benefits are distributed in the health sector for large segments of the population. Issues involved include the design of the scheme,

calibration of contributions, the way in which contributions are made, who is to make the contributions, the roles for the state and its agencies and other stakeholders, accreditation of facilities and modes of reimbursement, who is covered first and how fast the scheme moves to universal coverage, eligibility conditions and what specific health packages are to be covered by the scheme, and the enactment of enabling laws, among others. These issues take a long time to iron out, and so the process involves lengthy political dialogue with all shades of interest groups.

Ghana's NHIS was conceived in the 1980s but only started in 2003 as the materialisation of the electoral promise of the New Patriot Party made in its 2000 election manifesto, in which it proposed the abolition of user fees and cost-recovery policy of the previous government. Within two years, the NHIS was able to cover one-third of the population (Rajkotia 2007) and by 2009 the scheme had covered two-thirds of the population. It is now moving towards universal coverage.

The NHIS option was adopted by the Nigerian Ministry of Health in 1996 and formally promulgated into law through Decree 35 of 1999, which took effect in June 2005 after years of debate, dialogue, and consultations. It was designed for incremental expansion towards universal coverage beginning with those in the formal sector of the economy, similar to the pattern followed in the development of the German health insurance scheme (Bärnighausen and Sauerborn 2002). By 2008, the scheme had covered over 5 million employees of the federal government and their household members. The scheme has now shifted to covering the employees of subnational governments – state and local governments. There are, however, concerns that the scheme is not moving fast enough to cover the most vulnerable populations.

The State of Bayelsa, Nigeria, with a population of about 2 million, initiated a social health insurance policy in 2001 to pool resources across the country's population and to provide quality health care services for the citizens of the state (Ichoku et al., 2006). Enrolment requires a monthly premium of about US$1.5 per month, and this entitles the member to cover four other household members less than 18 years of age. It covers all treatment that can be obtained within the hospitals in the state.

The ideal of universal coverage has become the goal of the health financing system across both developed and developing countries. In Latin America, where there is a long tradition of national health insurance schemes, the rate of movement towards universal coverage has varied across countries ranging from 10% in the Dominican Republic to 80% in Costa Rica (Bärnighausen and Sauerborn 2002).

Typologically, NHISs could be classified as public-private partnerships (PPP) insofar as participating MHOs are private, as are most health care providers and employers of labour, while government is public. However, to the extent that an NHIS aims to raise funds for the public health sector

through public health sources, such as public employers (including government), it may be seen as a form of public-public partnership (PuP). The typology gets more involved when one considers the above possibility plus that of getting services from the private, not-for-profit sector: effectively a public-public-private-not-for-profit partnership.

Example 1 – South Africa

In South Africa, the debate about a national health insurance scheme has been going on for a long time. The objective is to address the wrongs of current (private) medical aid schemes and improve public access to affordable and decent health care. While the private insurance markets have been insufficiently developed or inaccessible to many individuals, large segments of populations have no access to any health insurance system mainly because of the high costs of contributions to the schemes. The problem with medical aid schemes is that they are selective in a sense that those with the greatest risk of illness are more likely than relatively healthy individuals to join.

Government direction on this issue was articulated by the former minister of health in South Africa, Manto Tshabala-Msimang, to a colloquium on "Health within a Comprehensive System of Social Security: Is NHI an Appropriate Response?" in which she indicated that:

> the idea of an NHI was a policy idea that was initially adopted by the African National Congress (ANC) prior to 1994. The NHI would be seen to address the crises in the medical aid sector and would be based on the principle of solidarity. This would then mean, amongst other things, that the NHI in South Africa would be compulsory and that current medical aid schemes could form the basis of the NHI, provided they met with specified statutory conditions governing the NHI system. (cited in Botha and Hendircks 2008)

According to McIntyre and van den Heever (2007), the concept has failed in South Africa because it is perceived as complex, which has limited constructive engagement among key stakeholders and the extent to which consensus can be achieved. Additional resistance has come from the private sector, which sees the introduction of the NHIS as undermining quality of care, and employees who fear that they will miss their benefits under current private medical insurance schemes or else have to pay for both the NHIS and the private schemes to maintain the current level of care. Government, however, has been unwavering in its determination to see the introduction of the NHIS. How this develops remains to be seen, but it provides an opportunity for the country to merge the public and private health systems into one, to improve funding for the public sector, and to expand access to health care for indigent populations.

Evaluations of NHIS

Equity: NHIS with comprehensive coverage equalises financial access to most health services (Lu and Hsiao 2003), although equal financial access may not necessarily translate into equal overall access, as unequal geographical distances may create other forms of inequity because of misdistribution of health facilities, particularly between urban and rural areas in SSA. However, as in the case of MHO schemes, the achievement of financial equity may be enhanced or compromised, depending on the design of the scheme. If NHIS contributions are designed to spread financing burden according to ability to pay, and benefits according to need, then it is likely to achieve the goal of equity to a large extent. However, a major problem in realising this critical objective is that in most cases the schemes begin with those employed in the formal sector, and those in the informal sector are the last to be covered (Donaldson and Gerard 1993).

This implies that public health resources finance the health of the well-off at the initial stages, which raises serious questions about social justice. Worse still, the scheme may lead to the displacement of the poor and those employed in the informal sector from public health facilities as most of the better equipped public health facilities are accredited and used to run the NHIS. However, when the scheme advances to universal coverage, the objectives of equity and equal access are achieved. In many situations, the solution to this equity problem is to cover the poor who cannot be enrolled through public tax revenue or through exemption schemes that enable them to use facilities without payment, as is the case in the Ghana NHIS. Furthermore, if payments are fixed and not varied by income level, it may lead to regressive contributions to the health system, thus defeating the goal of equity (Lu and Hsiao 2003).

Efficiency: NHIS generally tends to increase the amount of spending on health (Lu and Hsiao 2003), but whether that translates into a more effective health system depends largely on effective and efficient management of increased funds. Several efficiency issues arise in respect of NHIS. Some of these include questions around heavy administrative costs, moral hazard, and adverse selection. For example, it has been noted that administrative costs alone take up about 20% of insurance costs in the US (Lu and Hsiao 2003). Some inefficiency problems are sometimes countered by requiring co-payments at point of use, referral systems, and compulsory enrolment for all members of the group to be covered to avoid adverse selection. Scale efficiency in the operation of the schemes often entails a centralised operation rather than multiple small schemes.

Quality: Quality of care has not yet been evaluated for any of the NHISs operating in SSA. However, evidence from Nigeria indicates that quality has improved significantly in the accredited hospitals (Ichoku et al., 2006).

Evidence from elsewhere also suggests that NHIS is usually associated with improvements in quality of health care. For example, Szilagyi et al. (2004) noted large and significant improvements in important indicators of quality of paediatric health services in the State Children's Health Insurance Program in New York State.

Accountability: No systematic and detailed assessment has yet been undertaken about the level of accountability prevailing in the four operational NHISs in the subregion. However, in an environment of endemic corruption and grinding poverty, it is difficult to isolate the scheme from such social malaise. For example, reports of cheating, fraud, and overuse have already been identified as major problems threatening the Ghana NHIS.[1] Indeed, initiatives on national health insurance in Uganda have repeatedly been unsuccessful due to fear of corruption, and the same situation obtained in the 1980s and 1990s in Zimbabwe.

Sustainability: A study commissioned by USAID to assess the Ghana scheme noted with regard to its financial sustainability that because the premiums charged were too low, many regional branches of the scheme were already in financial distress, and some had to increase premiums illegally in order to sustain their operation. Sustainability problems also arise in times of economic hardship with high unemployment rates and reduced fiscal space, thus making social solidarity difficult to achieve.

Solidarity: Solidarity is a key factor in establishing the NHISs. The key consideration is the principle of cross-subsidisation by which the rich subsidise the poor, those employed subsidise the unemployed, and those who are well subsidise those who are sick.

Integration into health systems: NHIS is usually integrated within national health systems. In Ghana and Nigeria, the ministries of health directly supervise the schemes. The health care providers are also the government-owned and government-accredited private health facilities in the countries. Referral from a lower to a higher level of care is encouraged. The NHIS envisaged in South Africa will lead to the merging of the public and private sectors through a single funding mechanism and equal access by all the population to either sector.

FAITH-BASED HEALTH ORGANISATIONS

Mission-based organisations or FBOs represent a third type of alternative to privatisation and commercialisation in SSA. They are distinct from MHOs and NHISs in that they are direct health care providers

(not simply financing mechanisms for other providers). FBOs have a long history of active involvement in the provision of health services in SSA, with their origin generally traced to the efforts of the European Christian missionaries who followed colonising expeditionists by establishing hospitals and schools as instruments of their evangelising work (Barthel 1985). While the role of European missionaries diminished with attainment of independence by African states, the indigenous clergy and religious supporters who replaced them have continued with the tradition of building schools and hospitals as part of their vision of "holistic" development.

FBO health systems or church hospitals are usually SiNP organisations, run on a non-profit basis. The size and relative contribution of FBO providers varies across the subcontinent, but they constitute the largest single health care provider outside of government in most of the subregion (World Bank 1993, Green et al., 2002). It is estimated that the Christian Health Association of Ghana (CHAG), which is the umbrella organisation for all the Christian hospitals in that country, accounts for about 40% of health facilities in Ghana (CHAG 2008). USAID and FMOH (2009) report that the Christian Health Association of Nigeria (CHAN), an umbrella organisation for missionary health facilities, operates 3 500 health facilities across the country.

A study undertaken by Medicus Mundi International (2009) on the health care situation in Cameroon, Chad, Tanzania, and Uganda shows similar levels of faith-based activity. At the time of its independence in 1961, half of the health services in Tanzania were provided by Christian missions, and more recent statistics for 2000 to 2005 indicate that 41% of all hospitals and about 21% of all health centres in Tanzania are owned by FBOs. In Uganda, about 30% of health facilities are owned by private, not-for-profit groups, the majority being FBOs. In Chad, where the missionaries gained entry only after World War II, mission-owned health facilities have grown rapidly and now account for 20% of all health facilities in that country. Similarly, FBOs deliver about 25% of all health care provided in Kenya (Marek et al., 2005).

There has been a gradual recognition of the critical input of FBOs into the health sector. In Tanzania, the Democratic Republic of Congo (DRC), and Malawi, governments have collaborated with church-run hospitals and delegated to them responsibility for underserved regions (Gill and Carlough 2008). In Zimbabwe, the state funded the expansion of some mission hospitals that have been designated as district hospitals to serve rural people. In Tanzania, Cameroon, Lesotho, and Ghana, FBOs are seen as complementary to the public effort and are therefore sometimes subsidised by the state. In particular, since most FBO facilities tend to be located in rural and hard-to-reach areas, some countries have contracted out certain health services to rural populations through

them (Green et al., 2002, Medicus Mundi International 2009). In Tanzania, some FBO hospitals are designated as district hospitals: they receive funding and staff from government, and, in turn, they render services to the districts where they are located. Typologically, this arrangement is that of a PuNPP.

In Lesotho, many development partners and donors continue to support the government's health sector. There has since been a move to harmonise and align donor support with national plans to make aid more effective. As a result, a sector-wide approach mechanism has been put in place, with major partners including member churches of the Christian Health Council of Lesotho (CHAL), comprising denominations such as the Catholic, Lutheran, and Seventh Day Adventist, among others. CHAL affiliates are committed to the provision of quality health services to Lesotho particularly in hard-to-reach places around the country. There are nine CHAL general hospitals (each serving a large geographical area) and more than 70 health centres, clinics, and outposts (mainly in rural areas). These FBO facilities serve areas that would otherwise have no health service coverage.

There are equally successful partnerships between government and FBOs in Malawi, through the Christian Health Association of Malawi (CHAM), and in Zambia through the Christian Health Association of Zambia (CHAZ). In each of these countries, Christian mission hospitals make up a third of clinical health services (Gill and Carlough 2008). In Uganda, major religious denominations have coordinating structures for the health service networks they run all over the country. These are the Uganda Catholic Medical Bureau, the Uganda Protestant Medical Bureau, and the Uganda Islamic Medical Bureau. Through the various bureaus, the FBO sector has been able to negotiate partnerships with government whereby, for example, government seconds staff and provides drugs and other supplies to FBO facilities. One area in which the FBO sector in Uganda has made tremendous contributions has been in the training of health professionals, especially the nurses who are the backbone of the health sector.

Evaluation of FBOs

Sources of funds: Mission hospitals usually collect funds generated from health care services and external donors. They rely on user charges to sustain their services (Green et al., 2002). Sometimes, because of their affiliation to other international bodies, they are better able to obtain the services of expatriates that are paid from abroad (Gill and Carlough 2008) or equipment donated to them by charity organisations.

Participation: Mission hospitals are usually owned and managed by Christian bodies. This implies that democratic participation of the public in management decisions is usually limited to the authorities of the church. However, in many instances broad-based advisory committees, usually including medical and health care management experts, are set up to advise the authorities on critical management issues.

Equity: FBOs charge user fees to sustain their operations, but they also have limited exemption schemes for those who are unable to afford payment for treatment received. As Green et al. note, "Some church providers have demonstrated a particular concern for the poor" (2002, 349). A study by Levin et al. (2003) in three anglophone African countries found that many aspects of mission health services cost less than public health services, and their services are of better quality. However, a similar study by Ndeso-Atanga (2003) in Cameroon found costs of services to be cheaper in public health facilities. This suggests that the comparative cost advantage of mission hospitals over public ones may differ from country to country.

Efficiency: The culture and ethics that govern the management of church organisations is usually different from that which prevails in the public and other private health facilities, although there may be internal differences in the management culture of the different church organisations. Unlike in government hospitals, where proactive management is often absent, most mission hospitals, because they are independent and less encumbered by procedures and civil service hierarchies, seem better able to take management initiatives (Green et al., 2002, Gill and Carlough 2008). Their efficiency is also enhanced by the decentralised nature of decision making. Procurement and supply tend to be more efficient. For example, Gilson et al. (1995) found that in Tanzania the probability of a mission dispensary stocking chloroquine, a popular malaria drug, was 90% as against 50% by government dispensary. Similarly, the likelihood of a mission dispensary stocking penicillin antibiotic was 70% against 20% for a public dispensary. Decentralised procurement systems also enable facility managers to negotiate supplies directly with vendors and to obtain competitive market prices. For example, in Kenya, Uganda, Tanzania, and Malawi, formulary committees of mission health facilities regularly meet with the representatives of the Essential Drug Programme to review and update drug lists and treatment guidelines based on new epidemiological evidence (Gill and Carlough 2008).

Quality: The quality of care in mission hospitals is generally acknowledged to be higher than in both private for-profit and government hospitals (Green et al., 2002, Ndeso-Atanga 2003). According to Gill and Carlough (2008),

mission hospitals have values that encourage compassionate services even at the expense of personal comfort and career enhancement. They reported that in Ugandan religious not-for-profit health care facilities, qualified medical staff earn less than their counterparts from other providers, yet they were more likely to render services with elements of "public good". Similarly, Bowling (2004) reports that in Malawi, staff attitude towards service delivery improved remarkably when they joined the mission hospitals. Gill and Carlough (2008) attribute the relatively high quality of services in mission hospitals partly to closer supervision and to the fact that responsibility for hiring and firing of staff resides with on-site management rather than a remote civil service hierarchy. Levin et al. (2003) explain the reliable flow of pharmaceutical supplies in mission hospitals in terms of better management and efficient use of resources, all of which contribute to greater patient satisfaction with mission hospitals relative to other providers (Gilson et al., 1995).

Accountability: Accountability is often based on internal checks and balances within the Christian denomination that owns the health facility. Since they are usually independent of government funding, their managements are accountable to the church hierarchies that are the proprietors of such organisations. Without detailed case study evidence, it is difficult to comment on the extent of accountability within FBOs.

Sustainability and public ethos: The mission hospitals have endured over time. They have been part of churches that own them. Because they have often been supportive of government programmes, they are in some countries subsidised by government. Their ethos is typically guided by Christian beliefs and practices that discourage materialistic tendencies. Ethical difficulties arise, however, when health care provision is used as a forum for proselytising. It is, for example, considered unethical to use the opportunity of someone's sickness to sway him or her to a particular religious faith.

Integration into health systems: The relatively large size of the contribution of FBO facilities to the health systems of different countries in Africa demands the attention of health policy makers, as they have often been ignored by MOHs, which sometimes consider them as rivals (Green et al., 2002). The formation of national associations of Christian health institutions in some countries in SSA provides important opportunity for their integration within the national health system without necessarily being absorbed into it. It also gives them a strong voice in influencing national health policies. As discussed above, integration of FBO services into national health systems is happening in countries such as Tanzania, Lesotho, Cameroon, and Ghana.

THE CHALLENGES AND OPPORTUNITIES OF "PUBLIC" PARTNERSHIPS

Partnerships by governments with other organisations represent a strong current in the health sector. Countries such as Mozambique have benefited significantly from NGOs that have partnered with government to provide basic and essential services. For example, *Médecins sans Frontières* (MSF) – an international medical humanitarian NGO – first worked in Mozambique in 1984 and has now established long-term projects to support the government's response to the HIV/AIDS epidemic. MSF activities include treatment of people living with HIV/AIDS and provide voluntary counselling and testing, child and maternal health care, and prevention of mother-to-child transmission of HIV through clinics, hospitals, and home visits.

One way external influences have tended to sway health policies has been through pushing for contracting out health services to non-profit or for-profit providers in order to attain health sector goals. The services contracted out may be clinical or non-clinical. Several schemes have been initiated under such programmes as the Community Nutrition Project in Senegal and Madagascar and faith-based NGOs in Cameroon, Chad, Tanzania, and Uganda. Marek et al. (2005) document instances of the use of vouchers in purchasing insecticide-treated nets in Tanzania, delivering emergency contraception in Zambia and providing reproductive services in Kenya. Franchising, which involves a firm (the franchisor) offering a blueprint of how to sell its product to a local firm (franchisee) in a specified geographical area, has been used in a number of countries including Kenya (LaVake 2003). Marie Stopes International in collaboration with its local implementing partner, Marie Stopes Kenya, and with funding from KFW (*Kreditanstalt für Wiederaufbau*) – the German Development Bank – has been working with the Kenyan ministries responsible for health to coordinate a network of socially franchised private providers. The network targets poor, underserved populations in Kenya, borrowing from franchising models in the commercial sector to increase access to health benefits for rural and urban poor. The aim is to increase access to affordable, high-quality reproductive health and family planning in rural and major urban slums in three administrative provinces of western Kenya.

There have, however, been a number of criticisms against the partnership paradigm in the provision of health services (Buse and Walt 2000a, 2000b, Buse and Waxman 2001, Richter 2004). It is argued that partnerships with for-profit firms are a slippery route to privatisation and commercialisation as the state's regulatory authority may easily be compromised. It is also argued that such partnerships lead to the state abdicating the responsibility of protecting the health of their citizens, corroding essential values of equity, fairness, and universal access. We have therefore not

included examples of traditional PPPs in our discussion as they are often a prelude to deeper commercialisation of health services.

LOOKING AHEAD

McIntyre et al. (2006) and Mackintosh (2003) emphasise how powerful global ideological movements are in shaping events that influence health policies. The alternatives identified above represent new forms of health service delivery or innovations on existing structures to extend health services to reach greater segments of the populations of the region, without direct involvement of the for-profit private sector. Some of the emerging alternatives are aimed at expanding access and reducing barriers and complementing, rather than substituting, existing models of public health care service delivery and financing. For example, the emergence of MHOs was necessitated by the need to increase access to health services by reducing financial barriers that impeded access among the poor and rural communities, often building upon existing social and traditional community structures, as exemplified by the *mutuelles* in Rwanda. NHIS represents a global trend towards providing equal access and offering financial risk protection to all. On the other hand, Christian mission health services have been part of the health systems that complement state provision of health services in sub-Saharan Africa for many decades.

It is also very likely that the development of NHIS will be a major health policy focus in many SSA countries in the near future. The recent success of this model in Ghana, as well as its modest gains in Nigeria and pending adoption in South Africa, two of Africa's largest and most influential economies, may lead to its adoption by other SSA countries. This could result in the expansion of health providers, particularly not-for-profit providers, who are willing to provide services at government-determined rates. Another likely implication of the expansion and deepening of NHIS is the integration of MHOs into the NHIS as is already happening in Rwanda and Ghana. A natural development would be that after MHOs have served critical roles in providing access and hedging poor populations against catastrophic financing, they fizzle out in the end giving way to NHIS and universal coverage.

It is expected that in the future in SSA, the question of how to finance the health care of the population will assume more importance than the question of who provides it. In this context, the role of non-profit health care providers becomes important. As our analysis above indicates, the FBOs represent a viable middle ground between government and private, for-profit health providers. It would seem that they represent an opportunity for public/non-profit collaboration in ensuring that, at least in the medium term, those left behind by forces of privatisation receive quality health care.

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NOTES

1. These problems were identified in a report of the functioning of the Ghana NHIS presented during the first AFEA Congress in Accra, Ghana, 18–22 April 2009. See also *The Daily IIJ*, Ghana: National Health Insurance Scheme uncovers massive fraud at three hospitals. http://inwent-iij-lab.org/Weblog/2009/08/19/ghana-national-health-insurance-scheme-uncovers-massive-fraud-at-three-hospitals/ (accessed 14 October 2011).

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