



Pro MHI Africa

EU-African University Network to
strengthen community-based micro health
insurance

Solidarity in the extension of mutual health organisations – the impact of social factors on the success of the National Health Insurance System in Burkina Faso –

– Working Group Session II –

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1. Introduction and Context

- Less than 49% of population burkinabè is regularly using any health care facility (Ministry of Health, 2008)
 - Potential sociocultural factors
 - financial factors
 - problematic relations between providers and clients
- => Mutual health organisations (MHO)/*mutuelles de santé* provide the potential to increase utilisation of services (e.g. they respond to financial problems with adequate products and premiums)

- Development of mutual health organisations since 1990 in Burkina Faso
 - MHO are of great interest because they can help to cope with health care costs – "It's an opportunity that will enable us to pay for prescriptions" (people)
- => BUT: still very low enrolment rate amongst the target population

Possible factors for low enrolment rates:

- Insufficient financial means of potential members
- Quality of health care services
- Insufficient information among targeted population

BUT: social dynamics and logics are not sufficiently explored regarding low enrolment rates in MHO

✓ **Question: How far social constructions and certain community mechanisms based on solidarity and mutual help might hamper the development of MHO in Burkina Faso?**

Research objective:

To analyse social dynamics of solidarity and mutual help as basic principles regarding enrolment in mutual health insurance

Hypothesis:

1. Perceptions and social relations of solidarity and mutual help among the population does not favor the enrolment in community-based and mutual health insurance schemes
2. The perception of disease and its management routinely do not trigger a solidarity that could promote enrolment to mutual health insurance

2. Solidarity and Mutual Help in Burkina Faso

Solidarity and Mutual Help

- ✓ About 60 ethno-cultural groups live in Burkina Faso (e.g. Mosse, Jula, Gurunsi, Gulmantchema, Dagara, Peulh, Bobo, san, etc.)
- ✓ Agriculture constitutes the main income source of more than 80% of the population
- ✓ Coexistence of autochthons and migrants is common => hard to achieve true intercultural integration
- ✓ Mechanisms of mutual help and solidarity are based on lineage and inheritance, social networks, special alliance relations and religious affiliations

- ✓ Solidarity and mutual help play an important role in agricultural activities and other social events (weddings, baptisms, birthdays, obsequies or burials)
 - ✓ Important social security measures for individuals and the entire group
 - ✓ Lineages can spontaneously mobilize financial and human resources or material to solve problems of an individual whom one shares blood ties
- ⇒ **Solidarity and mutual help are not new concepts within the so-called traditional societies**

✓ New kinds of solidarity systems will therefore appear in the community (health care organisations, micro finance institutions, farmers organisations, social assistance organisations...)

=> BUT: Most of the MHO in rural and urban zones were born with the idea to assist and help the poor and vulnerable and to provide them access to proper health care services

3. Challenges in Mutual Health in Burkina Faso

Specific role of health within mutual solidarity:

- ✓ Social representations of illness and health may have an influence on public and common support for MHO
- ✓ Illness and health does not obligatory involve a systematic solidarity from members of the same village

Challenges in Mutual Help

- ✓ Specific illnesses and the patient are treated in the close family context and by members of the family only
- ✓ Management of illness and health is part of basic social dynamics of mutual aid based on parental relationships, friendships and specific alliances

- ✓ Family social arrangements are primarily applied regarding therapeutic research
 - ✓ Social initiatives are mobilized immediately when the risk occurs because a solution has to be found "here and now" and not in the "future" as the thought of mutual health insurance
- ⇒ "earn money now and enjoy the sustainable solidarity of the family in case of a later occurrence of risk."

Provisional result:

Solidarity in the management of health care risks is usually given and found in the close vicinity of someone, towards people with whom one maintains the same lineage or affinity ensuring social immunity

"Whatever of form of solidarity existed before, the marketing of a voluntary insurance becomes complicated when the community members are expected to understand and accept that their payments might bring benefits to persons outside the close family and their clan as well"

(Dror, 2003 :403)

=> Fact that might hamper the commitment to mutual health insurance schemes

Current situation in Burkina Faso:

- ✓ 146 MHO and mutual health cooperatives
- ✓ Number increased from six in 1997 and 60 in 2006 (more of 100 in 2009)



Difficulty regarding the acceptance amongst the targeted population: Evidence from the field

⇒ MHO of Bouahoun:

⇒ A significant decrease of 56.16% in the membership was observed that went from 2053 to 900 members from 1992 to 2003

⇒ Over 31 members resigned: 16% of them are indigenous people (Bwaba) and 84% are immigrants from other regions of the country (mostly Mosse)

Challenges in Mutual Help

- ✓ Villages of Guilla, Basma, Pissila, Mane, Baskoudré, Sabcé, Kongoussi (mainly populated by Mossi) and Toma (mainly populated by San people), showed less than 7% of their total population enroled in mutual health insurance
 - ✓ From 1999 to 2003, all MHO observed showed a strong decrease of 7 to 2% (5 or 7% of the initial rate of adhesion)
- => Ethnic identity can be a catalyst in the promotion of MHO, but not strong enough to establish a chain of solidarity beyond the closer family**

Main doubts as expressed during the interviews:

- ✓ "What happens with my contribution if I do not fall ill? Who will benefit from it?"
- ✓ "Why singles have to pay for care for childbirth which is included in the common benefit package?"
- ✓ "Why not allow those interested to register according to their needs for medical services (e.g. hospitalizations, medications, childbirth)?"

=> General lack of insurance literacy and mutual solidarity beyond the closest family

Problems faced by operating MHOs:

- Consumption and abuse of medical care by some MHO employees
 - Members are consulting the MHO regularly with the sole purpose of stockpiling drugs at home
- ⇒ Member and staff attitudes show the limitations in acceptance of a common risk management based on solidarity and mutual help (fraud, moral hazard, ...)

Important challenge and opportunity regarding the extension and acceptance of MHO in Burkina Faso:

=> the implementation of the National Health Insurance System, le *Système National d'Assurance Maladie* (SNAM)

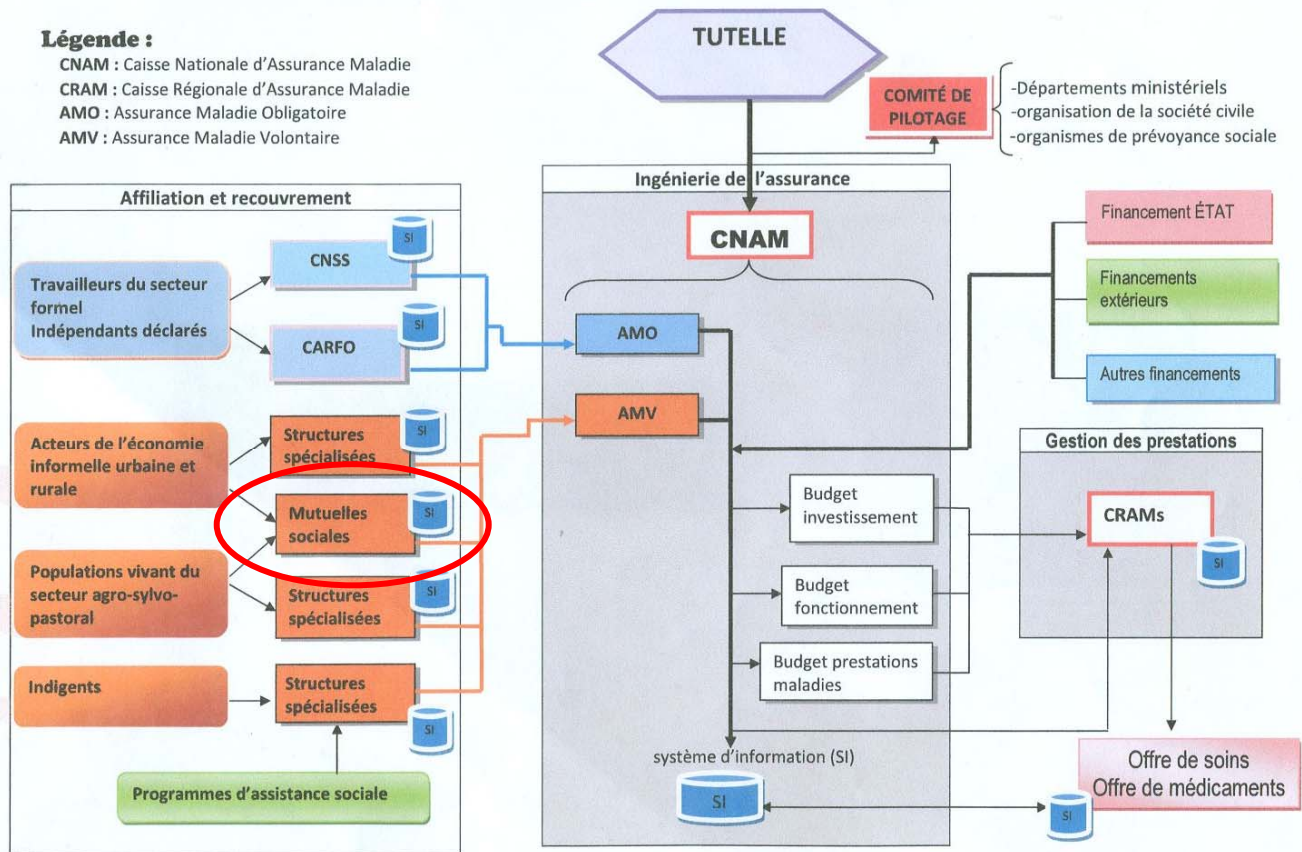
4. Description and potential of the SNAM



- Part of the common health care reform PNDS (Plan National du Développement Sanitaire) in Burkina Faso
- *Mutuelles de santé* are supposed to be integrated in the system to cover the informal and rural sector
- *Système National d'Assurance Maladie* (SNAM) will be designed as compulsory health insurance for the formal sector and as a voluntary health insurance for the informal sector

- At the moment: no public/social health insurance at all in Burkina Faso => even formal sector is not insured by a common social insurance
- Since February 2009 a “*comité du pilotage* » was established to develop the national health insurance system (SNAM)
- Members of the committee:
 - Several ministries (*ministère du travail, du finance et de santé*)
 - ILO-Step programme
 - Several stakeholders from the civil society
 - Cooperation with RAMS (*Réseau d'appui aux mutuelles des santé*)

SCHÉMA DU SYSTÈME NATIONAL D'ASSURANCE MALADIE



Assurance maladie pour tous, MTSS avril 2009

Source: Saïbou Seynou (2009)

2008/2010

- Cadrage et organisation
- Etudes et construction
- Préparation

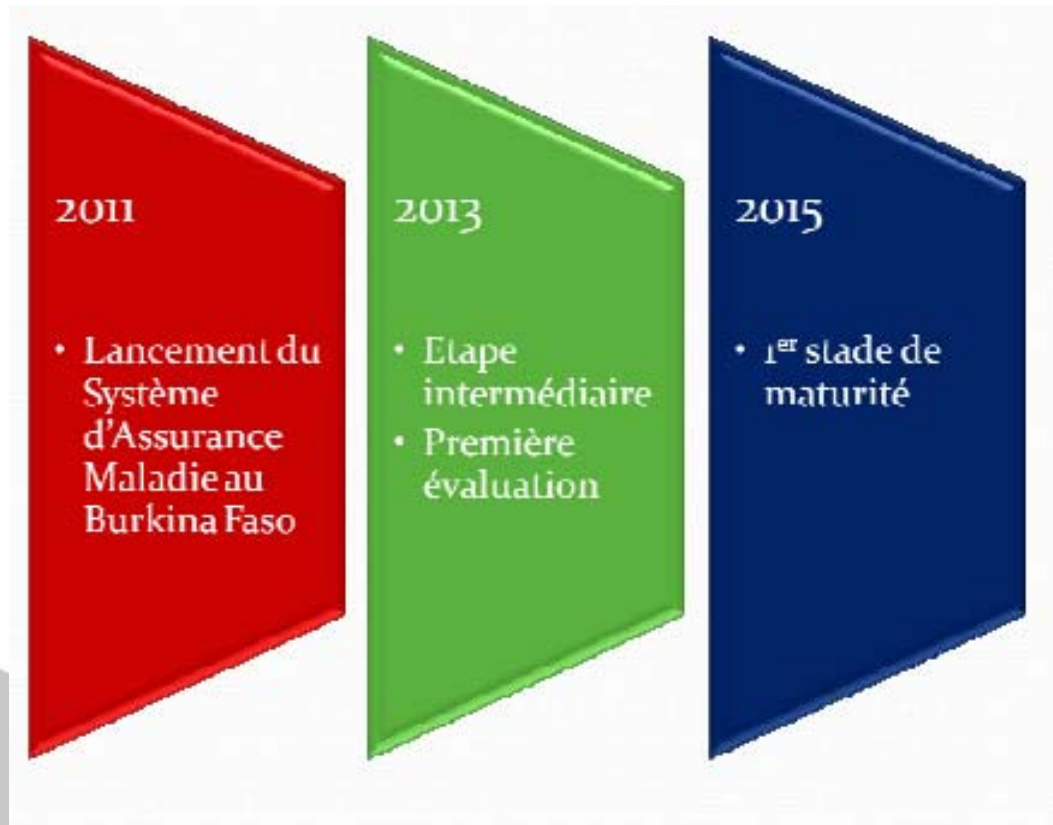
- **Full implementation until 2015**

- **Set up of system until 2011 (Introduction)**

- **Main objectives until 2010:**

- Design of benefit package
- Actuarial research and calculations
- Text elaboration
- Installation of operational and managerial arrangements
- Search for financing mechanisms
- Demand and willingness to pay study
- Study amongst health care provider and local schemes

Further steps forward....



- General approach: *mutuelles de santé* are supposed to remain autonomous
 - Common benefit package, but flexibility regarding the pricing and schemes are free to develop own products as well
- ⇒ **BUT still in question:** How *mutuelles de santé* will be integrated and achieve enrolment among the target population? (capacity building, awareness raising measures, insurance literacy measures, etc.)
- ⇒ As seen before *mutuelles de santé* have to be considered as very weak (in terms of outreach and capacities)

5. Solidarity and the SNAM: common challenges

Basic question:

What needs to be done to achieve enrolment in and commitment to mutual health insurance within the SNAM?

- ✓ Need to redefine the mutual health insurance system and adopt it to each social group:
 - ✓ which form of insurance for which group of society?
 - ✓ which services need to be covered ?
 - ✓ ...

- ✓ Economic situation of the targeted population needs to be ameliorated

- ✓ Traditional practitioners need to be considered within such a system (as their consultation is deeply rooted within traditional risk management)

- ✓ To achieve this, a feasibility study among the target population and common health care provider has to be conducted (as planned by the SNAM committee for 2010)
- ✓ Different dynamics and notions of solidarity have to be considered as basic indicators that might hamper the commitment to and enrolment in mutual health insurance
- ✓ Solid partnerships have to be established between mutual schemes and different actors (cooperatives, farmers organisations, saving banks, microfinance institutions, etc.)
- ✓ Common *mutuelles* of (formal) companies have to be encouraged to offer mutual health insurance to their employees

8. Conclusion and Outlook

Conclusion and Outlook

- ✓ It is essential to consider the social context and background within the set up of mutual health insurance to achieve enrolment and commitment among the targeted population
- ✓ Common difficulties have to be faced regarding the mobilisation of financial resources of members due to the economic background as well as traditional notions of solidarity and mutual help
- ✓ There is no frank acceptance of and commitment to a mutual health insurance system among the population burkinabè
 - => limited by social factors and traditional dynamics of solidarity and mutual help

General outstanding factors according to the extension of mutual health insurance to a national level within the SNAM:

1.) Insurance literacy:

- common consensus amongst the population and the schemes managers about mutual health and the national health insurance scheme;
- general trust in local schemes and the national scheme in general, the delivery of care and the benefits;

General outstanding factors according to the extension of mutual health insurance to a national level within the SNAM:

2.) Financial solidarity:

national solidarity amongst the target population

3.) Common capacities:

managerial and administrative capacities of the government and the executive institutions (e.g. *mutuelles de santé* to avoid fraud, adverse selection, moral hazard, ...)

- ⇒ If these factors are considered the SNAM seems to be a promising approach to support the mutual health system in Burkina Faso in an adequate way
- ⇒ Under certain circumstances an increased utilisation of//access to quality health care in Burkina Faso could be realized within the SNAM

Thank you very much for your attention!



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