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Scaling up Enrolment in Community-Based Health Insurance in Cameroon

Policy Brief

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PREAMBLE

The Centre for Development of Best Practices in Health (CDBPH) is a research unit established in June 2008 at the Yaoundé Central Hospital to foster Knowledge Translation and Exchange for Better Health in Africa with the financial support of a Global Health Leadership Award from the Global Health Research Initiative operated by the International Development Research Centre - Canada. CDBPH is a knowledge brokerage unit designed to link health researchers with health decision-makers. This initiative will serve researchers by harvesting, synthesizing, re-packaging, and communicating the relevant research evidence in user-friendly format that different stakeholders at many levels can interact with and understand. CDBPH intends to also serve health decision makers by providing capacity building opportunities, syntheses of research evidence and identifying needs and gaps related to Evidence to Practice.

This policy brief on community-based health insurance is the second product developed by CDBPH to synthesize and communicate research evidence backing particular policy options for the consideration of decision-makers. The policy options discussed in this document are not mutually exclusive; that is some or all of the options could be adapted concurrently as they are complementary strategies to reduce the level of out-of-pockets spending for healthcare and to protect Cameroonian households from catastrophic health expenditures.

Our intention is not to recommend any one option in particular over another but we attempt to highlight existing research evidence on the effects of several strategies tested in LMIC to improve equity in health systems. Decision-makers should remain the one choosing to consider one option over another, or all the options together according to the actual decision-making process with the relevant stakeholders.

The primary audience is interested parties in health financing efforts in Cameroon namely: governmental and administrative authorities, local municipalities, health development financial and technical partners, civil society organizations, media and promoters of health mutual organizations.

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Policy Brief

Policy Issue

1. Costs recovery through out-of-pockets payments is being practised in health facilities in Cameroon since the Independence, a long-time before the Bamako Initiative aiming at promoting community participation through user-fees with generated incomes managed by a community-based health board as the first financial bill of the Federal Republic of Cameroon in 1962 could certify. With the adoption of the Bamako Initiative, the costs recovery has become the most salient aspect of community participation in managing and sustaining the Cameroon health services. In 2008 and 2009, households are paying 77% to 90% of the annual total health expenditures with 94.8% as out-of-pockets spending during illness episodes for consulting, drugs and medicines and lab tests in the formal but also the informal sector. The estimated total expenditures in 2007 has increased to reach 600 billion FCFA from 403 billion in 2001 and ¾ of this total goes to medicines and lab tests. Out-of-pocket payments in state owned health facilities frequently generate numerous adverse effects including under the table payments, catastrophic health expenditures and exclusion of sick patients from timely access to needed healthcare.
2. Due to macroeconomic constraints related to structural adjustment programmes, LMIC including Cameroon are under pressure to explore innovative ways to promote voluntary private health insurance in order to i) mobilize additional funds for the health sector; ii) reduce the rate of catastrophic health expenditures; iii) improve accessibility of poor people to health services and reduce inequalities in accessing healthcare. Cameroon is engaged in a health sector reform including health financing since the adoption in 2001 of a Health Sector Strategy for the period 2001-2010. According to the strategy and acknowledging the high rate of employment in the informal sector, health risk sharing is promoted through existing community-based associations and microfinance institutions. A strategic paper on promoting MS was adopted and a Support Unit for MS (CAMS) was established within the Ministry of Health since 2005. A survey in 2007 has identified 120 functioning MS with a very low level of coverage, less than 1% of the general population. In 2006, as part of the national policy to promote social security, the government committed itself to promote MS. Despite theses commitments, several families and households are reluctant to sign-up for a CBHI schemes. The most effective MS are professional ones and those supported by municipalities. Reasons for poor enrolment in MS are diverse, including individual, community and organisational level reasons. For example, distrust vis-à-vis CBHI

management teams, lack of knowledge on benefits from CBHI, lack of legal and regulatory framework set forth CBHI.

3. MSs are not-for-profit community-based organizations aiming at providing voluntary health insurance to its members. There are built around values of democratic governance, autonomy, liberty, solidarity, self-reliance and accountability. By overcoming financial and geographical barriers, MSs are doomed to facilitate access to quality healthcare to their beneficiaries. Typically, the MS is created and managed by beneficiaries themselves who elected management board members as well as managing staff. Moreover, they incur all the financial risk because resources of the MS are mainly from premiums. The MS negotiate contracts with one or more healthcare providers in their jurisdiction to provide care to their members. The jurisdiction is usually a health district, the operational unit of the health system with the final objective to increase ownership by the community and healthcare providers.
4. As the Health Sector Strategy was revised in order to align to 2015 agenda to achieve Millennium Development Goals (MDGs), the Government and health technical and financial partners have decided to move towards a Sector Wide Approach – SWAP for its financing including support for demand-side as a priority. This paradigm shift will complement the historically primary option to strengthen the supply side. At the same time, a national think tank has been established to reform social security in the country and the Support Unit to *Mutuelles de Santé* is pursuing its mission. With the poor performance of MS, some actors are questioning the pertinence of MS as an efficient tool to promote voluntary health insurance in Cameroon. This policy brief intends to provide interested parties with relevant research evidence and best practices, if any, proven to increase enrolment in community-based health insurance thus enhancing their role in rendering healthcare services more accessible to the poor. In collaboration with the Technical Secretariat of the Steering Committee for the implementation of the Health Sector Strategy and the Alliance for Health Policy and Systems Research (AHPSR), the Centre for Development of Best Practices in Health has prepared this policy brief.

Methods

5. We have conducted a review of the strategic paper to promote MSs, evaluation reports of the Health Sector Strategy, statistical reports on health financing, the poverty reduction strategic paper and its evaluation report as well as scientific papers in English and French related to health financing options in LMIC in general and in Africa in particular with the objective to identify key determinants of enrolment in voluntary health insurance schemes, determinants of performance and best practices in CBHI. We searched particularly for systematic reviews of effects of health financing mechanisms and promotion of voluntary health insurance in LMIC. Findings are presented below to illustrate the magnitude of health financing in Cameroon, stakeholders mapping and analysis, the conceptual framework for MSs, the national strategy to promote MSs, barriers to the implementation of the national strategy and a summary on effective interventions

or potentially effective interventions to improve enrolment in MSs and to protect poor people against catastrophic health expenditures.

Magnitude of the Problem

6. **Health financing, an investment for human capital.** Financing constitutes one of the building blocks of a health system. Its organisation and functioning critically determine health systems performance especially in terms of equitable access, reduction of health inequalities and exclusion from healthcare. When comparing countries' wealth, there is a strong correlation between the economic performance and growth rate on one hand and level of health expenditures and equity-oriented mechanisms to collect revenues, risk sharing and healthcare purchasing on the other hand. Around the world, several health financing mechanisms are implemented from exclusive tax-based financing to completely deregulated mechanisms highly prevailing in LMIC thus transforming health sectors in completely commercial sectors. The report from the Commission on Macroeconomics and Health has advocated that health expenditures should no more be considered as a burden on public budgets in LMIC but as an investment to consolidate the human capital, the critical prerequisite for economic wealth.
7. **Effectiveness of health financing mechanisms in LMIC.** Although recommendations from WHO and UN agencies advocate for the reduction of health inequalities and ensuring equitable access to healthcare, recognised as a universal human right, enabling mechanisms to achieve this ideal situation are still subject to debate. Indeed, despite the availability of cost-effective essential health interventions and technologies, inequalities in access to those remain very high and unacceptable mainly because of financial barriers. Several innovative financial mechanisms have been developed in recent years such as the Global Alliance for Vaccines and Immunization (GAVI) or the Global Fund to fight against AIDS, Tuberculosis and Malaria, with the aim to support healthcare supply, quality of care and enhanced uptake of essential interventions. Results from several systematic reviews (Lagarde 2006) evaluating five health financing mechanisms in LMIC (user fees, MSs, social health insurance, contracting out, and conditional cash transfers to households) have found low or very low quality evidence on the effects and impact of most of these interventions on financial accessibility of care. Increasing or introducing user fees may lead to the exclusion of a majority of population from health services, and may not lead to quality improvement, even when this is an explicit aim of raising funds through this mechanism. On the other hand, removing user fees does not necessarily improve accessibility or raise services utilization rates. While looking at MSs, the authors conclude that MSs require specific technical competencies and skills to ensure their effective implementation; the effectiveness of this mechanism has remained marginal except from Rwanda where a 40% demographic coverage rate has been achieved in few years. With regard to compulsory social health insurance perceived to be effective, its implementation is seen as complex in LMIC under macroeconomic constraints and where employment rate within the formal sector is low and employment in the informal

sector represents the biggest share. Contracting out public health services to private actors such as NGO in remote underserved areas by state services has proven to be effective locally but its results on a larger scale are still to be assessed. Contractualisation could also constitute a threat for the stewardship and leadership functions of the State. Conditional Cash Transfers to poor households have proven their effectiveness in increasing health service utilization rate and even quality of healthcare. This mechanism is particularly successful where a strong primary healthcare system exists. Because of the macro economics constraints related to structural adjustment, Cameroon has opted for promoting MSs as a means to promote voluntary health insurance.

8. **Poverty and Health in Cameroon:** The last household expenditures survey ECAM III (2007) established that the monetary poverty rate in Cameron has been stable between 2001 and 2007 with an average of 39.9% in fact 12.2% in urban area (cities with more than 50,000 inhabitants) and 55% in rural areas. The poverty depth was 12.3% and the poverty severity was 5%. The Gini Index was 0.39. Close to 60% of farmers and pastoralists were classified under poverty threshold line. The informal sector was representing 80.6% of income generating activity in urban areas. The poverty threshold line was 269,443 CFAF per adult equivalent per year. Despite an increase of annual health expenditures in Cameroon above 77 USD per year per capita (twice the minimum 35USD recommended by the Commission on Macroeconomics and Health) some health indicators are worsening or stable. In terms of morbidity and healthcare seeking behaviours, according to the MICS 3 (2006), forty percent of households have registered a case of acute disease, chronic illness or injury during the thirty days preceding the survey. In total, 12% of members of households have been sick during that period. The disease was considered severe in 26% of cases, moderate in 40% and mild in 34% of cases. 44% of sick patients have relied on self medication while 26% and 17% respectively went to state-own health facilities and private health facilities. 8% of patients went to an informal health facility, mainly illicit drug retailers, traditional healers and religious healers. **44% of patients rely on self treatment in case of disease. Drugs and medicines consumption is not rationalised and constitute 81% of the total health expenditures.**
9. **Health Financing in Cameroon** is characterized by the contribution of both public and private contributions with the later mainly from households whose contribution has steadily increased from 73% of 173 billions FCFA in 1996, 83% of 409 billions in 2001 to 90% of 600 billions in 2007. An important part of health expenses still occurred in the informal sector (under the table sale of drugs in health facilities, directs payments to caregivers, purchasing drugs and care in illicit health facilities). In state-own health facilities, user fees are collected and managed by health district management boards and or district hospital management boards whose membership is made of representatives from caregivers, communities and administrative authorities. 10% of the bill is paid by some one out of the household or from salaries or available money in 62%, savings in 24% and loans in 8% of cases. When considering the overall amount, savings paid approximately 93%. The analysis of the cost structure for curative health shows that

drugs and medicines represent 81% versus 14% for consultation, nursing and hospitalisation; transport expenses represent 3% of the total. In 2006, the monthly expenditure for curative care was 1,454 CFAF per capita [1,671 CFAF for women – 1,222 CFAF for men; 1,948 CFAF in urban areas versus 971 CFAF in rural areas]. During the period of the survey, only 14% of households have had preventive health expenses, in mean 651 CFAF per household [994 CFAF in urban areas- 310 CFAF in rural areas]. Despite several mechanisms implemented by the Government and its technical and financial partners to improve financial accessibility, [harmonization of drugs prices in all the regions ; creation of a budgetary line for indigents in some health facilities ; anti TB drugs free of charges, antiretroviral drugs free of charge since 2007; HIV screening tests free of charges for pregnant women, prisoners and students ; 65% price reduction for essential drugs in state-own health facilities ; price reduction for insulin from 14,000 to 3,000 CFAF; subsidies for haemodialysis from 60,000 to 5,000 CFAF; price reduction for antimalarials, subsidies of some anti cancer drugs], the level of out-of-pockets payments by households remains as high as 94.7% according to the World Health Statistics Report 2009.

10. **Institutional Environment *of Mutuelles de Santé* in Cameroon:** The Government is promoting CBHI at the districts level with the aim of a greater equity and improvement of financial accessibility of healthcare. The Health Sector Strategy drafted as part of the national policy to reduce poverty in 2001 has set as an objective to establish at least one MS in all the 178 health districts and to reach a 40% coverage rate by the year 2010. A Support Unit for MS was established in the Ministry of Public Health and a steering committee for the reform of the social security is functioning in the Ministry of Labour and Social Security. The Support Unit for MS is in charge of drafting a mutuality code, defining a support strategy for MS, training and providing support to MS promoters, maintaining a national registry of MS and facilitating negotiation of purchasing mechanisms between MS and health facilities. The mid-term evaluation in 2005 of the national strategy to promote MS has revealed several problems encountered by the first created MS for pilot testing. In 2005, about sixty MS were operating with a demographic coverage under 1%. This evaluation has also lead to revise the strategy to promote MS with adjusted objectives being i) to achieve at least a 40% coverage rate by the year 2015; ii) to support community so as to create at least a MS in every health district; iii) to establish a mechanism to finance and manage healthcare to indigents people and iv) to guarantee a universally accessible healthcare package.
11. **Stakeholders in Health Financing in Cameroon are:** the State, NGOs, communities and financial and technical partners to health development. Those interested in the promotion of MS are the State, the communities, the local municipalities, micro finance institutions. Functioning MS were created under the lead of communities and partners of health development such as GTZ, Belgian Cooperation, SAILD, ADB (African Development Bank). GTZ is working in the North West, South West and Littoral regions while the Belgian Cooperation is present in the Far North and the SAILD is working in the Far North, North, North West and West. Since 2006, the ADB is supporting preparatory work for establishing MS in 11 health districts in the South

and Centre regions. An inventory financed by the GTZ has revealed the presence of 101 CBHI organisations including 79 geographic MS, 11 private insurance and 11 vocational MS with a great disparity among regions: the Centre, Littoral and West regions are hosting more than 76 MS followed by the Far North and North West with 19 MS.

12. **Barriers to proper implementation of the national strategy to promote MS** have been described in its mid term evaluation report and mainly related to first instalment and different conceptual framework and environment. **during the first instalment, problems encountered were related to calculation of entry fees and premiums, revenue collection and attempt of fraud.** It was very difficult to estimate household capacities to pay for their premiums because of the high level of economic activity in the informal and agro pastoral sectors. **With regard to supply side,** the lack of an effective standardization and normalization of nursing protocols, the absence of a standardised tool for costing of care depending on the type of health facility within the health pyramid were hindrance to adhesion to MS. In order to solve the problem, a package of benefits including consultations, medicines, laboratory tests, hospitalization, covering more than 90% of the types of care offered by Health centres, Medical Centres and District Hospital, was developed but its containment is still difficult with high disparities in utilization rate of the package of benefits 21% (Bamoungoum) versus 60% (Manjo) before establishing the MS but its raise was quite explosive. Revenue collection was also confronted to the seasonality of incomes in the rural area and actors of the informal sector. The most frequent fraud attempt was substitution of beneficiaries. **With regards to environment and viability of MS,** the absence of a national legislative and regulatory framework conducive for MS, controversial relationships between MS and caregivers and the lack of judiciary framework for negotiation of contracts and agreements between state own health facilities and MS were some of the barriers to the development of MS. Among other obstacles were over prescription by caregivers "in reaction to drop in under the table revenues generated by the more transparent processes in health facilities". Last but not least was the role of the MoH in reference pricing of care and services in state-own facilities thus preventing negotiation on user fees; the management process implemented in area supported by GTZ was not complying with the payment after services and care, MS were therefore obliged to make deposit to health facilities in advance. **In terms of quality of care,** several health system failures were registered such as out-of stocks, absenteeism of caregivers, informal practices and poor hospitality. Many populations were requiring a minimal standard of care to justify the payments of premiums. **Financial viability of MS and their federations is linked to their** capacity to cover recurrent operating charges, staff training or capacity building, medical advisor and external auditor. Estimates shows that in rural areas, 250 adherents are needed that's 1250 beneficiaries to cover recurrent operating charges and that 750 adherents meaning 3750 beneficiaries are needed to cover any other additional costs. Finally, at the current speed, a recently created MS needs 3 to 5 years to achieve the required critical mass of adherents.

13. **Factors analysis of the low enrolment in Cameroon:** a large majority of factors identified as facilitating or inhibiting enrolment in MS is present at different degrees depending on regions and socio economic conditions of households. In summary, the laisser-faire strategy, the absence of legal and regulatory framework, the lack of information and knowledge on the existence of and benefits from MS in one hand and perverse effects of out-of-pockets payments and different waivers systems on the other hand ; the 40% rate of monetary poverty in the general population, the 80% prevalence of the informal sector, the multiplicity of social networks of solidarity, the poor engagement of local municipalities and the lack of visibility on the package of care and services are feeding the low rate of enrolment in MS.
14. **Challenges for MSs in Africa: some** lessons learnt from case studies in Africa except from the low coverage rates are that MSs in Africa are confronted with moral hazard, adverse selection, non rational prescription and use of drugs, organizational constraints. **The moral hazard** defines the fact that, the risk insured by the insurance could be aggravated by irresponsible behaviours from adherents. The ex ante moral hazard is the consequence of adherent tending to reduce their preventive efforts. The ex post moral hazard designates over consumption of care and services because of the health insurance; a beneficiary will expend more than a non adherent for the same disease. **Organizational and operating constraints are linked to the complex environment where MSs are deployed.** Creating a MS has been judged complex and more difficult than many other development project (GTZ 2003) because MSs are location at the crossing road for 3 subsystems already complex, public finances, social sector and health services.
15. **Determinants of Adhesion to a voluntary health insurance:** Several theories are referred to when trying to understand individual or family decision-making processes to insure against health risk. Determinants of the decision relate to users, healthcare providers, health insurers as well as the socio economic context. These determinants are economic, financial, cognitive and socio cultural. **The ability of individual or household to afford entry fees and premiums is a prerequisite.** In a context marked by a high level of monetary poverty, the financial capacity of individuals and households is a strong barrier no matter the level of entry fees and premiums. Subscribing a health insurance is typically competing with other basic needs such as feeding, cloths, lodging, and school fees for children and transport. The monetary poverty could generate unexpected behaviours because of the poor knowledge and understanding of health insurance in general and MS in particular. Scarcity of means and uncertainty on health status in the future – the probability of being sick is unknown and may vary – the demand for a health insurance appears as a choice between an immediate loss of revenues (paying for entry fees and premiums) and an hypothetical loss incurred in case of illness. **The uncertainty on the probability of falling sick negatively influences** the individual decision to adhere or not to a MS when financial constraints are high. Basic and immediate needs usually lead individuals to sacrifice health insurance. In deed, people typically make a trade-off between immediate financial

losses and potential but uncertain gains in the future in case of disease. **Existing alternative financial risk protection mechanisms will also** influence negatively the decision to adhere or not to a MS. The high level of activity in the informal sector and traditional mechanisms of solidarity within African families, micro finance institutions could prevent people adhering in MSs. Social norms and cultural beliefs also influence how people will perceive potential gains from a MS. Empirically, assessment of benefits and harms of a health insurance scheme is correlated to socio economic status, poor individuals tend to consider losses in case of ill health inferior to entry fees and premiums because they usually resort to traditional healer or illicit drugs retailers perceived as cheaper. On the contrary, wealthier households could also underestimate benefits from MS because of the poor value of package of care offered and therefore decide not to enrol. **The attraction for a new product and foreseen benefits** in a context of poverty also influence the decision to enrol. Unanimously, benefits perceived from purchasing a new product are generally lower than the costs of denial of something usual and common. Patients will for example prefer the *status quo* to the adoption of a new and recent medical procedure; the higher the number of alternatives, the higher the risk for patients to choose the *status quo*. Poor households will adhere to a MS only if they perceived clear benefits in comparison to non enrolment. **The socio-cultural and political context** could be conducive or a hindrance when it promote mistrust instead of trust and confidence in relation to formal institutions in general and health in particular. **The level of trust vis-à-vis promoters of the MS** appears to also be a predictor of poor performance and low enrolment in MS. In fact, the populations distinguish the management capacity and transparency in the management of the system on one hand and the capacity of the MS to achieve its objective on the other hand. Trust in the management of a MS depends on competencies and skills and; moral integrity of managers; several MS have failed due to suspicious environment, corruption and the lack of sanctions against corrupted practices and the non respect of the rule of law. **The culture of solidarity and the capacity of communities to organize themselves** constitute critical determinants of the adhesion to MS. In many experiences of MS, a critical mass of adherents is necessary for establishing a community-based health insurance organisation. Depending on the size of the population in a given area, establishing a MS will be easier or impossible. **The lack of a national regulatory framework to promote MSs is** an obstacle to enrolment in a MS. In a country like Rwanda succeeding in achieving high coverage rate, the engagement of the Government has been instrumental to create and sustain a conducive environment adapted to socio political and cultural context and implementation of a specific pro poor incentives. **The lack of interest for MS, the lack of knowledge on advantages of MS and reluctant healthcare providers** restrict the expansion of MS because they influence negatively the perceived quality of care and satisfaction of healthcare users. **The contribution of quality of care** is ambivalent, perceived quality of care could be a critical factor and a prerequisite for the success of MS in the same way that MS could be a determinant of healthcare quality improvement. If potential adherents

misjudged quality of care and are not convinced that MS could improve upon quality of care, enrolment will remain low. **In summary, determinants of subscription are affective, cognitive and economics. These are typically, knowledge of stakeholders related to existence and benefits from MS, trust in promoters, contain and quality of the health package services and care, financial ability of populations to pay their entry fees and premiums.**

Evidence on the effectiveness of MSs

16. **Types of *Mutuelles de Santé:*** MSs are characterized by their size, organization, promoter, objectives and management structure. Empirically, several types of MSs are classified according to the nature of the promoter (clan, tribe, civil society organization, association), geographical location (territory, profession, enterprise, trade unions), the nature of covered risk (rare diseases but expensive, common diseases but cheaper), the types of contribution (system where adherents received direct subsidies from Government, health cooperative in villages or health districts, third-party contributor for the community, provider-based prepaid schemes, cooperative systems targeting consumers and providers such as Grameen Bank acting both as an insurer and healthcare provider in a jurisdiction). Waelkens & Criel (2004) distinguish 6 types of MSs: 1) community-based MSs on a geographical base managed by adherents; 2) provider-based initiatives; 3) professional MSs; 4) ethnic based MSs; 5) MSs of actors from the informal sector on a vocational basis; 6) federation of existing civil society groups or associations instead of households. Building on an inventory of 913 MSs in Sub-Saharan Africa, the same authors noticed that a great majority of MSs are from type 1: community-based on a geographical basis (a village, a district or a city) followed by vocation –based MSs primarily civil servants.
17. **Impacts and effects of *Mutuelles de Santé***: Theoretically, the expected positive effects of MSs are improvement of the financial access to care, a greater equity in healthcare access and improvement of the quality of care. In the real world, MSs do really protect adherents from catastrophic health expenditures by reducing significantly out-of-pockets payments according to the metaanalysis by Ekman. In the same line, MSs improve access to care and protect against catastrophic health expenses as members resort to health services more frequently than non members and members tend to consent timely before the disease reach complicated stage. However, the protection does not reach the poorest, who are still excluded because of the financial barriers constituted by fees. In terms of healthcare quality improvement, there is insufficient evidence on the effectiveness of MSs "because of the poor enrolment rate in MSs that does not allow generation of sufficient amount of resources needed to impact on health services quality and organization and delivery" (Waelkens & Criel 2004).
18. **Failure of exclusively community-based health insurance:** In reality, the effectiveness of the social control and the management of proximity theoretically considered to be assets for MSs, as they guarantee regular contribution from adherents and restrict overconsumption of

care and abusive use of the MSs by non members, still need to be demonstrated. Some cases studies describe the failure of MS managers to timely collect premiums and social control sometimes becomes an obstacle to access to care mainly for some stigmatizing diseases such as tuberculosis. The community-based initiative is confronted with weak management capacities and management by volunteers only from whom specific skills are expected for a time consuming assignment. The scarcity of resources for MSs also justifies the embargo on recruiting costly and highly qualified managers. From experiences in Eastern and Western Africa, a great level of ownership of the insurance scheme by the community does not necessarily correlate with negotiating power for equitable purchasing mechanisms or power to influence health services supply or delivery. **Main reasons of the failure of exclusively community-based health insurance particularly in rural areas is the weak management capacities, the power imbalance between healthcare providers and MSs management body as well as the exclusion of healthcare providers from the conception and management of MSs.**

19. **Value of MSs as a Health Financing Mechanism in LMIC:** MSs represent a very marginal part of the total amount of health financing in Africa. According to Ekman 2004, on average only 25% of resources for health facilities in LMIC are issued from MSs. In Sub-Saharan Africa, the share is even lower. For example, 4% of the hospitals incomes in Ghana, 2.5% in Thiès region in Senegal and 10% of the overall budget of Nouna Health Centre in Burkina Faso come from CBHI. The low level of participation, a major characteristic of MSs in Africa constitutes the main reason of the tiny share in health financing. Case studies help to understand reasons of the failure and poor performance of many of the MSs in Africa. In Tanzania for example, while promoters were expecting a 30% enrolment to progress to over 70%, the percentage of enrolment was barely 5.9%; in Ghana, while the initial coverage rate was expected to be 50% of the population in Dangme West Health Insurance Scheme, the year one total coverage was only 3%. According to Waelkens & Criel (2004), the small rate of enrolment happens mainly in community-based health insurance schemes managed by members as promoted in Africa. **Community-based MSs exclusively managed by their members remain a marginal health financing mechanism in Sub Saharan Africa.**
20. **The Rwandan Case:** As an Island in the pessimistic African context related to performance of MS, Rwanda is an exception. Indeed, thanks to a comprehensive political, legal and regulatory framework, the Government of Rwanda has planned to scale up MSs as a priority intervention to promote universal voluntary health insurance. In just a few years, the number of MSs has reached 300 in 2006 with a coverage rate increasing from 9% in 2002 to 43% in 2005. MSs and the health centres they serve are supported and coordinated within thirty health districts and a Government Unit to supervise districts, establishes norms, standards and procedures in terms of revenue collection, purchasing of care and services, defining the universal package of care and services. Typically the universal package of care and services include essential interventions supplied at the health centre level, including essential drugs and medicines, preventive and

curative services and care, ante and post natal care, delivery, laboratory tests, transportation costs for referrals to district hospitals, and some care and services at the district hospital. Support from external donors has served to pay premiums for the poorest and indigents. **The proactive strategy by the Government has enabled a high coverage rate in Rwanda in just five years.**

Policy Options for Improving Enrolment in MSs in Cameroon

21. **Six main interventions or strategies have been used in different settings to increase enrolment in health insurance schemes:** those are : 1) adjusting eligibility criteria through law and regulation, 2) Information, Education and Communication on existing health insurance schemes and des advantages through well oriented mass media campaigns, 3) improving financial accessibility of premiums through directs subsidies or indirect subsidies or sliding scale premiums according to incomes, 4) modifying enrolment procedures by simplifying procedures or changing the unit covered or introducing flexible mechanisms for revenue collection to adapt to seasonal incomes, 5) improving healthcare organization and healthcare delivery through the revision of the package of care and services, costs containment and quality of care including the assessment of the level of satisfaction of users, 6) improving management and insurance services organisation through optimal information system, capacity strengthening and development of personnel as well as participative governance. To increase enrolment in MS requires establishing a proactive comprehensive strategy towards potential beneficiaries and healthcare providers so as to bridge the identified gaps and resolve identified barriers. These options and strategies are not mutually exclusive but complementary. There are governance, financial and delivery arrangements.[Menq 2009]
22. **Option 1 : Creating and sustaining an enabling environment to promote and support development of MSs. Strategies**: establish laws and regulations related to creation and operation of MSs; build on existing community-based organizations, associations, micro finance institutions and local municipalities to promote voluntary health insurance through MSs; reforming hospital management to improve quality of care, transparency and accountability through a strengthened health management information system; allowing contracting between state-own facilities and MSs; reducing out-of-pockets payments at point of care to the strict minimum; management support to an umbrella organization with merging of several CBHIs to increase purchasing power at the district level; developing norms and standards for MSs in terms of purchasing mechanisms, operating costs but also in terms of standard of care; establishing norms and standards to improve quality of care. The evidence of effectiveness of this option is built on the Rwandan experience.
23. **Option 2: Subsidizing premiums by the Government, health development partners and local municipalities to reduce financial barriers and increase their affordability for poor populations in rural areas particularly. Strategies**: partnership between

Government and Financial and Technical Partners for financial subsidies to users and/or MSs to improve access of the poorest of the poor unable to pay premiums; engaging local municipalities to subsidize premiums for indigents; enforcement of the national drug procurement policy to contain inflation on drugs and health technologies. Subsidies for drugs have proven to be effective in increasing access. The Rwandan case study has also proven the effectiveness of this option.

24. **Option 3: Establishing flexible revenue collection mechanisms; organizing trustworthy and attractive risk-pooling and purchasing mechanisms**. Strategies: participative definition of the package of care at the health district level in order to adjust to local needs and increase ownership be local actors; flexible payment of premiums to adapt to the instability of incomes of those in the informal sector and rural populations revenues linked to cash crops; rationalizing production costs in healthcare organizations and promoting quality of care in health facilities; organizing media campaigns to inform, educate and communicate on MSs.
25. **Implementation issues:** A common barrier for all three policy options is the lack of knowledge of the general public and healthcare providers on the advantages of MSs, side effects of out-of-pockets spending in health facilities, negative effects of corruption and quality of care. To overcome this barrier, one effective strategy is Information, Education and Communication for behavioural change among the general public and healthcare providers through the mass media campaigns. Regarding barriers to implementation of policy option, participants at the policy dialogue held on 11 November 2009 have identified i) lack of means to enforce laws and regulations related to creation and operation of MSs; ii) mistrust vis-à-vis management bodies of MSs; iii) poor quality of care in many health district hospitals; iv) resistance to change among healthcare providers; v) budgetary constraints for subsidies; vi) high level of corruption practices with risks of inflation on healthcare costs, drugs; vii) intensity of poverty which could prevent the poorest to afford even low premiums; viii) resistance to change from private sector with conflicting interests; ix) risk of insurance pool fragmentation; x) lower subscription rates due to voluntary nature of schemes and mistrust. In overall, the environment for developing community based health insurance in Cameroon need a more proactive approach from the State and actors of the social and health development.

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