

Micro Health Insurance and Solidarity Groups: Redefining Strategies to Promote Healthcare Coverage for Underserved Populations

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Abstract

Micro health insurance schemes represent the contemporary form of easing healthcare access to underserved parts of the economy across West and Central Africa. Despite the virtues of these schemes such as the promotion of primary healthcare as outlined during the Alma Ata Conference, they face a huge challenge in terms of provision of this care by virtue of the small risk pool sizes. This means a certain inability to cover all cases of ill-health among their members. This is especially true in tropical areas where the incidence of diseases such as malaria is high. Increasing these risks pools means dedicating more resources for social marketing strategies targeting communities and individual households. This paper proposes the use of solidarity groups to increase such pools as a more cost effective way. As will be argued, it has a higher impact and represents many advantages as compared with the regular communications targeting the public at large.

Key Words: Universal health coverage, health insurance, underserved populations, social marketing, risk pool, solidarity groups.

Introduction

Problems of health care access and finance have always attracted international discourse due to the number of persons, especially members of underserved portions of the population and those in the urban informal sector, who, due to their socio economic status, still face difficulties in accessing quality health care (Asia-Pacific Leadership and Policy Dialogue for Women's and Children's Health, 2012). This is also coupled to the falling allocated government budget for health. The Alma Ata Conference of 1978 and that of Bamako, 1987 all accentuate the role of health insurance schemes as one of the most effective means of health financing.

Since the 1990s in Africa, there has been increasing interest in health insurance to improve access to health care services. In Cameroon, the government as well as other stakeholders, including the German International Cooperation for Development, GIZ, have worked since 2003 to create micro health insurance schemes to improve access to quality health care to all especially the poorest of the poor as it has been proven that they consistently have the poorest health (National Health Committee, 1998).

This is even more pertinent as these schemes not only encourage the attitude of pre-saving for health but also aim at eliminating the cash and carry system where individuals are expected to do out-of-pocket payments for health needed services (Wietler, 2010). These schemes also promote primary health care and ensure the participation of the community in health packages that are designed for them as opposed to just being passive recipients of such packages (Wietler, 2010; Atim, 1998).

Since their inception in 2003, very few studies have been carried out in Cameroon to assess the performance of micro health insurance schemes and analyse their challenges. As of 2015, micro health insurance schemes are being advised to target solidarity groups into their pools rather than individual families. Why this trend, given the fact that the main role of such non-for profit schemes is to improve health care access to the families especially those in the poorest parts, rather than a group of individuals who come together usually for, as it is perceived, economic gains? This study therefore aims at analyzing the relationship between solidarity groups and micro health insurance schemes within the framework of easing access to

healthcare for households. In other words, it will assess the role of solidarity groups in providing health insurance to the population.

Objective

The objective of this paper is to assess the role of solidarity groups in bringing micro health insurance to individual families, especially those of the informal economy.

Method

The overall methodological framework for this study is based on action research. The findings of this study will be relevant to the sector as well as the participants in the study. It aims at building the capacity of health insurance schemes in terms of improving coverage and increasing access to healthcare especially to underserved populations.

This study made use of the qualitative method of research. Given the study objectives, it is worthwhile to observe the modus operandi of such groups in order to have a holistic understanding of such a role. This is possible only with a qualitative design.

The study made use of personal interviews of the managers of the health schemes. These managers are especially important because they have a deeper mastery of the phenomenon under discussion and can therefore make honest appraisals of the roles of solidarity groups in easing and promoting access to healthcare through micro health insurance schemes.

Participant observation is another data collection method that was used in this study. This method is of importance as it permits the researcher to get an insider viewpoint ensuring that much relevant information is collected. Observation of solidarity groups during meeting days was done.

Secondary data (annual reports and other administrative paperwork) was equally gotten from the micro health insurance offices for further analysis.

Selection of participants for the study was done using expert sampling technique. Executives of such solidarity groups were sampled as well as programme managers of micro health insurance schemes. This allowed for more credible responses to be gotten, rather than a large sample with non-reliable responses.

The collected data was analysed using hermeneutic analysis. The analysis was dependent on the researcher's analytic and integrative skills and personal knowledge of the social context where the data is collected. The main guide for the analysis was making sense of and understanding of the phenomenon under investigation within its social context

Result and discussion

From the observations made, it can be inferred that solidarity groups can be described as an association of people, drawn together by a common characteristic, usually cultural. People from the same ethnic group for example who find themselves away from their hometown come together to form such groups, to "promote their culture" and encourage as well as teach the younger generations aspects of that culture. These groups serve as one of the means of passing down traditional rites and other cultural aspects of a people down to the younger generation. This is especially important in a globalised world where the notion of time and distance has been nearly eliminated not only as a result of the communication superhighway but as a result of the fact that people move in today's global economy to find jobs far away from home (Sheppard, 2002). Such groups serve as a constant reminder of what "home" is like. As such, it is common to find that each group has a peculiar uniform or some form of identification that helps distinguish it from another. It should be noted that membership has no economic limitation, as it is possible (and mostly so) to find people of varying economic levels being part of the same group. These groups therefore largely involve underserved parts of the population. There are quite a good number of such groups within the context of Cameroon as it is rare to find a middle age individual who does not belong to such groups. Examples of such groups include Meta Cultural and Development Association (MECUDA) – made up of people from the Meta Clan in Cameroon, Many Elements Cultural Association (MECA) – made up of people from Manyu division, etc.

They have the following objectives:

- Resource pooling: here, members put their financial resources for individual or collective growth. There are several forms of such pools. There is the regular savings in which each member saves any amount as convenient to them throughout the course of the year. At the end of the year, members are given their full amount including bonuses derived from interest from loans. There is also the "njang" in which members are expected to contribute a specific amount on each meeting day. Such contributions are given to an individual on such days. This cycle ends when everyone has had a turn.

- Risk pooling: here, members acknowledge the probability of catastrophe and take measures to reduce the impacts of such. Members pool in finance and support each other in times of death (to assist in funeral expenses), known under the name of "trouble fund", and ill health (hospitalisation only) of either the member in question or an immediate relative

- Development projects: these groups usually have an annual development project. This could range from building of schools to health centres, bridges, etc. The location of the project is determined by the group but usually it is done back home.

These solidarity groups have a proper management system based on well-defined principles. Within such groups, there is an executive board which is in charge of decision making, ensuring the day to day running of affairs. Membership is not *strictly limited*. This means that the family of registered members stands to benefit from the advantages that members enjoy. This is especially true in cases of ill health and funerals. As such, the family of members is known within the group.

It should be noted that micro health insurance schemes are financed mainly by the contributions of its members. Therefore, the larger the pool, the more effective the scheme will be. Given the relatively small pool of micro health insurance schemes in Cameroon, it is possible that the scheme can face difficulties handling all cases of ill health. This is also punctuated by the tropical climate favouring the prevalence of malaria and other tropical diseases. For example, in Tiko Health District in Cameroon, 62% of all clinical cases recorded in 2014 were malaria, with a 23% of those being children under 5. This represents a huge burden for a scheme that has a relatively small risk pool.

Conclusion

From our data collected, we propose a new solution to these schemes. Targeting these solidarity groups might prove a very fertile ground to increase the risk pool of such schemes.

Targeting these solidarity groups has a number of advantages:

- The solidarity groups represent a large catchment area as it includes not only the members but

also their families. Thus, a group of about 50 individuals, if registered can automatically enrol averagely about 200 individuals into the scheme assuming that each family has 4 members.

- It is relatively cheaper to target these groups than to implement a regular social marketing campaign targeting the entire public.

- Follow up, communication and feedback which are all important for the survival of the scheme, become easier and more effective with such groups.

- Monitoring and evaluation of the impact of such schemes becomes easier and more effective

- It becomes easier to ensure that members promptly have their health insurance renewed as the management of the group can make it compulsory for each member to do so before a deadline.

- Irregular situations with partner health facilities or of any other kind can be easily managed due to the organised nature of the group relative to individual families.

- Again, with individual families, the risks of adverse selection are higher than with solidarity groups.

As analysed above, solidarity groups seem to be playing a “middle man role” between the micro health insurance scheme and the population (individual households). It is therefore recommended for micro health insurance schemes to target these groups to increase their risk pool and ensure that the informal sector of the economy has some form of health insurance. It is also recommended for individuals to join these solidarity groups to have access to health care and just as Wilder Research 2012 put it, strong social ties can have a direct and positive impact on health.

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