USAID COMMUNITY CAPACITY FOR HEALTH PROGRAM

Community-Based Health Insurance Schemes: Addressing Financial Barriers to Accessing Health Care

PROGRAM SUMMARY

The USAID Community Capacity for Health Program—known in Madagascar as Mahefa Miaraka—is a five-year (2016–2021) community-based integrated health program funded by the United States Agency for International Development (USAID). The Program is a collaborative effort among the Ministry of Public Health (MOPH), USAID, and JSI Research & Training Institute, Inc. (JSI). Mahefa Miaraka provides tools and capacity-building training to approximately 10,000 community health volunteers (CHVs) who provide basic maternal health, child health, and family planning services to their local communities. The Program also works with national and local government stakeholders to strengthen the health sector and health policies.

MAHEFA MIARAKA

- OPERATES IN **7** REGIONS OF MADAGASCAR
- COVERING A TOTAL OF **4,708** VILLAGES
- WITH A TOTAL POPULATION OF **6.6** MILLION PEOPLE
- OR **28** PERCENT OF THE COUNTRY'S TOTAL POPULATION

JSI


Maheta Miaraka Sofia

OVERVIEW

It is estimated that at least half of the world's population lacks access to essential quality health services.[1] This unmet need is greatest in rural areas, where 56 percent of the population lacks health coverage compared with 22 percent in urban areas.[2] In addition, health care costs can overwhelm households; close to 100 million people are pushed into poverty each year due to out-of-pocket health expenses.[3]

In Madagascar, where more than 70 percent of the population lives in rural areas and works in the informal sector, accessing health services and having readily available funds to pay for the services remain a significant challenge. Coverage of the population against financial risks associated with health care remains almost nonexistent, with less than five percent of men, women, and children under age 18 having health insurance coverage.[4] Community-based health Insurance (CBHI) schemes, which have a long history in Madagascar, can be used to reduce the cost of health care and increase access to care, when needed. CBHI schemes are one way to address the health financing burden because they allow community members to pool resources, share risk, and improve access to care. They can also provide a mechanism for community members to advocate for improved accountability and quality of services at health facilities.

In 2015, the Government of Madagascar developed the National Strategy for Universal Health Coverage, which clearly outlines the need for CBHI schemes. In accordance with this strategy, the Mahefa Miaraka Program supported CBHI schemes as part of its commitment to the communities it served and to ensure that community members who needed care beyond the services that CHVs provided could access these services. To address financial barriers to accessing health care, Mahefa Miaraka supported community-based health mutuals (*mutuelles de santé*) and worked to fill health financing gaps through the integration of health funds (*caisse santé*) in existing village savings and loan associations (VSLAs) and similar community-based cooperatives.

APPROACH

Mahefa Miaraka supported CBHI schemes, including the mutual and the health fund models, to ensure that community members could afford to access care at local health centers when needed, thereby facilitating access to quality, timely care. Membership for both models was voluntary and was characterized by community members pooling funds to offset the cost of health care. Project activities built on the achievements of previous CBHI schemes used in Madagascar.

1 World Health Organization (WHO). (2019). Primary Health Care on the Road to Universal Health Coverage: 2019 Global Monitoring Report. https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf.

2 International Labour Organization (ILO). (2017). World Social Protection Report 2017–19: Universal social protection to achieve the Sustainable Development Goals. Geneva, Switzerland: ILO. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_604882.pdf.

3 World Health Organization (WHO). (2019). Primary Health Care on the Road to Universal Health Coverage: 2019 Global Monitoring Report. https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf.

4 National Institute of Statistics (Madagascar, INSTAT), United Nations Children's Fund (UNICEF). (2019). Madagascar Multiple Indicator Cluster Survey 2018. Antananarivo, Madagascar: INSTAT and UNICEF. https://mics-surveys-prod.s3.amazonaws.com/MICS6/Eastern%20and%20Southern%20Africa/Madagascar/2018/Survey%20findings/Madagascar%202018%20MICS%20Survey%20Findings%20Report_French.pdf.

Community-based health mutuals. Thirty-three health mutuals were established during the USAID Community-Based Integrated Health Program (MAHEFA) between 2012 and 2016. Mahefa Miaraka continued to support to these mutuals. The health mutual is a voluntary CBHI scheme formed at the commune level; the size can vary. Each mutual determines its own statute, and members decided collaboratively on rules related to membership, payment of fees, eligibility, and details of care and payment allowed. Mahefa Miaraka supported the mutual to establish and maintain the links among the local microfinance structures, the mutual's management committee, the basic health center, and the hospital through a partnership agreement. In exchange for membership fees, mutual members agreed on which health services the mutual would either reimburse or would pay for based on health costs and the level of contributions in the mutual. The mutual guaranteed its members payment or reimbursement of all or part of the health care costs (up to the ceiling decided by the mutual). Members who did not use health care services during the year were not reimbursed the amount of their contributions.

In addition, Mahefa Miaraka strengthened social micro enterprises for bicycle sale and repair that served as a source of revenue for the mutual in the same vicinity, with five percent of its profits contributing to a community's mutual.

Health funds. In 2018, Mahefa Miaraka looked to expand coverage of health risk pooling mechanisms in its program regions. Risk pooling at the commune level proved too abstract for members to perceive the tangible benefits, leading to a steep decline in the participation of community members in mutuals. As a result, the Program leveraged existing VSLAs by integrating a health fund to increase the funds available to members to defray health costs, and improve access to services and coverage in its program regions. VSLAs consist of smaller, self-managed, and socially cohesive groups of 15–20 people compared with the hundreds of people associated with a mutual that is spread out over a large geographic area. This approach offered a more viable option because there were already existing VSLA networks and partners with whom the Program could collaborate.

VSLA members come together to contribute and save their money and access loans for their income generating activities in 12-month cycles. At the end of the cycle, accumulated savings and interest from loans paid out are paid back to the common fund and redistributed among members in proportion to their original contributions. VSLAs traditionally have a social fund used for marriages and funerals. Like the social fund, the Program introduced the idea of a health fund that would be managed by each individual VSLA. However, one important difference was that the contributions from the health fund were not redistributed among group members at the end of the 12-month cycle.

***Caisse santé* (health funds) are free to join. The average *caisse santé* membership fee varied according to the economic well-being of the community. Membership fees ranged from 500 Ariary (USD 0.15) to 2;000 Ariary (USD 0.50) per week. The fund can cover a range of services at the health center, depending on the costs of the service. Each VSLA determines what the fund will or will not cover—or the maximum amount that they are able to contribute to a specific service.**

FIGURE 1. STEPS TO SET UP EACH CBHI MODEL

MUTUAL

- Feasibility and accessibility study is undertaken in collaboration with all stakeholders to assess the local costs of services, which services the insurance scheme will pay for, and in what amounts.
- Awareness is built about the insurance scheme's benefits among interested community members and groups, and advocacy for its creation.
- Community elects the preparatory committees and the General Assembly.
- The mutual is registered at the commune and district levels to become a legally recognized association.
- Partnership agreement is established among the local microfinance institution, management committee, the health center, and the hospital.
- Members decide on the contributions, methods of payment, and who and how they want to manage the fund.
- Train and progressively build the capacity of the management committee on mutual principles, implementation steps, and operations.

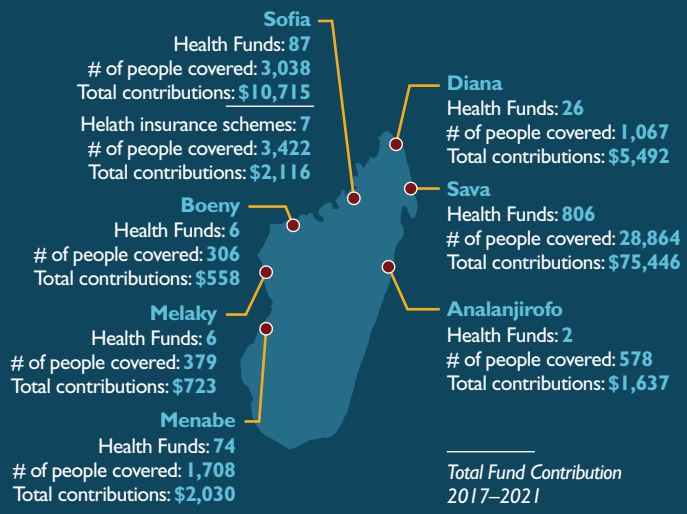
HEALTH FUND

- Feasibility and accessibility study is undertaken in collaboration with all stakeholders to assess the local costs of services, which services the insurance scheme will pay for, and in what amounts.
- Awareness is built about the insurance scheme's benefits among interested community members and groups, and advocacy for its creation.
- Train and support local partners' VSLA promoters, who help individual VSLA groups to establish the health fund.
- Members decide on the contributions, methods of payment, and who and how they want to manage the fund.
- Partnership agreement is established between the VSLA management committee and the local health center.

KEY ACTIVITIES

Training of district health teams and health center staff. Training was conducted on the concept of mutuals and health funds, and the need to maintain a high quality of services to contribute to the health centers' understanding and acceptance of the CBHI. Gaining the buy-in of health center staff was critical because it allowed a means for the mutual and the VSLA to have a regular accounting of their members' use of services and ensure reimbursement to the health center by the health fund on a monthly basis. Figure 2 shows the breakdown between the mutuals and the health fund scheme contributions, and the number of people covered under the scheme, by region.

FIGURE 2. COMMUNITY HEALTH FUNDS AND INSURANCE SCHEMES IN PROGRAM-SUPPORTED REGIONS



Collaboration with national VSLA network partners for the introduction of health funds. Mahefa Miaraka collaborated with the national network for VSLA (*Réseau des Promoteurs de Groupes d'Epargne à Madagascar*) to advocate for the inclusion of health funds in VSLA nationally, and to share program experience in national policy and program fora through the network's partners, such as the Aga Khan Foundation in Sofia, *l'Association Longo Iaby* in Menabe, the nongovernmental organization, Durrell Wildlife Conservation Trust in Boeny, and the *Platforme VSLA* in SAVA region.

Leveraging local VSLA promoters to conduct community discussions with VSLA members for the introduction of health funds. Working in collaboration with various VSLA partners, the Program gauged a strong interest from VSLA members to establish health funds in existing VSLAs and similar community-based savings groups. Mahefa Miaraka trained VSLA promoters on the health fund model, who then helped establish the health funds in the VSLAs with whom they already worked. Leveraging VSLA promoters who already operated in the regions to support and expand VSLA activities facilitated the rapid establishment of health funds.

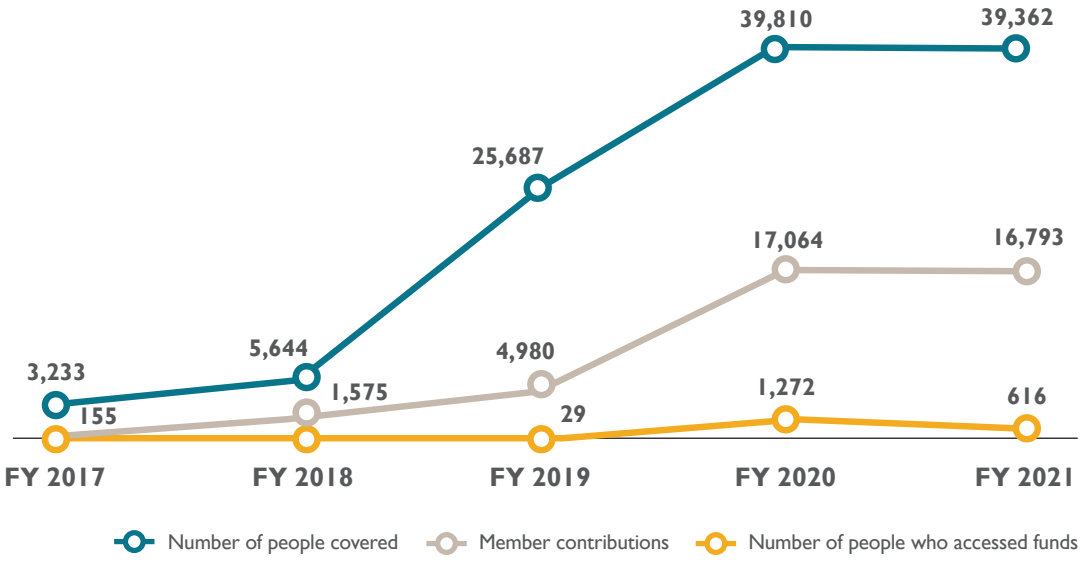
Addressing transport barriers in tandem with CBHI schemes. The Program supported villages to establish their own emergency transport plan, thereby helping communities identify and organize appropriate and affordable modes of emergency transport to address one major delay in receiving critical care.

RESULTS

Expansion of risk pooling mechanisms in communities. The integration of health funds in VSLAs and other community-based savings groups helped significantly increase the total number of people covered by health risk pooling mechanisms in Mahefa Miaraka-supported regions. The total number of health risk pooling mechanisms increased from just 17 at the start of 2017 to 1,005 by the end of the Program. From 2018 to 2019, the number of members participating in CBHI schemes increased five-fold, from 5,644 to 25,687. By 2020, a total of 39,810 mutual and VSLA members could access funds to defray health costs, collecting $98,717 in contributions. Health funds from VSLAs accounted for nearly all health risk pooling mechanisms. Figure 3 shows the breakdown of the number of contributing members, the number of people covered, and the number of people who accessed funds by year.

Benefits of VSLA health funds were readily recognizable, and greater transparency on how members used contributions. The smaller size and inherent bonds of solidarity of the VSLA allows greater understanding and group cohesion in terms of the use of funds to support the health needs of its members. Similarly, the benefits of the health funds were more tangible because they were tied to an established affiliated group. Even if a member does not directly benefit from the fund, he or she would know exactly who in their community benefited.

FIGURE 3. CBHI SCHEME COVERAGE, CONTRIBUTIONS, AND USE



Viability of health fund increased when anchored by income generating activities. Health funds were situated in an existing income generation scheme, whereas the majority of mutuals were not. Of the seven functioning mutuals, four operated in communities supported by the revenue from enterprise box (eBox) activities. VSLA embers therefore had an inherent advantage in that they met on a weekly basis to contribute, distribute, and repay loans. Contributions to the health fund occurred in the context of a well-defined routine of financial transactions among members.

CHALLENGES

Tangibility of benefits for those who contribute to mutuals. The MAHEFA project, which closed in 2016, had a total of 33 functioning mutuals at that time. By the time Mahefa Miaraka began its health mutual activities in 2017, the number had dropped to 17 mutuals, and by 2020, had declined further to seven functioning mutuals. Because the management of mutual funds took place at the commune level, creating tangible benefits for its members was an inherent challenge. The mutual model suffered from the same challenges as the national health fund in that people were asked to contribute financially, but did not necessarily see the direct benefits of the mutual for themselves, their families, and their larger community, (i.e., if you are relatively healthy, you will not need the service). Without a perceived tangible benefit for members, their families, and their larger community, members were less willing to remain active members of the mutual.

Unreliability of health commodities at the health center. Although the mutual and health fund represented viable options for members to access health services at the health center, the availability and costs of health commodities were not always reliable. When stocks were depleted at health center pharmacies, the heads of the health center would resort to selling their own personal medicine stock at a higher cost, resulting in fluctuating costs for mutual and caisse santé members at the health center. Moreover, when service providers at the health center pharmacy were not paid, the pharmacy would close altogether. In response, the Program continued to address issues that affected the resupply of health center by district pharmacies through analysis of commodities data with the district health office and joint visits at the district and health center pharmacies.

Lack of receipts at the health center. Lack of health center receipts proved a challenge in the Menabe region, which resulted in a decrease in participation, from 5,846 members across the region's 557 VSLAs in 2019, to just 1,409 members in 2020. With members unable to get reimbursed without a receipt from the health center, health funds were discontinued in many communities.

RECOMMENDATIONS

Leverage existing community income generating and savings associations to expand the number of people covered by CBHI schemes. Working through existing VSLAs and similar community groups benefits from the smaller size of the groups and thus its inherent bonds of solidarity. The uses and the benefits of the health fund were more tangible because they are tied to an established affiliated group. Working with existing VSLAs and community-based savings groups contributed to increased self-management by communities and improved health outcomes.

Build the skills and capacity of VSLA promoters to establish health funds. Leveraging VSLA promoters is essential to effectively frame and establish a health fund in the VSLA and savings groups. Once trained by the Program, VSLA promoters served as important links for the continuation of health fund activities and the overall sustainability of the approach, and worked as intermediaries on behalf of the VSLAs that they supported to review and settle VSLA member accounts at the end of each month with the health center.

Strengthen the links between VSLAs/savings groups and health centers to maintain health fund payments and reimbursements for care received. A collaborative relationship between the local health centers and VSLAs is critical to ensuring the long-term impact and success of the approach. Monthly review of the use of the health fund by these groups ensures accurate information on the use and impact of these CBHI schemes in communities, and promotes the further replication of successful results by other groups in the community.

This product is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this product are the responsibility of JSI Research & Training Institute, Inc. (JSI) and do not necessarily reflect the views of USAID or the United States Government.