Improving Access Through Mutual Health Organisations: The Case of Mali

Alexander Schulze

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Mutual Health Organisations – Health Financing for Rural Populations & Informal Sector Workers

- Health financing mechanism relatively widespread in Western & Central Africa;
- Model known as *mutuelles de santé* in French speaking Africa, emerged from French & Belgian forerunners;
- Target populations of Mutual Health Organisations (MHO): rural populations & workers in the informal private sector;
- **Main goals**:
  - Improved access & financial protection for the insured;
  - Resource mobilisation for health services.

Main Features of Malian MHO

- Private, non-for-profit association, separated from health care provider;
- Regulatory framework (1996 law etc.);
- Technical support structure: *Union Technique de la Mutualité Malienne*;
- Voluntary membership of individuals, households, families or other groups;
- Members at the same time insurance beneficaries & providers;
- Honorary management.

Mali – Reform of a Fragmented System of Social Health Protection & Financing

Health Protection Mechanism	Mode of Governance	Source of Financing	Covered population segments
Selected health services free of charge	Hierarchy	State & foreign aid	Children under 5, pregnant women (e.g. malaria, vaccination), women with birth complications (e.g. cesarian), people suffering from „social“ diseases (e.g. TB, HIV/AIDS, leprosy)
Newly introduced ***Assurance Maladie Obligatoire***	Hierarchy	Employer & employee, state	Employees of the public sector & formal private sector, MPs
Newly introduced ***Régime d'Assistance Médicale***	Hierarchy	State & municipalities	Needy people, 600‘000-750‘000 estimated persons
Régimes d'entreprise (corporate schemes, contracts with commercial insurance schemes etc.)	Market	Companies	Employees in the formal private sector
Régimes d'Assurance Maladie	Market	Membership fees	A priori open to everyone, de facto solvent employees in the formal private sector
Mutuelles de santé	Solidarity	Membership fees, state & foreign aid	Rural populations, workers in the informal private sector

Mutuelles de Santé in Mali – Facts & Figures

Indicator	1997	2000	2003	2006
No of functional MHO in Mali	7	22	51	102
No of beneficaries	-	-	469‘815	-
% of population covered	-	-	~4%	-

Source: Concertation 2004; Ndiaye et al. 2007: 159

- Total number of beneficaries remains rather modest;
- Increase in beneficaries due to higher number of MHO, but not due to growing *mutuelles de santé.*

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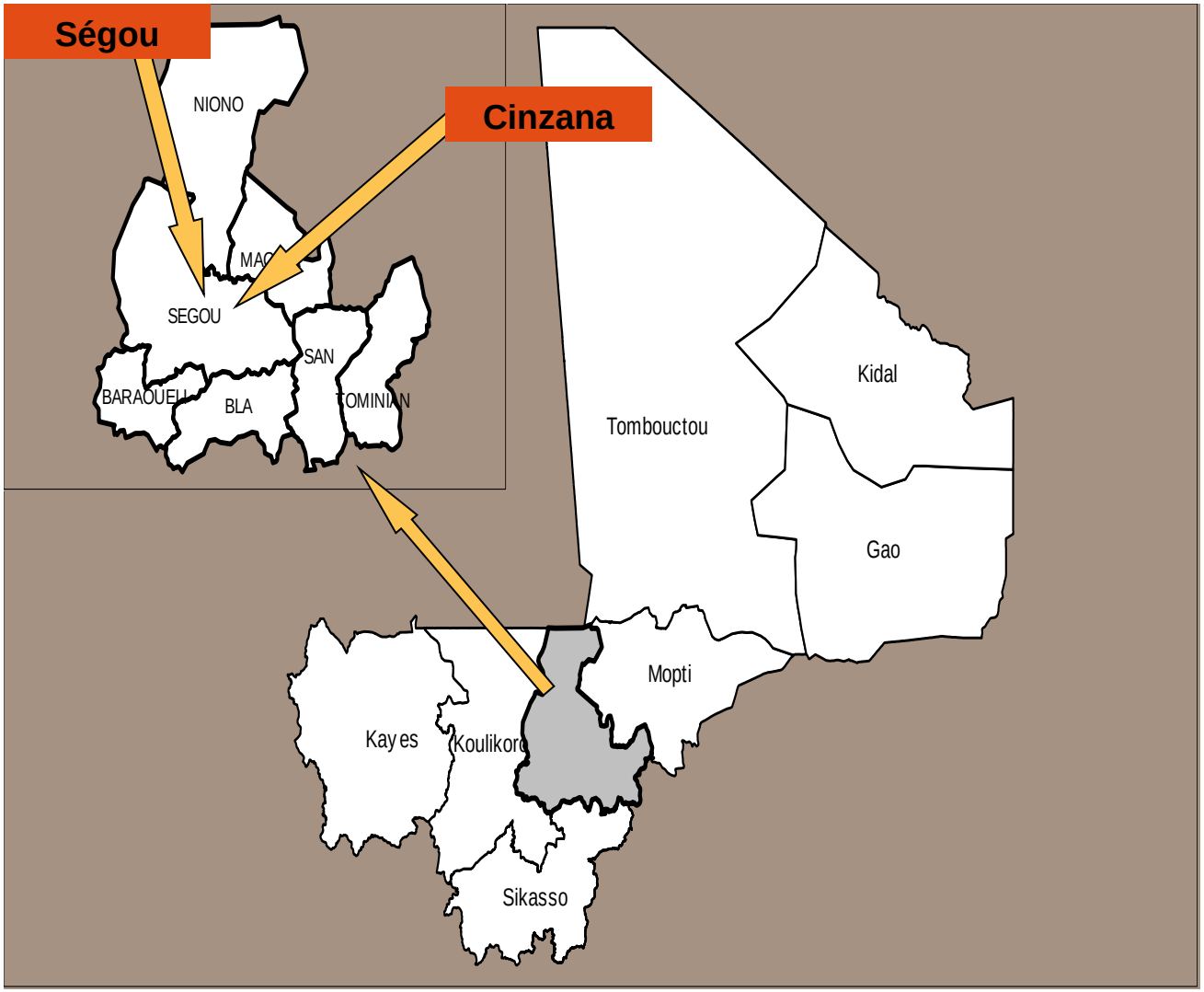
Exemplifying the Challenges Faced by MOH: An Urban & a Rural Scheme in Ségou Region



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The Case of the *Mutuelle Interprofessionnelle de la Ville de Ségou* – Main Features

Characteristics	2009
One time membership fee	2500 FCFA (5.40 USD)
Annual premium per person	5400 (11.70 USD)
Benefit package (% of insurance coverage)	
Consultation & medicines	75%
Normal delivery	75%
Birth complications (cesarian)	75%
Hospitalization (basic surgery)	75%
No of contracted providers	5 in Ségou, plus providers in other regional capitals (except Kidal & Tumbouctu)
No of beneficaries	3‘969
Population coverage	3,8% of 104‘108 people
Premium recovery rate	-

The Case of the *Mutuelle de Santé de Cinzana* – Main Features

Characeristics	Before 2010			2010-
One time membership fee	1000 FCFA (2.15 USD)			1000 FCFA
Annual premium per person	1150 FCFA (2.50 USD)			2000 FCFA (4.30USD)
Benefit package (% of insurance coverage)				
Consultation & medicines	60%			75%
Normal delivery	60%			75%
Birth complications (cesarian)	75%			100%
No of contracted providers	1			2 (+2)
	2006	2008	2009	2010
No of beneficaries	1‘556	1‘746	2‘008	2‘135
Population coverage	12,2%	11,3%	13%	13,5%
Annual premium recovery rate	67%	29%	26%	-

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Impact on the Beneficaries: Improving Access & Financial Protection Through MHO

Indicators

- **Access**: Utilisation rates (curative services) of insured & non-insured persons;

$$\frac{\text{No of new contacts* (insured / non-insured)}}{\text{Total target population (eligible insurance beneficiaries** / target population – eligible beneficiaries)}}$$

- **Financial protection**: Out-of-pocket expenditure of insured & non-insured persons for an illness episode (consultation fee, medicines, transport, food etc.).

Impact on the Beneficaries: Improving Access & Financial Protection Through MHO (2)

Value / Scheme	Annual utilisation rate 2008 insured	Annual utilisation rate 2009 insured	Annual utilisation rate 2008 non-insured	Annual utilisation rate 2009 non-insured	% of people treated, with insurance 2008	% of people treated, with insurance 2009	Average treat-ment costs 2008, insured, in FCFA	Average treat-ment costs 2009, insured, in FCFA
Rural scheme	17.47%	16.14%	27.66%	33.41%	7.45%	6.64%	2‘310 (2‘097)	2‘140 (1‘872)
Variation 08/09		-7.61%		+20.79%		-10.96%		
Urban scheme*	42.82%	36.36%	54.89%	86.24%	5.46%	4.59%		
Variation 08/09		-15.09%		+57.11%		-15.85%		

* Data from 3 out of the 5 contracted providers.

Impact on the Healthcare Provider: Increasing Resource Mobilisation Through MHO

Indicators

- **Resource mobilization**: Cost Recovery Ratio (CRR)

$$\frac{\text{Total annual amount of payments made by MHO to healthcare provider plus co-payments made by beneficiaries}}{\text{Total annual expenditure of healthcare provider (medicine, medical supplies, salaries, infrastructure)}}$$

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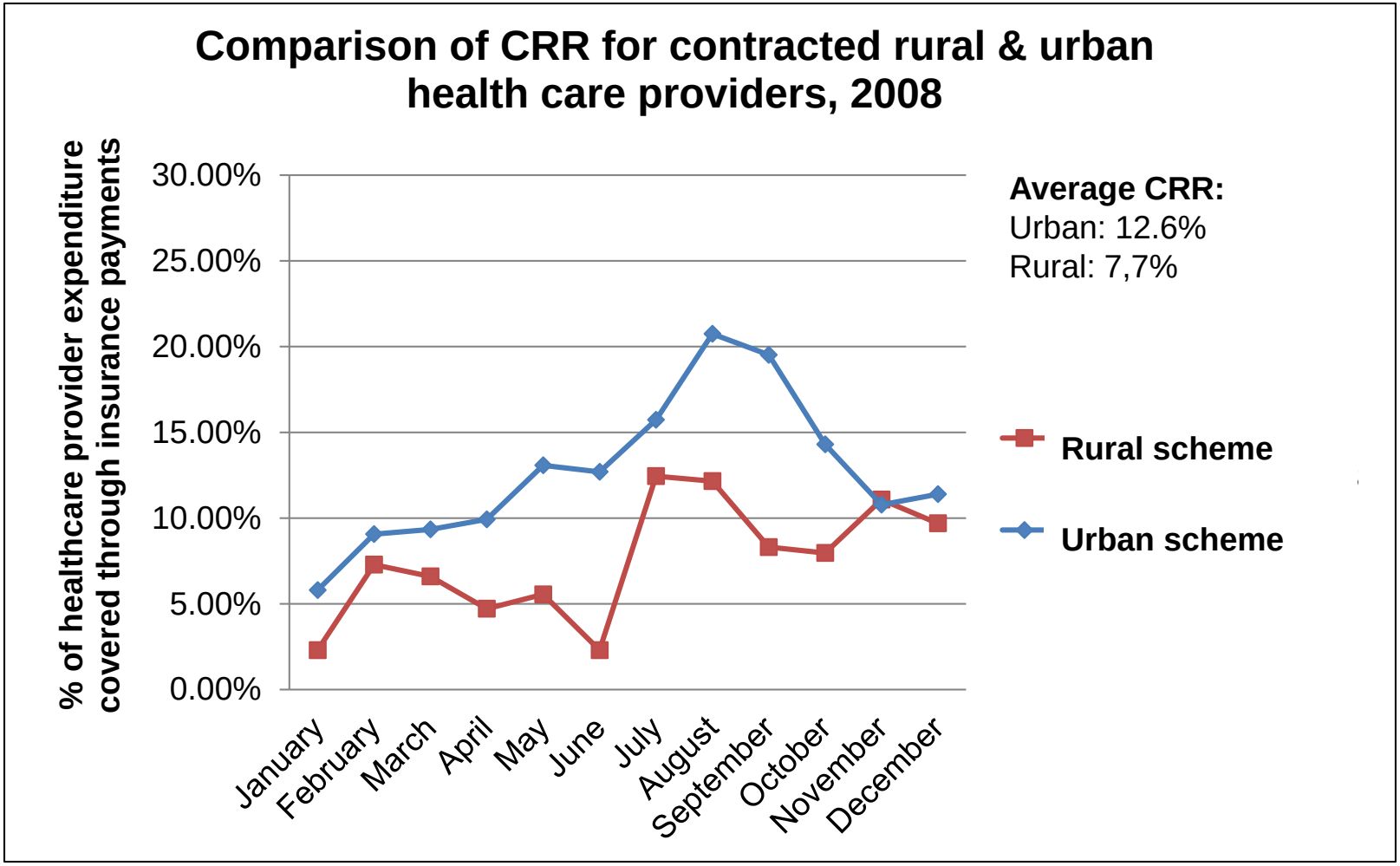
Impact on the Healthcare Provider: Increasing Resource Mobilisation Through MHO (2)



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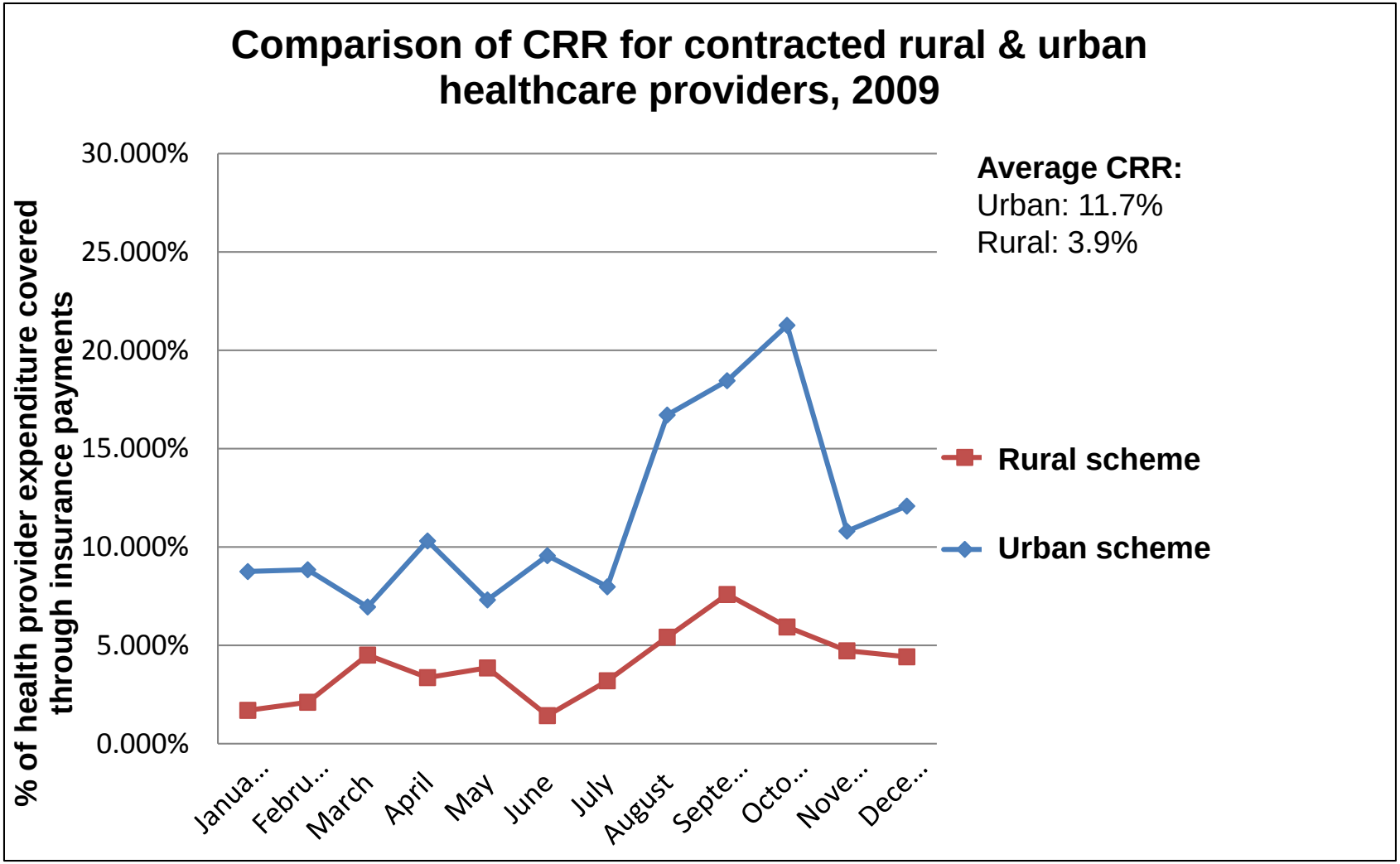
Impact on the Healthcare Provider: Increasing Resource Mobilisation Through MHO (3)



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Impact on the Healthcare Provider: Increasing Resource Mobilisation Through MHO (4)

Benchmarks - Cost-recovery Ratio

Cost-recovery Ratio	Effect on resource mobilization
< 15%	Marginal positive effects
16% - 40%	Limited positive effects
41% - 60%	Substantial positive effects
61% - 100 %	Monumental positive effects

Source: Ekman, 2004: 254

- Only marginal positive effects in terms of resource mobilisation.

Conclusions

- Modest enrolment rates;
- Low premium collection rates;
- Modest utilisation rates;
- Modest cost recovery ratio;
- Effect with regard to financial protection of insured persons to be confirmed;
- Need for action at the level of the:
  - State;
  - Insurance scheme & healthcare provider;
  - Target population.

Necessary Steps to Increase Impact of Voluntary MHO in Mali (1) – Supply Side

- Extension of catchment area beyond national policy of „one MHO per municipality“ (under discussion for rural scheme);

  ➡ more beneficiaries.

- Improvement of benefit package:
  - Reduction of co-payment;
  - Inclusion of services for critical high-cost/low probability events (hospitalization).

- Professionalization of scheme management:
  - Employment of qualified administrator;
  - Continuous IEC of target population & proactive premium collection;
  - Regular refresher training for all organs of the MHO;
  - Supportive supervision & monitoring of MHO performance.

Necessary Steps to Increase Impact of Voluntary MHO in Mali (2) – Supply Side

- Linking of existing schemes (sharing best practices & eventually services, risks & costs?).
- Combining promotion of insurance coverage with improvements in quality of care (e.g. *Initiative Accès*):
  - Infrastructure, equipment, medicines, human resources;
  - Health service management;
  - Clinical procedures (proper diagnosis & adequate treatment);
  - Medical communication between patient & provider;
  - Control of average treatment costs.

→ State to link both elements more explicitly within health policy.

Necessary Steps to Increase Impact of Voluntary MHO in Mali (3) – Demand Side

- Fostering group enrolment (e.g. cooperatives, women groups).
- Strengthening resource base of target groups:
  - Access to micro-credits & support of profitable income generation;
  - Promotion of entrepreneurial skills.
- Improving targeting of potential members through better knowledge of (rural) communities:
  - Households with less support from extended family;
  - Households more receptive to innovations;
  - Households with relatively good socioeconomic status (not the poorest -> subsidies through the State & foreign aid);
  - Decision making at household & family level.

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