The Potential Contribution of Community-Based Health Financing Schemes Towards Achieving Universal Health Coverage in Sub-Saharan Africa

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Abstract

The objective of this article is to review different models of integrative Social Health Insurance (SHI) systems of low-income countries in sub-Saharan Africa concerning their contribution to Universal Health Coverage (UHC). The focus is on four country case examples, where community-based approaches played a crucial role within the implementation of the national SHI system.

Besides an extensive desk review, a comparative analysis of Strengths, Weaknesses, Opportunities and Threads (SWOT) of the chosen country case examples is presented. The SWOT analysis complements qualitative data from the country cases.

The research undertaken reveals that each of the analysed country case examples chose unique approaches and tools to approach UHC, with the common element of considering community-based approaches as integral parts of the national SHI system. On this basis, common factors that may hamper or favour a national integrated SHI system can be identified.

An integrative national SHI system in a low-income context of sub-Saharan Africa should be based on an integrated bottom-up approach. Main drivers are a step-by-step method, public and private commitment as well as comprehensive participation, communication and inclusion of relevant stakeholders. Components that could be considered as the core of any integrated SHI system are the existence of a mandatory element, adequately designed indigents for various marginalized groups and most vulnerable parts of the population and the regular monitoring of quality of provided health care.

Keywords: Community-based Health Financing, Social Health Insurance, sub-Saharan Africa, Integrative Social Health Insurance Systems, SWOT analysis.

Introduction

While Universal Health Coverage (UHC) and Access for All are uncontested concepts within the international development community [1-4], the implementation of inclusive and/or integrated health and health financing systems are a remaining challenge for many low-income countries of sub-Saharan Africa. Public measures in the area of social health protection are regularly designed for public servants and formal employees only, while private health insurance products are not tailored and/or affordable for people of low-income. This leads to the devastating situation, that the most vulnerable groups of the population – namely informal sector employees and low-income farmers – are excluded from any type of social health financing, while their exposure to regular shocks is high [5-7]. The common exclusion of informal sector employees – representing a better part of low-income countries of sub-Saharan Africa – from social health protection measures results in a decreased level of resilience of these households, and hence an increased risk of falling (deeper) into poverty.

It is against this background that innovative approaches evolved in most low-income countries of sub-Saharan Africa, aiming at serving the informal sector and providing a minimal level of social protection in health to low-income people. The most prominent examples in this context are Community-Based Health Financing (CBHF) schemes, which are based on a cooperative approach. In the theoretical background of micro health insurance, CBHF schemes are classified as the "mutual model" besides three other types of micro health insurance. While the "benevolent insurer", the "provider model", the "partner-agent model" as well as the "commercial model" involve external entities in the areas of management and general ownership of the insurance scheme, the unique characteristics of the mutual schemes is the identity concerning the insurer and the insured, which provides the members a high level of flexibility to design tailored processes and products. Other mentioned types of micro health insurance would either involve a commercial health insurance scheme, a hospital and/or an NGO or similar benevolent organization to design and provide the health insurance products to its beneficiaries [8]. Community-owned and managed, CBHF schemes are hence able to develop tailored products and processes to their specific low-income target group. Furthermore, CBHF schemes operate on a basis of trust of the respective community they are serving, which allows them to gain support through local leaders and to partner with local health facilities. Given their essential participatory approach in sensitizing their members on the insurance concept as well as in identifying indigents and waiving mechanisms within their target community, the level of insurance literacy amongst their members as well as the level of inclusion can be rated as high [9-13]. CBHF schemes usually cover a small percentage of the population only (1-2%), leading to the perception of CBHF schemes as low-impact institutions with weak technical and institutional capacities. Advantages and disadvantages of mutual CBHF schemes are hence a widely discussed topic amongst international development actors [14]. Recent evidence suggests that once implemented adequately, the innovative approach of CBHF schemes can contribute significantly to the achievement of UHC in low-income countries [15].

Many governments of low-income countries in sub-Saharan Africa acknowledged the potential of CBHF scheme towards covering the informal sector with innovative and tailored health financing measures, and hence innovative integrative national Social Health Insurance (SHI) systems evolved. While recent evidence proved the promising potential of this integrative approach [16] different countries implemented various integrated approaches combining public and private efforts towards social health protection and UHC.

The National Health Insurance Authority (NHIA) of the Government of Ghana started implementing a national SHI scheme, namely the National Health Insurance Scheme (NHIS) in 2003. The established system aimed at making use of existing community-based health financing structures and based the entire national system on District-wide Mutual Health Insurance Schemes (DMHIS). In this case, MHI schemes are serving as substitutes of the NHIS, which is comprehensively based on the local schemes.

In Burkina Faso, the government with the assistance of the ILO Step-Programme, initiated the establishment of a national SHI system, the Assurance Maladie Universelle (AMU) in 2000 and piloted it for about ten years until 2010. The system was initiated to provide universal coverage to the Burkinabé population and existing local Mutuelles de Santé were supposed to be integrated into the system to cover the informal sector. From 2011 on, the Partners for Health Network, in cooperation with WHO, made efforts in designing and implementing the AMU [17]. The envisaged system in Burkina Faso is considered to use MHI schemes as complementary institutions to the national SHI system.

The integrative TNHIF/Community Health Fund (CHF) system in Tanzania was set up in 1996 by

the Ministry of Health as a voluntary pre-payment scheme, containing exemption mechanisms for the poor [18]. Prior to the establishment of the CHF, only few established mutual health insurance schemes were to be found in Tanzania. The aim of the government was to guarantee sustainable access to basic health care for poor and vulnerable groups within the population. The Tanzanian CHF is closely linked to the Tanzanian National Health Insurance Fund (TNHIF) and is complementing the same. In 2009, the TNHIF started to overtake main managerial functions of the CHF. Hence, the Tanzanian system is to be regarded as a closely interlinked system of community-based and public approaches towards social protection in health. Recently, the Government of Tanzania decided to introduce a Single National Health Insurance (SNHI), based on challenges experienced in the scope of the hybrid TNHIF/CHF system [19].

In Rwanda, the Programme de développement des mutuelles de santé was established in 1999, while the tradition of mutual health insurance schemes has been in existence since the 1960s [20]. The number of mutual health insurance schemes increased from six in 1998 to 76 in 2001 and to 226 in 2004. In 2005, the programme covered about 2,101,034 people, representing 27% of the entire population of Rwanda [21]. By 2008, 85% of the population were benefiting from mutual health insurance. Furthermore, a law, passed in April 2008, obliged every Rwandan to become a member of a health insurance scheme [22]. The program is supposed to be a national health care financing program based on solidarity. Consisting of 294 mutual health insurance schemes operating throughout the country, it complements national social security measures for the formal sector, such as the Rwandaise d'Assurance Maladie (RAMA). The primary objective of the program is to reach the informal sector of the country, which is not covered by the RAMA. The system is financed by a national fund, the Fonds Nationale au Solidarité aux mutuelles de santé. It also benefits from external funding from donors such as USAID [22]. In Rwanda, MHI schemes are complementing the national system, but given the fact that the RAMA does not cover the informal sector at all, the Rwandan system of Mutuelles de Santé can be considered to be substitutive to the RAMA.

While Rwanda is often considered to be the Best Practice case towards providing UHC and Access for all, other countries are facing various challenges on technical and institutional levels in designing and implementing an integrative national SHI system. A comprehensive analysis of various implemented approaches is necessary to assess the impact and develop common lessons learnt towards this crucial process. This article uses the mentioned cases of Ghana, Burkina Faso, Tanzania and Rwanda as examples to review and analyse existing approaches and systems towards integrative national SHI systems in low-income countries of sub-Saharan Africa. The generated lessons learnt will determinate common recommendations as well as a standard model to consider when implementing integrative national SHI systems in low-income countries of sub-Saharan Africa.

On the background of the above-illustrated situation, the overall research objective of this article is to explore the potential contribution of CBHF schemes towards UHC in low-income countries of sub-Saharan Africa through integration into a national SHI system. The specific research method is set as follows:

(1) To review and analyse the design and implementation of integrative SHI systems in chosen low-income countries of sub-Saharan Africa towards the potential of approaching UHC; to serve this purpose, an adjusted SWOT analysis will be used, determined by insurance specific indicators, namely Design, Sales, Servicing and Sustainability;
(2) To generate lessons learnt and common recommendations from the adjusted SWOT analysis of chosen low-income countries of sub-Saharan Africa;
(3) To identify common limitations and opportunities in the scope of designing and implementing integrative SHI system in low-income countries of sub-Saharan Africa.

Methods

To review existing integrative SHI systems, four examples – two from Eastern and two from Western Africa – were identified to illustrate different approaches and priorities set by the respective governments and stakeholders. After the general characterization and description of case examples, an adjusted SWOT analysis will be carried out, which will reveal common strengths, weaknesses, opportunities and threats in the chosen systems. To lay the focus of analysis on health insurance specific indicators, the four SWOT categories will be furthermore divided into the following sub-categories: (1) Design, (2) Sales, (3) Servicing and (4) Sustainability. A common conclusion combining the outcomes from the case example analysis will be drawn.

The SWOT analysis will provide insights into internal strengths and weaknesses of the analyzed health systems and will reveal external threats and opportunities. As a formal definition, the SWOT analysis can be defined as "an examination of an

organization’s internal strengths and weaknesses, its opportunities for growth and improvement, and the threats the external environment presents to its survival. Originally designed for use in other industries, it is gained increased use in healthcare.” [23]

Within the SWOT analysis, several steps are taken to undertake an extensive analysis of a specific system. In step one, relevant data is gathered depending on the main objective of the SWOT analysis, while in step two, the data will be analyzed regarding the four given categories of strengths, weaknesses, opportunities and threats. In the third step of the SWOT analysis, a SWOT matrix is developed and finally, in step four, the results from the SWOT matrix are used to analyze the entire system.

This analysis is further used to undertake a comparative analysis of presented case examples as well as to generate common lessons learnt for the successful implementation of integrative SHI systems in low-income settings of sub-Saharan Africa.

Results and Discussions

Country Analysis

Ghana

In Ghana, main internal strengths can be identified in the area of exemption measures and indigents for identified vulnerable parts of the society. In addition to this, the GNHIA put in place a comprehensive marketing strategy with various tools and approaches, also involving district chief executives and district assemblies, which is a favourable asset in terms of sales of the NHIS [24, 25]. Moreover, the benefit package offered under the NHIS is of comprehensive nature and does require only low co-payments by the beneficiaries. A unique approach in Ghana under the NHIA is the inclusion of eye and dental care as well as the focus on maternal services, so that main needs of the society are fully covered by the NHIS [26-29]. A significant success in Ghana is furthermore the increased health care utilization by NHIS beneficiaries, which increased from 6,262,765 in 2005 to 17,603,216 in 2009 and strengthened the servicing component of the NHIS [30]. In terms of sustainability, the NHIS is based on existing district structures and involves local authorities and the target communities, which ensure its long-term effect and successful operations. Furthermore, a high percentage of the NHIS system is tax-based, as 62.37% of the overall funding is generated through public taxing. This avoids over-reliability or dependencies on external donors and/or the beneficiaries [31].

The NHIS faces several internal weaknesses that can mainly be located in its initial design. The vertical NHIS control structures, which do not provide decision-making authority to the district-based NHIS units, result in a lack of financial autonomy and/or flexibility on schemes level.

The NHIS units are furthermore multiply dependent on the hierarchal structures of the NHIS and opportunities towards cost control are very limited on district level. The NHIS shows a general low level of transparency, which – through the hierarchic structure – affects the entire NHIS system. In addition to this, it has to be noted, that while the general OOPP rates reduced slightly to 22-37% in Ghana, they are still above the WHO recommended average rate of 15-20%. The NHIS was furthermore designed with a pro-poor focus, but is de-facto mainly serving the middle- and high-income sector, resulting in the fact that well-designed pro-poor measures are de-facto not operational and/ not effectively implemented [29, 32]. The designed exemption measures within the NHIS are so far not applying to informal sector employees, excluding a larger part of the society from the national scheme. Children can access the NHIS through their parents only, while child-headed households and OVCs are not adequately considered within the scheme. This results in the overall observation that the identification of indigents within the NHIS is imprecise and the existing indigents are insufficiently designed. The overall NHIS coverage still remains below 50%, while the overall progress is to be rated as slow [28]. The MIS is to be rated as limited and cannot generate crucial data for effective data management and M&E within the NHIS [33]. In the area of sales, the NHIS lacks expertise in the fields of technical and managerial capacities on schemes level as well as adequately implemented insurance education and social marketing measures, while the servicing component is threatened by low quality of drugs and major delays within the claim settlement process [31]. In most NHIS health facilities, only low-quality drugs are covered by the NHIS, which results in a decreased level of trust of the beneficiaries in the scheme and an increased level of co-payments, as most beneficiaries tend to purchase high quality drugs externally. The common rejection of NHIS beneficiaries in certain health facilities furthermore led to an over-usage of other facilities where patients faced long waiting hours and shortages of drugs. In addition to this, further gaps in the Ghanaian NHIS could be observed in the areas of effective referral mechanisms as well as the existence of informal payments of NHIS members that represent up to 40% of all OOPP. Moreover, there is a general gap

of human resources in the Ghanaian health sector to be noted. As a result, 56% of the NHIS DWMHI schemes are exposed to under-staffed health facilities [32]. The introduction of unified tariff lists through the NHIS led to an enormous cost increase at health provider level. As a result, health providers were trying to gain profit out of the NHIS patients, which compromises the entire NHIS. There is a tendency of contracted health providers to oversubscribe certain drugs due to the increased tariff lists for drugs, leading to a de-facto system of incentives for over-subscription, threatening the entire NHIS. Furthermore, most contracted health providers are located in the Greater Accra region, while the better part of the NHIS beneficiaries live in rural areas and can hardly access the contracted providers [33]. Regarding the sustainability of the NHIS, it has to be stated that the offered NHIS benefit package is very generous covering 95% of the disease burden, resulting in a high financial burden to the national scheme. At the same time, the referral system is not well developed and ineffective, while the M&E system is not operational. In addition, there is an increasing politicization of the NHIS through GNHIA representatives leading to the common perception amongst the target population of the NHIS being a political led scheme, rather than being a universal health scheme for all Ghanaians [27, 32].

Given these numerous weaknesses in the design of the NHIS, there are various external opportunities to be noted to possibly address the same.The existing government funds for social protection could be used to support the NHIS or to create linkages for NHIS beneficiaries to other social protection measures. This should be done in a combined effort of all relevant line ministries of the Government of Ghana. Furthermore, the needs of the informal sector should be specifically acknowledged and targeted within the NHIS, so that currently excluded parts of the society can gain access to the NHIS.

Children should be decoupled from their parents, to ensure proper access for child headed households and OVCs as well. In line with that, proper measures to integrate vulnerable parts of the society into the NHIS system should be applied. To ensure a more professional, transparent and accountable operation of the NHIS, an adequate IT-based MIS should be developed. With regards to the sales component of the NHIS, a standardized training curriculum for scheme personnel and health facility staff, especially in the areas of insurance education and social marketing, should be put in place. Furthermore, to ensure an increase in numbers, group approach and/or mass community registration efforts should be considered. To improve the servicing component of the overall NHIS, an IT-based claim-processing centre should be considered. This should be implemented in line with a functional and effective M&E system as well as regular clinical audits [33]. With regards to sustainability, a crucial opportunity would be to transfer more influence and power to the district level and the communities to ensure a certain level of ownership of the scheme on various levels.

External threats to the existing NHIS are parallel structures of CBHF schemes that could not be absorbed by the NHIS [7]. Given the recent challenges of the national scheme, the probability for the target group to consider alternatives to the NHIS can be rated as high. In terms of sales, the low awareness about the scheme and the general low level of embracement of the insurance concept amongst the target community can be rated as a main threat to the NHIS. Due to the mentioned challenges, the trust level towards the NHIS amongst the target population is to be rated as low [7]. Effective measures to build up trust and confidence towards the system would be needed to successfully sell the NHIS concept to the population. In the area of servicing, the already mentioned low quality of drugs results in an increased mistrust and dissatisfaction amongst NHIS beneficiaries as well as potential members of the NHIS. Low quality paired with shortages of drugs also resulted in a high percentage of OOPP for high quality drugs purchased at external health care providers. This opposes the main objective of the NHIS to decrease OOPP amongst its beneficiaries. The external purchase of drugs equally led to a high level of competition between external pharmacies and NHIS contracted health care providers. This can be rated as an unhealthy competition, which compromised the principles of common harmonization within the health sector towards best quality service delivery to the patients. In terms of sustainability, the NHIS stands at high risk to lose its long-term supporters, as the mentioned challenges related to trust and transparency might be against common standards of most international NGOs and/or donors and development partners.

Table 1: Strengths (Internal) of Ghanaian SHI system

Strengths (Internal)	
Design	• Comprehensive exemption measures for identified indigents and specific groups
Sales	• Comprehensive marketing strategy with various tools and approaches • Involvement of district chief executives and district assemblies in marketing of the scheme
Servicing	• Comprehensive benefit package, no or low co-payments, comprising eye and dental care and focus on maternal services • Increased health care utilization (from 6,262,765 in 2005 to 17,603,216 in 2009)
Sustainability	• Based on district structures and (even if limited) involvement of local authorities and target communities • High percentage of system is tax-based (62.37%)

Source: own SWOT analysis.

Table 2: Weaknesses (Internal) of the Ghanaian SHI system, Source: own SWOT analysis.

Weaknesses (Internal)	
Design	• Vertical control structures • OOPP rates reduced slightly, but are still above the recommended average rate as recommend by the WHO • Even if officially designed with a pro-poor focus, the NHIS is de-facto serving mainly the middle- and high income sector • Inadequate and limited MIS • No exemptions mechanisms for informal sector employees • Access for children only through parents • Identification of indigents is imprecise/insufficiently designed indigents • No autonomy and/or financial flexibility of DWMHI schemes • Multiple dependency of schemes on external hierarchal structures – no opportunity of cost control on DWMHI schemes level • OOPP rates reduced slightly, but are still above the recommended average rate as recommend by the WHO • NHIA shows low transparency levels • Low coverage level • Slow process and progress
Sales	• Low level of technical and managerial capacities on scheme level • Lack of adequate insurance education and social marketing measures
Servicing	• Low quality of drugs • Delay in claims settlements results in rejection of NHIS clients in certain facilities leading to an over-usage of other facilities facing long waiting hours and shortages of drugs • Main gaps in health system and health care delivery system (e.g. in terms of referrals, informal payments for NHIS members: 40%) • Inadequate human resources (56% of DWMHI schemes) • Enormous Cost increase due to unified tariff lists • Most contracted hospitals are located in Greater Accra Region while most beneficiaries live in rural areas • Only low-quality drugs are covered by the scheme (decreased level of trust of beneficiaries towards the scheme)
Sustainability	• Provider incentives to oversubscribe • Generous benefit package covering 95% of the disease burden • Ineffective referral system • Underdeveloped M&E system of the NHIS • Politicization of the NHIS

Table 3: Opportunities (External) of the Ghanaian SHI system, Source: own SWOT analysis.

Opportunities External	
Design	• Use government social protection funds to support the NHIS (combined efforts of all ministries) • Target and acknowledge needs of informal sector • Decoupling of children and parents • Apply proper measures to integrate vulnerable parts of the society into the NHIS system • Implement an adequate IT-based MIS
Sales	• Trainings of scheme personnel and health facility staff on insurance education and social marketing • Group-approach/mass community registrations into the NHIS
Servicing	• IT-based claims processing center • Clinical audits • Functional M&E system
Sustainability	• Giving more influence and power to the district level and the communities would ensure ownership on various level

Table 4: Threats (External)of the Ghanaian SHI system, Source: own SWOT analysis.

Threats (External)	
Design	• Parallel structures of mutual health organizations not absorbed by the NHIS
Sales	• Low awareness about the scheme and low level of embracement of insurance concept • Low level of trust among the target population
Servicing	• Low quality of drugs result in distrust of members in NHIS and high percentage of OOPP for high quality drugs – high level of competition between external pharmacies and contracted NHIS health care provides
Sustainability	• Moving out of long-term supporters and donors because of challenges in the areas of trust and transparency

Burkina Faso

In Burkina Faso, a significant internal strength towards the design of the envisaged SHI system is the bottom-up-approach. This was insured through a close involvement of Mutuelles de Santé from the initial stage of design and implementation of the system. In addition, a comprehensive involvement of various institutions and relevant stakeholders was ensured, aiming at a common incorporation of various needs and demands of the multifaceted society in the future SHI system [34-36]. In terms of sales, the involved Mutuelles de Santé are supposed to play a major part in sensitization, mobilization and training of the target communities and future members of the SHI system. This engagement is supposed to be based on a standardized training and capacity building curriculum that was developed during the previous ILO Step-Programme engagement in Burkina Faso, which supported and developed various CBHF schemes [37]. The envisaged close involvement of health providers in all stages and processes of implementation of the AMU may positively affect the servicing component of the system in Burkina Faso, as the involved health providers will be aware about the system and – once the concept of health insurance and the role of health providers in the system are well embraced – will guarantee a high quality of provided health services [34]. Through the comprehensive involvement of various stakeholders, a common ownership is ensured, which will strengthen the overall operations of the system, and will contribute to its sustainability.

An internal weakness of the system in Burkina Faso is the identified over-reliance on Mutuelles Sociales, which are not yet regulated by any public body in Burkina Faso. Furthermore, the AMU is not yet linked to any comprehensive social protection strategy, which is already established or planned to be implemented in the near future in Burkina Faso. The fact that the AMU is supposed to be a voluntary health insurance scheme for the informal sector [34], can be identified as a main weakness as well, as people from the informal sector might not develop commitment towards the AMU and rather rate the AMU as an offer they would not necessarily benefit from. It might also be challenging to expect people of low income working in the informal sector to invest their limited income and resources into a voluntary health insurance scheme. Another significant weakness of the system in Burkina Faso is its major delay in implementation. Keeping in mind that initial discussions about the AMU started as early as 2008, it is a main challenge that until the year 2015, the system was not yet moved towards its initial piloting and/or implementation stage. In addition to this, there is not clear strategy on design of adequate indigents and/or waiving mechanisms to serve the most vulnerable and marginalized parts of the population. The design of the AMU hence lacks a number of essential components, which will challenge the final success of implementation of the

system. In the area of sales, the system to be implemented in Burkina Faso shows weaknesses in terms of a low level of managerial and technical capacities of involved Mutuelles de Santé and Mutuelles Sociales in general. While there are manuals and capacity building tools available through the ILO Step-Programme, the institutional expertise is still to be rated as very low and insufficient, as most Mutuelles operate through volunteers and without a properly equipped office, often without power supply and adequate stationary for simple membership and claims management. In addition to this, the awareness about Mutuelles de Santé amongst the target population is still low. On health provider level, there is still a low level of insurance literacy to be noted. In addition, the lack of a legal framework for Mutuelles de Santé to operate as well as the lack of a more comprehensive social protection strategy in place, significantly threatens the overall sustainability of the envisaged AMU in Burkina Faso.

External opportunities within the AMU in Burkina Faso are closely related to the weaknesses addressed and are above all to be identified in the area of a future contextualization of the AMU within a broader national social protection strategy. In addition to this, the development of a legal framework and common rules and regulations for Mutuelles de Santé and Mutuelles Sociales in general would clarify their role and responsibilities in a future AMU. To complement the strengthening of existing Mutuelles de Santé, a comprehensive IT-based MIS and M&E system for Mutuelles de Santé and Mutuelles Sociales in general may be considered. To support the overall sales component of the AMU, a broad campaign on insurance education and social marketing to prepare the society as well as all involved stakeholders for the roll out of the AMU, is a promising approach to consider. Health providers should be closely involved in this public campaign to ensure ownership and a common understanding of the system by all stakeholders. Moreover, an extensive assessment of quality of care should take place to agree with the involved health providers on certain minimum standards to be implemented once they will be part of the AMU. In terms of sustainability, the AMU planning committee might consider to link up with other government departments that are engaged in social protection interventions as well as common donors and stakeholders in this area to win them as strong supporters and drivers of the future AMU as well as to ensure effective linkages and referral mechanisms to other social protection measures for the AMU beneficiaries.

The AMU is exposed to specific external threats that above all can be identified in the unclear role of the AMU in case of implementation of a national social protection system or strategy. In addition to this, an increased level of competition of Mutuelles de Santé with private for-profit health insurance schemes may arise due to the lack of clear rules and regulations of Mutuelles de Santé in Burkina Faso. In addition, the role of other actors within the landscape of health care provision in Burkina Faso, such as private and faith-based health facilities remain unclear, as the envisioned AMU only considers public health providers. This may cause challenges towards the smooth servicing within the AMU. Regarding sustainability of the AMU, the transformation process from the voluntary health insurance within the AMU for the informal sector towards UHC in Burkina Faso remains unclear and was not yet discussed by the involved planning committees [34]. The significant delay of implementation equally threatens the overall success of the AMU in Burkina Faso, because major donors and technical partners may move out due to a decreased level of trust and confidence in the system to be implemented in the near future.

Table 5: Strengths (Internal) of the envisaged SHI system in Burkina Faso, Source: own SWOT analysis

Strengths (Internal)	
Design	• Bottom-up approach • Close involvement of *Mutuelles de Santé* from initial design stage • Involvement of various institutions and stakeholders aiming at meeting various needs and demands of a multifaceted society
Sales	• Acknowledgement and involvement of *Mutuelles de Santé* in sensitization, mobilization and trainings of the target communities • Standardized curriculum due to former ILO Step-Programme engagement
Servicing	• Close involvement of contracted health providers from initial stage
Sustainability	• Close involvement of all crucial stakeholders ensures ownership

Table 6: Weaknesses (Internal) of the envisaged SHI system in Burkina Faso, Source: own SWOT analysis.

Weaknesses (Internal)	
Design	• Over-reliance on *Mutuelles Sociales* • No public regulation yet • No public social protection strategy developed that would be linked up with AMU • Voluntary health insurance for informal sector • Major delays in implementation process • No clear strategy on design of indigents and waiving mechanisms for the vulnerable parts of the society
Sales	• Low level of managerial and technical capacities of *Mutuelles de Santé* • Low level of visibility of *Mutuelles de Santé*
Servicing	• Low level of insurance literacy amongst health providers
Sustainability	• No legal framework for *Mutuelles de Santé* • No public social protection strategy or framework

Table 7: Opportunities (External) of the envisaged SHI system in Burkina Faso, Source: own SWOT analysis.

Opportunities (External)	
Design	• To contextualize the AMU within a broader national social protection strategy • To set up a legal framework for *Mutuelles de Santé* in Burkina Faso to clarify their role and responsibilities within the AMU • To design and implement an IT-based MIS and M&E system
Sales	• To develop a broad campaign on insurance education and social marketing to prepare the society for the roll out of the AMU
Servicing	• To closely involve health providers in the public campaigns (insurance education, social marketing) • To assess level of quality of care before rolling out the AMU and to agree on certain standards for contracted health providers within the new system of AMU
Sustainability	• To link up with other government departments in charge of social protection as well as donors/stakeholders in the field of social protection

Table 8: Threats (External) of the envisaged SHI system in Burkina Faso, Source: own SWOT analysis.

Threats (External)	
Design	• Unclear relevance of AMU system in case of implementation of national social protection system and/or strategy
Sales	• High level of competition with private commercial health insurance schemes
Servicing	• Unclear role of private and faith-based health facilities
Sustainability	• Unclear transformation process from voluntary health insurance to UHC • Moving out of donors because of significant delay of implementation process

Tanzania

The Tanzanian system of decentralized CHF units, which shows a clear objective of targeting the informal sector, has various significant internal strengths to be mentioned. The comprehensive coverage is ensured through the combined governance structure of the CHF and the TNHIF, which targets members of the formal and informal sector and meets their specific needs [38]. In the area of sales, many local CHF units make use of the decentralized structures of the government and involve regional and district medical officers as well as local authorities and chiefs in the common marketing of the CHF [40]. Through the commitment and support of these stakeholders in sensitization of the target communities, the public good will and political commitment is visible. The offered CHF product comprises of curative and preventive health services at health providers of different levels and shows a high level of comprehensiveness [38, 40]. The public matching grant ensures a certain level of sustainability of the entire system, as it does not rely on external funding or premium contributions only, but has a strong public financing component [18, 41, 42].

Internal weaknesses of the Tanzanian System can be observed in the area of standards and harmonization, as the two systems of CHF and the TNHIF are not yet fully integrated and interlinked which each other. The general approach of the Government of Tanzania is top-down as the entire system is still supervised and controlled by the

central government with only minor decision-making authorities on district level, leading to a low level of community participation and/or involvement. Due to the low level of experience in serving the informal sector of the TNHIF, the overall coverage remains low with most districts not expanding 15% of coverage through the CHF/TNHIF system [38, 43, 44]. In addition to this, there is an over-reliance on district structures and a non-existence of appropriate community-based structures, resulting in a limited involvement of crucial stakeholders, e.g. the communities themselves, but also NGOs or other private social support structures [45]. The identification of indigents within the Tanzanian TNHIF/CHF system was rated very complex and not transparent and is not well understood and/or accepted amongst the target communities. Furthermore, it results in a common exclusion of needy people to access indigents within the system [18]. In terms of social marketing, the measures in place a very limited, which might be one reason for the low coverage of the overall SHI system. The existing government structures are not effective in social marketing and insurance education and at the same time, the level of knowledge about how to cover the informal sector amongst the TNHIF is to be rated very low. In addition, the managerial capacities amongst the district-based CHF units are not advanced, which results in main weaknesses on various areas, e.g. financial management, claims management, and membership management, affecting the overall performance of the respective CHF unit [39]. In terms of servicing, a general low level of quality of the provided health services at contracted health providers could be observed [7, 38]. Moreover, there is a lack of qualified full-time staff serving the CHF/TNHIF system. In terms of data management and M&E, there is no adequate nationwide MIS and/or M&E system in place, which supports the CHF/TNHIF system in these crucial areas [46]. This results in a low level of accountability and overall sustainability within the system, especially on CHF level. The low level of community participation in processes and product design is another weakness affecting the sustainability as processes and products in place may not meet the needs of the actual target community.

External opportunities within the design of the Tanzanian SHI system are above all in the areas of governance, where it is promising to create independent CHF units that are supported by the TNHIF in certain areas only, e.g. in terms of standard procedures, funding, coordination [39, 44]. Another opportunity for the existing Tanzanian system would be the introduction of a compulsory SHI for all citizens. This would result in higher numbers and a general public commitment towards the system. This overhaul of the system may also include an intensive community involvement and community consultation to enable the system to address certain needs of specific parts/groups of the population, e.g. the informal sector and other marginalized and/or vulnerable groups. It is also a promising opportunity to extend island or pilot projects, such as the IMIS project in Dodoma Region [40], to other regions or to scale it up to the national level. In the area of sales, the approach of using local administrators as well as district medical officers and regional medical officer for common sensitization and mobilization should be expanded to all CHF districts. Servicing within the hybrid TNHIF/CHF system could be improved by inclusion of a comprehensive referral system to upper levels of health facilities of the Tanzanian health system. This would avoid the recent limitation of beneficiaries that are mainly accessing dispensaries and health centres. To guarantee sustainability of the system, the compulsory element of the TNHIF/CHF system should be emphasized by a sound and understandable public policy. In line with that, the common commitment of other public and private stakeholders in the field of social protection in health can be increased towards a joint effort to improve the current system. This can be achieved through a public visibility campaign. The close involvement of the target communities in this process will lead to an increased level of community ownership and insurance literacy. External threats to the Tanzanian SHI system were observed regarding the low support on national and international level, which may result in an inability to redesign the scheme adequately.

Common threats to SHI scheme may also threaten the Tanzanian system, e.g. moral hazard, adverse selection or a common mistrust by members and/or non-members of the schemes [7]. The already mentioned low quality of health care, predominantly the regular shortages of drugs and supplies as well as the lack of well-skilled health personal, could threaten the system significantly [46]. The low-rated impact of the entire system as well as common issues related to corruption and in-transparency may also result in a low future support of external donors, which might not be convinced about the positive long-term impact of the system. Due to the low level of success of the Tanzanian SHI system, the evolvement of alternative health financing schemes to suit specific needs of excluded parts of the society is furthermore possible and should be expected in case no general overhaul of the system is being implemented in the near future.

Table 9: Strengths (Internal) of Tanzanian SHI system

Strengths (Internal)	
Design	• Targeting and (partly) coverage of informal sector • Combined governance structure CHF/TNHIF (informal and formal sector health insurance schemes)
Sales	• Involvement of *Regional Medical Officer* (RMO), *District Medical Officer* (DMO) and local authorities in sensitization of local communities
Servicing	• Comprehensive product of curative and preventive health services at dispensaries and health centers
Sustainability	• Public matching grant

Table 10: Weaknesses (Internal) of Tanzanian SHI system

Weaknesses (Internal)	
Design	• CHF system is not yet fully harmonized with the TNHIF • Limited involvement of crucial stakeholders • Limited coverage (15% CHF and TNHIF) • Top-down approach • Low level of community participation and/or involvement • Very complex system for identification of indigents • Over-reliance on district structures • Lack of experience of TNHIF to serve the informal sector
Sales	• Very limited social marketing measures • Existing government structures are not effective in social marketing and insurance education • Low level of managerial capacities amongst the district-based CHF units • Low level of knowledge about how to cover informal sector amongst TNHIF
Servicing	• Low level of quality in provided health care • Lack of qualified full-time staff serving the CHF • Lack of adequate and nationwide MIS and M&E system
Sustainability	• Low level of community participation in processes and product design • Low level of accountability on CHF level

Source: own SWOT analysis.

Table 11: Opportunities (External) of the Tanzanian SHI system

Opportunities (External)	
Design	• To introduce a compulsory element of CHF, to design and implement a compulsory SHI for all citizens in Tanzania • To create independent CHF units, supported by the TNHIF in certain areas • Intensive community involvement • To address certain needs of specific parts/groups of the population (e.g. the informal sector, marginalized groups) • To extend pilot projects of IMIS (e.g. in Dodoma Region) to other regions and the national level
Sales	• To extend the approach of using local administrators as well as DMOs/RMOs for sensitization and mobilization to all CHFs districts • To apply comprehensive insurance education and social marketing measures on TNHIF, CHF and community level
Servicing	• Inclusion of referral services to upper levels of the health system, rather than limiting the beneficiaries to dispensaries and health centers
Sustainability	• To introduce a compulsory element of CHF, to design and implement a compulsory SHI for all citizens in Tanzania in line with a public visibility campaign about the system • To involve all government entities and donors in the field of social protection to contribute to a common TNHIF/CHF system • To increase the level of community ownership • To increase the level of insurance literacy amongst the target population

Source: own SWOT analysis

Table 12: (External) threats of Tanzanian SHI system, Source: own SWOT analysis.

Threats (External)	
Design	• Low support on national and international level may lead to an inability to redesign the scheme
Sales	• Moral Hazard, Adverse Selection, mistrust by members and non-members of the scheme
Servicing	• Low quality of health care, shortage of drugs • Moving out of Health Providers due to delay of claims settlement and general corruption of the CHF system
Sustainability	• Low support of external donors due to low impact and issues linked to lack of transparency and corruption • Evolvement of alternative health financing schemes to suit specific needs of excluded parts of the society

Rwanda

In Rwanda, internal strengths can mainly be identified in the area of design of the overall system, which is designed with affordable premiums and indigent subsidies for the most vulnerable parts of the society. The system is based on a bottom-up approach ensuring high levels of community participation and involvement, which resulted in an increased enrolment amongst the target community, a national scale up process as well as good governance of the SHI scheme [47, 48]. The Rwandan system is furthermore based on formally and legally acknowledged public guidelines and policies, including a compulsory element, which led to a high level of public commitment and awareness nationwide. The coverage amongst the informal sector is equally high as compared to other countries in the region. The national coverage increased from 7% in 2003 to 91% in 2010 [49]. The Rwandan system implemented an adequate sub-system of the Ubudehe categories to identify vulnerable parts of the population, which are to be classified as indigents. The system in Rwanda was implemented very promptly, without major delays [49, 50]. Through the public acknowledgement, the Rwandan system shows main strengths in the area of sales. This is a result of the establishment of a comprehensive supporting and strengthening structure of public and private stakeholders, as well as financial and technical partners of the system [49]. In the area of servicing, the Rwandan system benefits from the performance-based funding of health providers by the Government of Rwanda, which ensures a high quality of care, and regular monitoring and evaluation of the same. Through the high level of community participation in processes and decision-making, most crucial procedures are tailored to the target group. Furthermore, the technical working groups according to different health clusters are continuously improving the quality of care and the common insurance supply [49, 51]. In terms of sustainability, the Rwandan system reveals its strengths in the high level of community participation and involvement, which – in combination with the political goodwill and supporting public policies and guidelines – results in a more sustainable implementation of the overall system. The compulsory element within the system furthermore ensures a long-term commitment and enrolment of a larger part of the target population. Another guarantor of sustainability of the Rwandan system is the result-driven approach of the Rwandan government, which results in a continuous process of monitoring and evaluation of the Rwandan SHI system [5, 29, 49].

Common internal weaknesses of the Rwandan system can be identified in the area of community-based structures that are considered as main drivers of the SHI system, and are equally supposed to serve as a transferring link to a comprehensive national SHI system. In the current situation, it remains uncertain, how this final transfer will look like and how feasible the transfer is. In terms of a comprehensive MIS, the currently system in place to serve the Rwandan health system, the RHMIS, is not yet tailored to serve the system of Mutuelles de Santé in the areas of a comprehensive MIS and M&E system [52]. In addition, there is still not enough emphasis being laid on the implementation of effective social marketing and insurance education campaigns within the Rwandan system, as there is no standardized manual for the Mutuelles de Santé in place to carry out such activities and the general awareness about the actual benefits and functioning of a health insurance is still rated low amongst the target group [48]. Regarding the sustainability of the Rwandan SHI system, the existing capacities of Mutuelles des Santé in institutional and/or managerial regards as well as on health facility level are still rated as low and there is need for a comprehensive capacity assessment and building plan. The transfer of Mutuelles de Santé towards a national comprehensive SHI system is not clear yet, which threatens the long-term success of the current system [49]. An external opportunity for the

Rwandan system could design an adequate transfer strategy on how to set up a national comprehensive social protection system, after the potential of community-based schemes is fully explored [49]. Another opportunity for the Rwandan system would be to develop and implement an adequate and tailored insurance education and social marketing campaign to strengthen the overall awareness about the system as well as to increase the general level of insurance literacy amongst the target group. Other important areas for capacity development include the areas of financial management and general scheme management [48]. A further opportunity in the Rwandan context would be the inclusion of enrolment within a Mutuelle de Santé into the districts performance contracts between the local governments and the central Government of Rwanda [49]. The strong government leadership and political goodwill and commitment can furthermore be regarded as a basis for a variety of opportunities to further develop the Rwandan system. New components and/or evolvements within the system should be developed on the basis of the general existing culture of solidarity and mutual assistance and/or aid amongst the target group, which forms an ideal basis for a sustainable and effective social protection system in the long term.

External threats to the Rwandan system could be the inappropriate priority setting of the Rwandan government who feels that they have too many tasks to fulfil in the health and social protection sector [49]. Priorities should hence be identified and followed-up accordingly. Another threat might occur once current financial and technical supporters of the Rwandan system move out, assuming that their support to the SHI system is no longer needed, given that the ultimate goal of UHC was already achieved [49]. While the funding of the Rwandan system is balanced, the moving out of crucial partners might threaten the entire system in a significant way. The high poverty levels in Rwanda, showing 44.9% of the population living below the poverty line and 24.1% living in extreme poverty, is still reason enough to question the overall success of the Rwandan SHI system, as it is supposed to reduce poverty in a significant way. The low levels of insurance literacy amongst the target population are also potential threats to the system, because this situation may lead to an increased level of adverse selection, moral hazard and fraud. The role of health facilities in a future transformation process towards a national SHI system is not clear, given that there is no involvement of health providers in common decision making processes [5]. With regards to sustainability, the weak financial risk sharing between the different community-based schemes and other health insurance schemes may become a concern [48]. Moreover, the external funding of up to 50% through external donors creates a common dependency of the system on the same and threatens the long-term sustainability of the system. Innovative exit strategies have to be designed, so that the funding of the system can be well balanced without creating common dependencies.

Table 13: Strengths (Internal) of Rwanda SHI system

Strengths (Internal)	
Design	• Affordable premiums with indigent subsidies for most vulnerable parts of the society • Bottom-up approach: High level of community participation and involvement led to large take up and scale-up as well as good governance of the scheme • Based on formally and legally acknowledged public policies and guidelines • Compulsory element • Huge coverage of informal sector (increased national coverage from 7% in 2003 to 91% in 2010) • Adequate system of *Ubudehe* categories to identify the parts of the population that are to be classified as indigents Prompt implementation process without major delays
Sales	• Public acknowledgement and comprehensive support through government and relevant stakeholders
Servicing	• Performance-based funding of health providers ensures high level of quality of care • High level of community participation in processes and decision-making • Technical working groups according to different health clusters are continuously improving quality of care and insurance supply in general
Sustainability	• Bottom-up approach: High level of community participation and involvement • Political good will and supporting public policies and guidelines • Compulsory element • Result-driven approach of the government

Table 14: Weaknesses (Internal) of Rwandan SHI system, Source: own SWOT analysis.

Weaknesses (Internal)	
Design	• Community-based structures as transferring link to comprehensive SHI system: How will the final transfer look like? • RHMIS is not yet tailored to serve the system of *Mutuelles de Santé* in the areas of MIS and M&E
Sales	• Gap/Lack in the areas of social marketing and insurance education campaigns
Servicing	• Human resource constraints: Lack of skilled personal on various levels
Sustainability	• Low institutional and managerial capacities • Community-based structures as link to comprehensive SHI system: How will the final transfer look like?

Table 15: opportunities (External) of the Rwandan SHI system, Source: own SWOT analysis.

Opportunities (External)	
Design	• To design an adequate transfer strategy how to set up national Social Protection System after potential of community based schemes is explored
Sales	• To set up an adequate and tailored Insurance Education and Social Marketing Campaign • To train all involved actors on the Insurance Concept as well as Financial and Scheme Management
Servicing	• Inclusion of *Mutuelles de Santé* enrolment in districts' performance contracts between local governments and the President of the Republic of Rwanda
Sustainability	• Strong government leadership, political commitment • Synergy between reforms in health sector • Culture of solidarity and mutual assistance and/or aid

Table 16: (External) threats of Rwandan SHI system, Source: own SWOT analysis.

Threats (External)	
Design	• Priority-Setting of government • Moving out of donors and technical support units assuming ultimate goal of UHC was achieved • High poverty levels of population of Rwanda (44.9% below poverty line and 24.1% living in extreme poverty)
Sales	• Low level of insurance literacy amongst target population • Adverse selection, moral hazard and fraud due to low level of insurance literacy amongst the target population
Servicing	• Unclear role of health facilities in transformation process towards national SHI system due to low involvement in decision-making
Sustainability	• Weak financial risk-sharing between CBHF schemes and other health insurance schemes • External funding of system of up to 50%, dependency of external donors and other stakeholders

Comparative Analysis of Case Examples

Based on the illustrated SWOT analysis, it became evident that each of the four countries and respective SHI system shows certain strengths, weaknesses, opportunities and threats in specific areas, which significantly determine its success and general impact.

While Rwanda shows promising elements in its basic design, e.g. the mandatory element, the general bottom-up approach and its main objective to reach out to the informal sector, Tanzania applies a different approach, maintaining typical government top-down structures and a low level of general community participation. However, Tanzania applies an innovative approach of a matching grant of public and private funds for the national scheme, while sustainable funding of the respective systems remains a challenge observed in all case examples applying different options of tax-based and private/donor-funded options.

Low managerial and institutional capacities and a general need for technical capacity building in the area of insurance education are identified gaps which were revealed in all four case examples through the adjusted SWOT analysis. Existing manuals and guidelines for social marketing and insurance education are in place in Ghana, while Burkina Faso integrated technical support in these areas through the ILO-Step programme as well as

through technical and human capacities available at Mutuelles de Santé level. Rwanda follows a similar approach by implementing the national system based on Mutuelles de Santé. Here again, Tanzania shows a different approach by relying significantly on existing government structures at different levels.

Further critical factors determining the success of a national system are the existence of a legal framework as a basis for the national scheme as well as a well-developed health infrastructure providing services in the scope of a national system – the legal aspect was adequately considered in Rwanda as well as within the development of the AMU in Burkina Faso, while the absence of clear legal structures causes challenges in Tanzania and Ghana. Performance-based financing of health providers – as applied in Burkina Faso – may be one option to foster the development of an adequate health infrastructure as part of a national health insurance scheme and to avoid common challenges the other countries faces in this area. In addition, health providers have been part of the entire process in Burkina Faso, which enables them to be critical stakeholders and decision-makers in the envisaged system. This is a common gap observed in the other three country case examples.

The Ghanaian system in its initial design shows interesting and commendable approaches in the area of Inclusiveness, applying adequate exemption measures and indigents for the poorest as well as a comprehensive basic package and a low level of co-payments for all NHIS members. However, in practise, the scheme seems to exclude the poorest and focuses on the middle-income sector. In addition, vertical control structures and low decision-making at district level compromises the system in its decentralized character. Rwanda and Burkina Faso show more promising approaches in their general bottom-up and participatory design and implementation process, while Tanzania remains top-down oriented.

Finally, a common need for adequate and tailored systems in the area of IT, MIS as well as M&E could be identified in all four cases. While promising pilot interventions in these areas have been observed in Tanzania, these would need further scaling and tailoring to respective contexts.

Lessons Learnt

Based on the illustrated country case examples, the following lessons learnt and recommendations can be generated in a cross-country perspective. To comply with the common health insurance framework, the cumulated lessons learnt and recommendations are divided into the sub-categories of Design (1), Sales (2), Servicing (3) and Sustainability (4).

Design

- Many countries in sub-Saharan Africa introduced national insurance schemes that are mandatory for formal sector employees and public servants, while the informal sector is supposed to be covered by voluntary insurance. As most low-income countries in sub-Saharan Africa comprise a large informal sector, it is advisable to target the same. In this context, it is crucial to design simple processes and affordable premiums tailored to the specific needs of this target group who will build the basis for the national scheme. Each health insurance – either with a commercial or a social protection focus – is highly determined by the number of members, clients or beneficiaries that are contributing to the common risk pool. A low coverage will result in higher premiums, limited products and benefits and low ceilings and is challenging the overall attractiveness of the health insurance scheme.
- A clear and transparent way to identify and implement indigents and waiving mechanisms is indispensable to ensure that vulnerable parts of the society will also benefit from the scheme, while their ability to pay for the same may be limited. If this is not given, the scheme will exclude larger parts of the society, that could not have been properly identified under the defective system. To adequately identify vulnerable parts of the society, a participatory approach to classify indigents should be used. Participatory Integrated Community Development (PICD) provides various approaches to empower the target communities to identify their indigents and design adequate categories for tailored premium payment. A low level of community participation in this area may negatively impact the target population towards a low level of ownership and general acceptance of the scheme.
- Centralized scheme management applying a top-down orientation and vertical control structures will result in the fact that the target communities will not own the local structures of the national scheme. Local SHI scheme structures will equally not be flexible in their operations, e.g. to design tailored products and processes. It is hence advisable to opt for a bottom-up approach to ensure a high level of community participation and ownership, which

will lead to larger level of take-up and scale up as well as an advanced level of good governance of the scheme. In this context, a close involvement of existing community-based organizations as well as all other relevant stakeholders during the scheme design is highly advisable to ensure that various needs and demands are met within the process. To ensure a high level of community ownership, the local units of the national SHI system should be self-dependent and flexible in their decisions of handling funds and processes.

- While the overall approach should be bottom-up-oriented, the implementation process of a national SHI scheme should be embedded in clearly formulated, formally and legally acknowledged policies and guidelines. In this context, a compulsory element for the target population to become member of the scheme is to be considered as a main driver of the scheme. Evidence in countries with a high coverage (e.g. Rwanda) reveals that a compulsory element was necessary to convince the target population to join the scheme. In addition, a national SHI scheme that is not closely linked to existing government policies or programmes is unlikely to survive, because the level of public awareness and acknowledgement will be low.
- Once the government or certain government entities are closely involved in the design and implementation of the national SHI system, the danger of politicization of the scheme is given. In this scenario, clear guidelines have to be developed to delink the system from political activities and in the same way show its independency clearly to the public and the potential target group.
- The implementation process of a SHI scheme should be prompt without delays, as a bureaucratic and time-consuming implementation process may result in a low level of confidence towards the scheme amongst the target population as well as common supporters and funders of the scheme. In this context, it is advisable to allocate enough time and resources for the pre-implementation phase, in which the design of the entire implementation process of the scheme is agreed with all stakeholders. Neglect towards the involvement of crucial stakeholders in the scheme implementation process may lead to the failing of the scheme due to a low level of ownership and commitment. Once the general support of the scheme on national and/or community level is low, the scheme in its operations is seriously threatened as the multi-level support of it– especially in its initial stages, but also in a long-term-perspective to ensure sustainability of the scheme – is more than crucial.
- On central level, it is advisable to have a national coordinating body, which sets standards and provides tools and systems as well as exchange forums for the local units of the system. In the long term, to achieve UHC, local structures of the system have to be up-scaled to, linked to or embedded into national structures. To ensure this, an adequate transfer mechanism as well as an adequate implementation plan and timeline should be designed during the initial stage of the national SHI system.
- Proper systems should be established within the national SHI system to support all involved stakeholders to adequately fulfil their duties. For this purpose, a clear guideline about roles and responsibilities of each stakeholder has to be developed during the initial design stage of the SHI system. It is necessary to ensure a high level of professionalism, accountability and check and balances.
- If the national SHI system is purely based on one kind or type of institution or structure, e.g. district structures or CBHF schemes, this structure has to be very stable and reliable, because once the structure fails, the entire scheme system will the threatened to fall. It is hence recommendable to design a system with various approaches and different structures/institutions to serve different groups of the society.
- A clear channel of communication as well as adequate systems for data gathering and management are crucial in a national SHI scheme. Many systems neglect the named components, resulting in conflicts between the different stakeholders because of poor communication as well as an inability to measure success and failure due to a common lack of data. Moreover, a low level of transparency is a potential threat to a national SHI scheme on different levels. Internally, it will lead to a general doubting of most involved stakeholders towards the system. Externally, the system will lack acknowledgement and donor support once its level of transparency is questioned. Especially in initial stages, national SHI schemes are in urgent need of public acknowledgement to cope with the initial phase of implementation with an adequate level of external and internal support. A serious threat to a national SHI system would be the potential moving out of donors and/or technical support units. This might happen once the need for their support is no longer seen (e.g. UHC was

achieved or almost achieved) or the system is doubted in terms of its accountability, legitimacy and/or transparency.

- Especially during the initial stages of scheme design and implementation, a close monitoring will be important to ensure a proper implementation of the national SHI system within a long-term-perspective. A well-developed M&E system should be established and accessible on all different levels of the system (e.g. community, county/district and national level), and should be able to capture all crucial component and indicators (e.g. regarding membership dynamics, financial and scheme management). Ideally, it should be IT-based containing web and mobile phone applications, to ensure and extensive use and it should also entail elements of a comprehensive MIS.
- Focus on extensive premium payments to finance the SHI scheme, rather than considering a comprehensive tax-financing element as well as a generally flexible and balanced funding of the system bares the danger of excluding large parts of the society as well as creating financial dependencies of the system on the beneficiaries. In addition, a successful SHI scheme is supposed to minimize OOPP. Once the OOPP are at a medium or high level, the overall objective of Access for All and UHC cannot be met.
- High poverty levels of the target group – the potential beneficiaries of the scheme – are threatening the scheme, as their monetary contributions in forms of premiums are main carriers of the scheme. In most existing schemes, tax- and/or donor funding alone was not rated as able enough to sustain the scheme and without contributions of the members, the main concept of pooling of risks and resources would be extensively compromised.
- In most countries of sub-Saharan Africa, different models and institutions of community-based health insurance schemes are in existence. When implementing a SHI scheme, it is possible that few structures cannot be absorbed by the system due to institutional weaknesses, a low level of commitment of those schemes or other crucial factors. The co-existence of local schemes and schemes part of the national scheme moreover will result in a very heterogeneous landscape of local social health financing institutions resulting in a common confusion and low commitment of the target population towards the national SHI scheme.

Sales

- The lack of effective and efficient social marketing and insurance education measures within a national SHI scheme will result in a low level of public visibility of the national scheme and an equally low level of support through the government and other crucial stakeholders, e.g. donors and development partners as well as technical supporters of the scheme. In this context, the close involvement of relevant government entities as well as recognized local leaders and devolved government authorities in the areas of insurance education and social marketing will ensure a smooth implementation process as well as a high level of commitment towards the scheme. In addition, the involvement of community-based structures and other local stakeholders, such as churches, in sensitization, mobilization and trainings of the target communities is indispensable for the overall success of the scheme. A remaining low level of insurance literacy amongst the target population of the system can seriously threaten the scheme, as conflicts may arise due to a misunderstanding of the overall principles of health insurance, e.g. people would expect to get their premiums back once they did not fall sick after one year or would expect people that fall sick more frequently to contribute higher premiums. Furthermore, comprehensive insurance education and social marketing measures amongst the target group are to be seen as guarantors of a sustainable SHI scheme. These measures should be applied in an extensive way to cover all levels of the system. Ideally, they should be standardized in a way that standard modules and a certain timeline are provided to ensure proper implementation.
- To ensure a successful implementation of the scheme, a standardized training curriculum should be put in place. To ensure that the scheme is marketed in a professional way, a high level marketing strategy with various tools should be designed and implemented. For this purpose, technical assistance from commercial marketing professionals should be considered.
- The provision of a tailored and comprehensive benefit package within a national SHI system is highly recommended. The package should cover curative and preventive services, as well as involve only minimal co-payments, while a focus on maternal health services and other crucial needs of the target society will result in a high level of perceived attractiveness and relevance of the national scheme towards the target population.
- Inadequate management capacities among the key scheme staff of the national SHI scheme

on community level will result in a low level of trust amongst the targeted communities, which will not be willing to trust and invest their limited resources in a poorly managed scheme.

- To ensure high enrolment into the scheme, existing group structures on community level should be used. Introducing the scheme to an already organized group will result in a high social commitment amongst the group members and a high number of absorption of community members into the scheme. Following this approach may lead to a fast coverage of huge parts of the targeted population.
- Private commercial health insurance schemes that are not involved in the national SHI scheme will be serious competitors of the contracted health providers, e.g. in terms of offering better quality of services. Due to this potential threat, it is advisable to include private health insurance schemes, e.g. in the area of technical advice and support regarding actuarial specific of the system, such as an adequate premium calculation or smooth claims procedures, into a national SHI scheme equally to public, private and faith-based health providers.

Servicing

- The close involvement of health providers from the initial stages of implementation of the national scheme will ensure that their needs, interests and demands are met and that a high level of ownership is ensured. In addition, it is very important to ensure that health providers are sensitized on the insurance concept as well as the implications of fraud for all involved parties within the system. Health providers are crucial stakeholders that are usually neglected when implementing a national SHI System. Besides their role as service providers and guarantors of high quality services, they should also play a crucial role in the marketing of the scheme as well as in general member recruitment for the scheme.
- Universal access to quality health care is one key objective of a national SHI scheme and hence to ensure the same should not be neglected. To provide a high quality of services includes avoiding high co-payments as well as “informal payments” of scheme members to the health providers. In addition, the accessibility of accredited health providers as well as a certain level of insurance literacy amongst the health personnel should be insured. A low quality of care at contracted health care providers of the national scheme will result in a common mistrust and dissatisfaction of members towards the scheme. To avoid this, regular assessments and audits of the contracted health providers may support the relevant government entities to ensure a high level of quality of care within the national SHI system. The level of quality of care should be assessed during the initial planning stages of the SHI system and equally be followed up regularly after the successful establishment of the system. Regular clinical audits of contracted health providers are one opportunity to serve this purpose. In addition, a compensation of contracted health providers according to the delivered services (performance-based contracts) will ensure a high level of quality of health care and a continuous review of provided quality by the health facilities of relevant authorities of the SHI system. Governments have developed specific agreements on district performance. To include the level of enrolment into the health insurance scheme of the district population into these contracts seems to be a motivating practice towards a common commitment of the district authorities towards the scheme. The establishment of an independent entity on national level, e.g. a technical working group comprising national and international development partners and research institutions, which provides continuous technical support and input can furthermore ensure a continuous improvement of quality of care and health insurance supply to the target population.
- Through a high level of involvement and participation of the targeted communities in common processes and decision-making within the national scheme, the services delivered will be tailored to their needs and the level of satisfaction will be increased.
- The establishment of an effective referral system will result in a more cost-effective national SHI system as occurring illnesses will be treated adequately and members will not forego treatment because of a lack of access to higher-level facilities. The premium should include the coverage of transport costs to referral health facilities.
- A low level of managerial capacities at the local scheme level will result in the provision of poor services, e.g. delays in claims settlement. In addition to the danger of inadequate capacities amongst local scheme managers, the lack of capacities to reach the informal sector with all its specific characteristics will result in a lack of ownership of the scheme by the targeted communities. In addition, if main principles of good governance of the health insurance are

not maintained, the scheme will be threatened by a low level of support by the contracted health providers that would rather move out of the entire system than cover the depth of the national scheme.

Sustainability

- Through a long-term financial commitment of the government, the national SHI scheme is to be considered as more viable in terms of financial sustainability. A public matching grant or a comprehensive tax-based element of the national scheme can fulfil this purpose.
- To achieve commitment amongst the target population, a strong political goodwill and commitment is needed, that will also lead to sustainable operations of the scheme. Common reforms of the respective public health sector are to be considered to contribute to the overall success of the envisioned system. If relevant reforms are tailored to support the new system, it will be carried by these reforms and support its sustainable components in a crucial way. Public commitment and policy support through the respective government, e.g. through the introduction of a compulsory element of the scheme, will further lead to a higher level of acknowledgement and commitment amongst the target population towards the scheme and will result in an increased level of sustainability of the overall national SHI scheme.
- A well-balanced funding of the national scheme through national and international, public and private sources, will ensure financial sustainability, and protect the scheme against dependency on a certain funding source or donor. An adequate tax-financed element of a national SHI scheme will provide sustainability and the necessary back up funding once premium payment becomes unpredictable or unreliable. If a national SHI system focuses on premium payment rather than on taxation, it is vulnerable, because once the income levels of the target group decrease or the priorities of the target group change, the main funding cannot be provided anymore and the system fails. An over-dependency of more than 50% on external donor funding is seriously threatening the long-term-operation of the scheme. It is therefore advisable to consider premium payments as well as tax- and donor funding in a well-balanced way so that none out of the three elements becomes main driver or carrier of the system.
- Many governments in sub-Saharan Africa envisaged implementing a national SHI system and/or strategy to fit in the global request and conviction of social protection as a guarantor for development. In cases where the SHI scheme is not developed in line with existing social protection strategies, a side-lining social protection system will threaten its overall existence and sustainability.
- Some countries in sub-Saharan Africa consider implementing national SHI schemes that in its initial stages will cover the informal sector in forms of a voluntary insurance only. As in the long term a transition to UHC is envisioned, a clear strategy on how the voluntary insured beneficiaries will later be integrated into the mandatory national health insurance is highly advisable to serve the purpose of sustainability.
- A promising approach towards sustainability is to involve a high number of relevant committed stakeholders, which will own the scheme and ensure its long-term operations. To convince relevant stakeholders about the benefits and relevance of a national SHI scheme is the biggest challenge in this regard. The common commitment of all stakeholders is also needed to ensure adequate technical and financial inputs towards scheme implementation as well as an extensive public visibility of the scheme in the long-term.
- Once the scheme is not designed in an inclusive way considering including all parts of the society, the probability of alternative institutions to serve specific needs of specific groups of the society can be rated as high. This fact would compromise the overall objective to provide a transparent and harmonized system of social protection in health for all citizens.
- The involvement of existing public and community-based structures, e.g. to base the scheme on existing district structures, will lead to more stableness of the scheme in a long-term perspective.
- Once the impact of the scheme is rated as too low or concerns related to corruption become more evident amongst the national and international community around the national scheme, the trust of external donors will decrease and a general decrease of external support is expected. A delay of the implementation process or a general low level of transparency will result in the same.

Conclusion and Recommendations

During the comprehensive analysis of the four country case examples from Ghana, Burkina Faso, Tanzania and Rwanda, it was illustrated, that each of the analysed low-income countries of sub-Saharan Africa – while showing similar

preconditions – chose a unique path towards approaching UHC. In the different processes of designing and implementing an integrative SHI system, various stakeholders were involved, showing potential and commitment to contribute to the ultimate goal of UHC. The reviewed national SHI systems and models in this article emphasize diverse approaches based on various institutions and structures of public and private nature. The common element of the elaborated examples is the consideration of community-based approaches to supplement or complement public efforts to provide UHC to the target population.

On the basis of the analysis of the four country case examples, several key messages and policy recommendations for a national SHI could be identified in the different core areas of Design, Sales, Servicing and Sustainability of an integrated national SHI system.

Key messages and policy recommendations from the research:

- Besides the focus on the informal sector, the adequate design of indigents through participatory category setting at community level, a general bottom-up approach, and clear public guidelines and policies, including a mandatory element, proved to be factors of success of an integrative national SHI system.
- A prompt and structured step-by-step implementation process as well as a clear structure of the system on central and devolved administrative division's level are further guarantors of success of a national SHI system, while adequate systems and clear channels of communication and information should not be neglected as well.
- The funding of the system should be flexible and equally be based on premium payments as well as on a tax-based element and monetary contributions from public social protection funds and external donors. This will ensure a balanced funding, which reduces the level of OOPP, as well as avoids dependencies of the system on one funding source.
- In the area of sales, comprehensive measures in the fields of social marketing and insurance education should be implemented on all institutional levels as well as amongst the largest target group of the informal sector. In addition, capacities of all involved stakeholders have to be built, specifically in the areas of financial and general scheme management.
- A system that is designed in an inclusive and participatory way, e.g. by involving representatives from public social protection funds or supporting structures for vulnerable groups as well as public and private health providers and various types of health insurance, has high probability to implement a stable system, built on a joint and harmonized effort of the named stakeholders.
- To ensure smooth enrolment process amongst the informal sector, existing group structures and the approach of mass registrations of entire groups and/or companies should be used.
- Another crucial element within a successful integrative is the provision of high quality of care at contracted health providers, which can be ensured through close monitoring of the health providers as well as performance-based contracts. Health providers should also not be seen as pure service providers, but also as implementers and building blocks of the integrative SHI system. Hence, the close involvement of health providers within the marketing of the national SHI scheme is indispensable.
- An effective referral system is a further component, which can be associated with a high level of quality of delivered health care within a national SHI system.
- The benefit package should be tailored to the needs of the target population, and the expertise of CBHF schemes in participatory and community-based product design can be used to ensure the same.
- In terms of sustainability of the analysed schemes, the study revealed that a long-term financial commitment of the government would lead to a long-term commitment amongst the target population as well. A strong political good will would always strengthen the general acceptance and take up of a national scheme.

This study and its presented results are limited by different factors, which are described in the following.

- The empiric data analysis of the study considered a certain period of time and hence captured specific evolvement and/or development stages of the different systems, which comprised the years of 2009 to 2014.
- The analysis was restricted to sub-Saharan African countries and neglected approaches towards integrative national SHI systems implemented in other geographic contexts.
- A further fact that has been neglected in this study is the proofed evidence that (social) health insurance usually faces difficulties in being accepted by and sold to the target group, because of its nature of being an insurance for

a risk that people are trying to avoid and are usually not willing to spend their limited resources on. In some cultures, to pay for health in advance can be translated to call for illnesses or bad luck in general, which is another hindering factor for selling health insurance in a certain context. Nevertheless, the recommended social marketing and insurance education measures are one opportunity to cope with the named assumptions.

- The analysis presented cannot be rated as comprehensive, as further research would be needed to exhaust the topic. In this area, a longitudinal impact evaluation of the analysed country case examples is recommendable to measure the de-facto impact of the implemented systems towards UHC. Furthermore, integrative SHI system in other geographical contexts, such as South and/or Latin America, should be analysed to measure their potential relevance for the low-income context of sub-Saharan Africa.

The presented results oppose the common view of some researchers rating the potential of CBHF as low, while focusing on their institutional and technical weaknesses. Furthermore, this article aimed to emphasize advantages of community based initiatives that can be strengthened through adequate measures in the areas of capacity building and contextualization of the micro level institutions in a national framework.

Author Contributions

While the corresponding author LMO was responsible for data collection and structuring of the article, SF was responsible for technical backstopping and general technical expertise regarding the article topics.

Conflict of Interest

None declared

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