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Contractual arrangements between Community Health Insurance schemes and health care providers as a means to improve the quality of care: an overview in sub-Saharan Africa.

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Community Health Insurance (CHI) aims to improve the access to health care. Quality of care is one of the most important determinants of enrollment, as well as a condition for retaining members. Then it could be the cement of the partnership between CHI and health care providers.

Stakeholders (CHI managers, health care providers, organizations that provide technical support to CHI development and the managers of the health system) agree that CHI have role in the improvement of quality of care but they don't use or know how to use properly the contract to define and activate the role of each partner.

Actions to involve CHI in the improvement of the quality of the care should necessarily pass by the backing of health care providers to reinforce and maintain the partnership, and especially organizations that provide technical support to CHI that they can prepare CHI in this specific mean and the health system managers for the surveillance of the partnership.

Health systems analysts endorse the hypothesis that CHI, through the intense dialogue it implies between users and providers, could be a lever capable of influencing quality of care. This partnership is sealed in a contractual arrangement (in French the term *convention* is often used). Several actors are involved in the development, management and follow-up of such contractual arrangements: the CHI managers, the health care providers, the organizations that provide technical support to CHI development, and the managers of the health system at both national and local level.

We carried out an extensive mail survey composed by open and closed questions and a series of statements, in 14 countries of West and Central Africa. We investigate in a systematic way the potential of such contractual arrangements for

improving quality of care. A contextual and comparative analysis is achieved through qualitative and quantitative methods.

The mail survey gathered about 400 respondents from Benin, Burkina Faso, Burundi, Cameroon, Ivory Coast, Guinea, Mali, Mauritania, Niger, Democratic Republic of Congo, Rwanda, Senegal, Togo and Chad. The analysis shows whether quality of care is being addressed in these contracts, the nature and suitability of the wording used to describe quality of care, the perception by the various stakeholders of whether such contractual arrangements are the proper tools to influence quality of care, the existence of good practices of joint action to improve quality of care, and, finally, recommendations from all stakeholders on the use and appropriateness of such contractual arrangements.

Thirty years after the declaration of Alma Ata, access to quality health care remains a challenge. CHI contributes to better financial access through the pooling of resources. In addition to this financial function, however, CHI can empower the community in its relationship with the supply-side. The preliminary results of our investigation show that quality of care is a formal demand of CHI members. CHI, in its position at the interface between supply of and demand for health care, can modify the relationship between the two. As such, CHI is a new actor in local health systems with which it will be necessary to deal for matters of quality of care.