Voluntary health insurance in Bwamanda, Democratic Republic of Congo. An exploration of its meanings to the community

B. Criel1, M. Van Dormael1, P. Lefèvre1, U. Menase1 and W. Van Lerberghe1

1 Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium
2 District Medical Officer, Bwamanda Health District, Democratic Republic of Congo

Summary

An insurance scheme covering hospital care in the rural district of Bwamanda in the North-west of the Democratic Republic of Congo, which locally is called the mutuelle, was conceived and developed in 1986 on the initiative of Belgian doctors working in the district under the arrangements for bilateral Belgian aid. After more than 10 years of operation the Bwamanda scheme has achieved a high rate of coverage, contributed to a significant improvement in access to hospital-based in-patient care, and constitutes a stable source of revenue for the operation of the hospital. We present an investigation conducted through focus groups in 1996 of the population’s social perceptions of this risk-sharing scheme to identify ways to improve it. The findings pertain to the reasons for people to subscribe to the scheme; to the perception of its redistribution effects; to people’s frustrations and questions; and finally to the relationships between the insurance scheme and traditional mutual aid arrangements. The difference between a hospital insurance scheme (a logic of contract) and the traditional systems of mutual aid (a logic of alliance) is highlighted, and the impact of the hospital insurance scheme on social inequalities is discussed. The implications of this study on the management of the Bwamanda health insurance scheme are reviewed, and this study may be useful to health managers working in similar contexts.

keywords voluntary health insurance, community financing, social perception, focus groups, Democratic Republic of Congo

correspondence Bart Criel, Department of Public Health, Institute of Tropical Medicine, Nationalestraat 155, 2000 Antwerpen, Belgium

Introduction

The term health insurance, as used in this paper, does not refer to health insurance schemes managed by the state within a national social security system. In sub-Saharan African countries such centralised systems, based on compulsory contributions from employers and/or employees, have serious limitations (Gruat 1990; Vogel 1990). In a context in which only a small fraction of the population is earning a wage, the coverage of such systems is low, particularly in rural areas. In this paper health insurance refers to systems established and managed at the peripheral level, for example by the executive team of a health district. However, the principle on which these local systems are based is still that of an insurance system covering health-related risks, financed by voluntary prepayment of contributions by the population. The introduction of such decentralised insurance schemes is an element of the community financing movement of health care at district level. ‘Community-based’ health insurance is a method of financing health care which is attracting increasing interest, although so far there have been few experiments in this field (World Health Organization 1993).

An insurance scheme covering the cost of hospital care has been operating for more than 10 years in the health district or zone of Bwamanda in north-western Democratic Republic of Congo (former Zaire). This system of financing health care, known as the mutuelle, has reached a satisfactory level in terms of financial and technical performance and has achieved the objectives set by the managers of the district health care system when they introduced the scheme in 1986. On the one hand, it has made it possible to generate stable financial resources to ensure the functioning of the hospital, doubling the volume of available resources, so that the Bwamanda hospital has become less dependent on external sources of finance (Criel & Kegels 1997). On the other hand,
this system of financing has significantly improved access to hospital care for patients whose state of health justifies the use of the hospital without compromising the efficiency of its operation (Criel et al. 1997). From this managerial viewpoint the Bwamanda health insurance system is a success, and it supports Ahrin's view that in certain conditions health insurance is a feasible option in sub-Saharan Africa (Ahrin 1995).

But health insurance, whether compulsory or voluntary, is not a socially neutral phenomenon. Rushing (1986) in his analysis of the social functions of health insurance in both modern and traditional societies, suggests that the introduction of such mechanisms may lead to qualitative transformations in terms of social relationships. They may thus exert considerable influence, either positive or negative, on social cohesion and integration in society. As a rule there has been little study of these social repercussions. Health planners tend to consider the financing of health care in general, and the mechanisms of health insurance in particular, from a strictly technical viewpoint, frequently limiting themselves to the study of the financial results of these systems and their consequences on the pattern of use of health services.

This paper seeks to contribute to the investigation of social perceptions of the Bwamanda health insurance system. It may provide useful indications to district health managers considering the implementation of insurance systems in similar environments. To begin with, we shall describe briefly the functioning and the underlying rationale of this financing mechanism, together with the general context within which it was conceived and established. We shall then present in detail the questions studied in our research and our results. This set of data bears on the meanings of the health insurance system, on the motivations of the population to subscribe or not, and on the interactions with the very common practice of mutual aid existing within well-defined social groups. Finally, we shall discuss the operational and management implications of our research.

**Description of the Bwamanda hospital insurance system**

This insurance scheme has been extensively described elsewhere (Criel & Kegels 1997). Briefly, the rural district of Bwamanda in north-western Democratic Republic of Congo is an area of about 3000 km² and had in 1994 a population of around 158000. The great majority of the inhabitants live by subsistence agriculture, and the annual income per inhabitant is estimated at around US$75. The health services are based on a two-tier system: on the one hand a network of 23 health centres distributed throughout the district and on the other a 138-bed referral hospital. The formal owner of this institution is the diocese, but the hospital operates as a first referral hospital for the Bwamanda area, in accordance with the national directives on health policy. In spite of Congo’s current social, economic and political crisis this system of health care continues to function remarkably well.

The development of health services in Bwamanda was one element in a wider project for integrated development known as the Centre de Développement Intégral (CDI) Bwamanda. The CDI Bwamanda is a Congolese nongovernmental organization, established in the late 1960s, which has progressively developed a series of activities in sectors other than health care, for example in agriculture, transport and communications infrastructure, primary education and rural development. The Catholic mission, which has been established in Bwamanda for several decades, was, at least initially, the structure around which the project’s activities were developed. Throughout its existence the CDI has enjoyed considerable external support, in terms of both financial and human resources. For example, under the arrangements for Belgian bilateral aid a team of 2–3 Belgian doctors was maintained in the Bwamanda district from the late 1960s to the beginning of 1990. In addition three expatriate nurses (Sisters of the Medical Mission) worked in Bwamanda hospital until the mid-nineties. From the early eighties a number of Congolese doctors joined the district executive team. In June 1990 termination of the co-operation between Zaire and Belgium ended the presence of expatriate doctors.

The subsidies provided by the Zairian government were always very limited and stopped completely in the mid-eighties. The CDI Bwamanda thus developed in an environment in which the state was absent. This led those responsible for running the project, and the managers of the health care system in particular, to develop on a more or less autonomous basis the various social and economic services provided for the population of Bwamanda. Thus the CDI Bwamanda progressively took over a considerable share of the responsibilities properly falling on public authorities.

Towards the mid-eighties inflation and the progressive reduction in external subsidies made it increasingly difficult for the Bwamanda hospital to meet the cost of providing hospital care. The flat-rate payments to the hospital were increased several times a year. Moreover the financial accessibility of hospital care, at least at certain times of the year, was becoming more and more of a problem for the poor rural population of Bwamanda. Patients referred by a health centre sometimes arrived at the hospital only after some days – a delay occasioned by the need to find the money required in case hospitalization proved necessary. The challenge, which then faced the executive team, was to establish a system for financing hospital care which facilitated access to care while safeguarding the financial viability of the hospital.
With this in mind, the executive team led by a Belgian medical officer initiated discussions in the CDI on various possible strategies for financing hospital care. An insurance system was considered the most promising alternative in terms of political and social acceptability, people’s ability to pay, potential for risk-sharing and effects on the financial viability of the hospital (Moens 1990). The executive team then continued the discussions with the health centre nurses at one of the regular working meetings held under the arrangements for the continuous training of the nurses. As a result of these discussions a consensus was reached on the features of the insurance system, as shown in Table 1.

This financing system was presented to representatives of the various development committees, who agreed to it in 1986. The first subscription period (the time for subscribing) was March 1986. The yearly individual premium was set by the executive team at 20 Zaire (the currency prevailing at that time), a sum then equivalent to about one-third of a US dollar. This sum – less than half the payment per episode of illness at health centre level – was considered by the district team to be within the reach of the population. Proof of payment was provided by a stamp on the back of the file, which was opened for each family and held at the health centre. A similar stamp was affixed to the individual ‘census card’ or, for children under five, to their well baby clinic record. In addition, a register of subscribers was established in each health area in which the health centre nurse recorded the names of all that joined the scheme. The registers, and the money collected, were transmitted to the district administrator at the end of each subscription period. The funds collected were then paid in to the CDI, which had opened a specific account for the scheme. At the end of the subscription campaign the health centre team received a sum equivalent to one percentage of the funds collected in their area in compensation for the additional work involved.

The local population showed remarkable interest, exceeding all expectations, in this mechanism of payment: in 1986 32,600 people – 28% of the population of the district – had joined within 4 weeks and, in subsequent years, the number of subscribers increased regularly (60,000 in 1987, 80,000 in 1988). The premium was increased each year to compensate for the effects of inflation. Since 1990, a period marked by the total implosion of the Zairian state and by an unprecedented social and economic crisis, the proportion of subscribers has remained around 60–65% of the population, except in 1992 and 1994. The drop in subscriptions in 1992 can be explained in part by ethnic tensions in the Bwamanda region at that time and the 1994 decrease was probably due to a change in the currency (the ancien Zaire being replaced by the new Zaire). Table 2 summarizes the characteristics of the first 10 years of the Bwamanda health insurance system.

Table 1 Features of the insurance system

- Payment in cash of a premium which is the same for all, without regard to age, sex, area of residence or state of health;
- Annual subscription, to be paid at the time when peasants are selling their crops of coffee and soya;
- The family as subscription unit, but with payment of individual premiums;
- Coverage of risks limited to hospital care, with a copayment of 20% of the fee in the event of hospitalization;
- Decentralised collection of premiums by the health centre team at each health centre;
- Simultaneous introduction of the scheme throughout the district, the whole population of the district being taken as the target population (and thus excluding people from other districts);
- Scheme managed by the district executive team.

Table 2 General characteristics of the Bwamanda health insurance scheme

- Genesis within the framework of a ‘development project’ centred on a Catholic mission and active in the region as an economic and social operator for more than 15 years;
- Development in a context of almost total absence of intervention by public authorities;
- Development in a context in which the level of rationalization, functioning and utilization of district health services is markedly higher than the national average;
- Substantial presence of ‘substitute’ expatriate technical personnel, at least in the early years;
- Establishment of a planning process initiated from the district;
- High subscription rates (proportion of families joining) throughout the existence of the scheme, in an environment of grave social and economic crisis;
- Satisfactory operation when measured against precise and pre-established technical objectives.
Research questions

The primary logic of our investigation was managerial. It was hypothesized that the conception of ‘egalitarian’ and ‘universalistic’ solidarity as viewed by the Belgian doctors who largely guided the conception and design of the scheme was not necessarily shared by the local population, and that the population interpreted the insurance scheme in the light of its own experience of traditional mutual aid systems. This may be a source of misunderstandings. We therefore wished to get an insight into the meaning of the insurance scheme to the population in order to identify potential areas of misunderstandings and, eventually, suggest possible ways to overcome them to improve the insurance’s functioning.

The specific questions, which we sought to answer in our study, were as follows:

- After 10 years of operation of the hospital insurance scheme, to what extent do perceptions of this risk-sharing scheme by the organizers on the one hand and the population of the area on the other differ or converge?

- Do the traditional mechanisms of solidarity, usually limited to small groups of population, which are relatively homogeneous in terms of social characteristics, influence perceptions of the insurance scheme?

- What is the value of the mutuelle in the eyes of the population? What are the perceived limitations of this scheme?

- Why do two-thirds of the population of the district subscribe, in a context in which health care in general, and hospital care in particular, are only a relative priority?

- Who within the family decides in favour of subscribing?

- Why does a third of the population of the district never subscribe? From lack of interest and/or inability to pay the premium?

A small-scale investigation previously carried out at the Kada health centre in 1995, 10 km from the hospital, indirectly illustrates the relevance of these questions. The cohort of subscribers to the insurance in this area had remained relatively unchanged over the period 1988–96. The families who subscribed in 1988 (when the subscription rate was about 65%) had continued to do so in the following years when similar subscription rates were achieved (except in 1992 and 1994). This suggested that subscription to the insurance was not a fortuitous event but is a continuing concern of a proportion of the population: the numbers of subscribers and nonsubscribers in 1988 remained approximately the same during the eight following years (see Figure 1).

Methodology

To investigate these various questions, 10 focus groups were organized in Bwamanda district over a period of three weeks in March-April 1996. The focus group method was adopted because of its ability to generate full and detailed information by bringing together a large number of people over a relatively short period. The organization of the focus groups was adapted to the practical constraints related to the specific environment of Bwamanda (poor communication and transport infrastructure, need to involve health personnel in the identification and choice of the participants, etc.). Obviously, it was not possible to be methodologically entirely ‘orthodox’; the discussions nevertheless provided important new insights in the scheme’s perception.

The focus groups were moderated by the head of one of the primary schools of the little town of Bwamanda, a native of the region. The discussions, which took place in the Ngbaka language, were recorded by a nurse of the maternity department of the hospital whose mother tongue was also Ngbaka. He took no part in the discussions and was careful to remain in the background. In addition, one of the authors (B Criel) was present as an observer.

Initially, detailed discussions were held, first with the district executive team and with a sociologist working on the CDI project and then with the local investigators. The methodology of focus groups (Krueger 1988; Kitzinger 1995, Andrien et al. 1993) was presented and explained. Guide questions to be discussed were prepared and translated into Ngbaka. There was a series of seven questions for the focus groups consisting of subscribers to the insurance in 1995 and a separate list of four questions for discussion with nonsubscribers (see Appendixes 1 and 2). One of the questions in each list specifically addressed the issue of traditional mutual aid systems. The first series of questions was pretested with a group of 12 women subscribers living in Bwamanda itself. These preparations took about one week.

Figure 1 Proportion renewals of subscription (%) among the initial 1988 cohort, Kada health centre (1988–96).
The selection of focus groups and of group members was done in two stages. First, the villages were selected. The population of Bwamanda district lies within two different local government areas. Five villages were chosen in the Lua area around Boto, in the West of the district. This region is more difficult to access and the subscription rate has traditionally been below the district average. The other five villages were in the Mbari area, in the villages of Isabe, Kada, Botela, Mbari and Botuzu with an easier access to the hospital and with higher subscription rates. This was done with the purpose to have a reasonably representative population participating in the different focus groups (Figure 2).

At the second stage, individual group members were selected within each village. The general knowledge of the population by the nurses in charge, and the availability of family files stored at each health centre level, greatly facilitated the identification of those individuals in their community that are member (or not) of the insurance plan. Hence, groups of subscribers and nonsubscribers could be easily identified and constituted. In each case groups of 7–14 adults, relatively homogeneous in terms of age and socio-economic status, were formed. In as much as possible people who did not know each other were selected. Conventionally, indeed, the focus group methodology advocates the recruitment of strangers although this has recently been recognized as not necessary and an overly rigid restriction (Morgan & Kreuger 1993).

Around 100 people took part in the various focus groups, all of whom lived within the Bwamanda district boundaries. Three focus groups were held with nonsubscribers and five consisted of women only. The moderator and the health centre nurses contacted the participants a few days before the date fixed for the conduct of the group and each participant was individually briefed on the aim of the focus groups.

On average the discussions lasted between 1 and 2 hours. They were held in a public building of some kind (a school classroom or the local church), while preserving a certain intimacy. Following the discussions a portion of rice was distributed to all the participants. After each session the organizers and researchers systematically discussed the record of the meeting. A preliminary analysis of the material was presented to the district executive team a few days after the organization of the last focus group. Later, the material was further analysed in Antwerp. Three researchers independently analysed the full transcripts of all 10 focus groups to achieve analyst triangulation (Patton 1990). A cross-case analysis was conducted with a focus on the initial hypotheses—i.e. the presumed different conceptions of solidarity, and the interpretation of the insurance scheme in the light of people’s own experience of traditional mutual aid arrangements—without ignoring other issues that emerged from the discussions.

**Results**

In general, the participants showed great interest in this opportunity to discuss the insurance scheme. Their attitude to the functioning of this system of financing hospital care was critical; sometimes even aggressive and demanding. The name of the CDI cropped up very frequently in the discussions, since for the population of the district the health services in general and the insurance scheme in particular are regularly identified with the CDI project. Examples from other social services run by the CDI were sometimes used to support an argument in the discussion of the insurance scheme.

Why do people subscribe or not subscribe?

All the focus groups, both of subscribers and nonsubscribers,
brought out the fact that the insurance scheme is recognized and appreciated for its effectiveness and that it must continue to operate. The quasi-monopoly position of Bwamanda hospital in the region is also recognized, since for the majority of the inhabitants of the district there is no alternative. This was made explicit by the comment that ‘we must join the scheme: we have no choice’.

The benefits of the insurance were expressed in most groups in terms of financial advantages: ‘the mutuelle means that we need to pay less at the hospital,’ while the existing mechanisms of mutual aid at all levels of the Bwamanda community are there ‘for happiness and enjoyment’. The act of subscribing to the scheme is also expressed in terms of a financial transaction: mi-futa in Ngbaka, meaning I have paid. People frequently think of the insurance as a ‘pass’ or ‘travel warrant’ giving access to cheaper health care. Documents of this kind are required for the purposes of travel and transport in the region, and the authorities were very ready to impose penalties, on an arbitrary basis, on people who could not produce them.

The decision to subscribe is usually taken by the housewife – a fact frequently acknowledged in the groups consisting of men – even if they sometimes apply to their husband to find the necessary money. The decision is largely influenced by earlier personal experience or by the experience of other local people. The period for subscribing is usually in February and March, so that this payment does not compete with another major item of expenditure – the school fees for children, which are due in September. Nevertheless, many groups had reservations about the choice of the subscription period. A question about the respective importance of the health insurance premium and the school fees sometimes received the reply that ‘health comes first, for if you are ill you cannot go to school’.

The reason most frequently cited by nonsubscribers for not joining the insurance scheme was that of lack of money. This did not, however, imply any rejection of the system: far from it. The nonsubscribers would say, for example, ‘We are not refusing to pay, but we can’t afford to’, or ‘The mutuelle must go on, if only for those who can afford to subscribe’. On the other hand, nonsubscribers were sometimes identified by subscribers as wealthy people who wanted to distinguish themselves from the rest of the population by showing that they could easily pay the full fee charged for hospital treatment. Some subscribers referred to the ‘arrogance’ of this category of nonsubscribers.

Solidarity among subscribers

The redistribution effect inherent to an insurance system in which the premiums are independent of such variables as age or sex which might point to differences in state of health (and thus in illness risk) was not explicitly questioned by participants in the focus groups. It is not certain, however, that the planners of the scheme and the population understood this redistribution effect between individuals and families living in different parts of the district in the same way. For the former it was a question of promoting social justice and mutual aid beyond existing personal relations within the community. It is interesting to note that in the focus groups this value was interpreted in essentially Christian terms: ‘God will reward us one day’, or ‘If this money does not benefit us it is an offering to the community’.

Complaints and questions

The discussions also provided an opportunity to the participants to express certain frustrations and questions about the insurance scheme. Thus there were complaints.

The pattern of organization of the insurance

- Criticisms of the subscribing arrangements and of the payment of individual premiums at a flat rate were expressed in the following terms: ‘Why should it be the same premium for everyone, when there are different charges for adults and children at the health centre and the hospital?’ The limitation of subscriptions to a particular period and the requirement to pay the whole premium at the same time (whereas school fees can be paid in instalments) were also criticised. Most people subscribe only at the end of the subscription period, because ‘the money has to be found first’. Figure 3 indicates the numbers of household subscriptions in the 6 week enrolment period in one of the two health centres located in the Bwamanda town. It confirms that a peak is reached towards the end of the enrolment period (data for 1996).

- The coverage of risks only at the second level of care (the hospital) and not at the primary level (the health centre) is perceived as arbitrary, indeed as an injustice: ‘Subscribers pay the same price at the health centre as nonsubscribers’; ‘We don’t understand: the CDI exploits people’, or ‘The alliance between the CDI and the population should not exclude care at the health centre’. The fact that coverage is confined to the narrow field of health care was also mentioned: ‘Why cannot the body of a subscriber who has died in hospital be transported to the village?’;

- The reason for the copayment of 20% at the time of hospitalization, designed to discourage unjustified use of the hospital, is apparently not understood. Some consider it as a failure to meet the commitments of the...
health service: ‘We’ve paid the premium but they want more money at the hospital’; ‘Even if you are a member of the mutuelle you still need money when you’re ill, though you’ve used all your resources to subscribe to the mutuelle’ or ‘If subscribers don’t pay they are refused admission to hospital.’

The relationship between the insurance scheme and its members

- As regards the management of the scheme, the participants in the focus groups complained about their limited involvement in decisions on the premium to be paid by subscribers and the subscription period, which were settled unilaterally by the health service. They also complained about a lack of information about the destination of the funds collected and of the lack of control over their use. During the first years of operation of the hospital insurance the funds were invested in the purchase of drugs in order to counter the effects of inflation. Thus when stocks of drugs at the primary level ran out – an event over which the insurance had no control – this was considered unacceptable and unfair. These feelings of frustration were expressed in a variety of ways: ‘If the money disappears we can’t know’; ‘We have never been shown the mutuelle’s accounts’; ‘In the mutuelle we don’t know one another: if the money is misappropriated the treasurer can’t be punished’; ‘The CDI is having us on, because all the decisions have already been taken’; or ‘The alliance is unilateral and not bilateral’. This feeling of resentment, however, was frequently accompanied by a positive appreciation of the scheme or by constructive suggestions for the operation of the insurance scheme: ‘If the mutuelle runs out of money we could always help’; ‘The mutuelle is a good thing, but it does not belong to us, since we play no part in its management’; or ‘We can’t close down the mutuelle, but its method of operation needs to be changed’.

- The insurance scheme’s lack of ‘clemency’, for example in dealing with nonsubscribers requiring hospital treatment and who in previous years subscribed regularly was mentioned several times. It was also complained that the insurance did not allow credit. It was said, for example that ‘the mutuelle is hard’; or ‘The mutuelle gives no presents: if someone dies on the day he joins the money is not paid back to his family’. This lack of clemency is associated with a lack of confidence: ‘When someone needs to be admitted to hospital urgently the hospital insists on seeing the census card which has been left at home, even though we know its number by heart’; or ‘After 10 years of the alliance couldn’t the CDI allow a year’s grace for those who have subscribed regularly? If you don’t pay your premium for one year you are cut off’.

- The reception of nonsubscribing (poor) patients by the nursing staff of health centres and the hospital and their general attitude, which was sometimes disagreeable or even humiliating, were also commented on. Non-subscribers were regarded as being at fault and were made to feel this: ‘We are called ignorant or stubborn’; ‘They look down on us; we are ashamed to appear at the hospital’; ‘Subscribers are neglected in the hospital in favour of nonsubscribers who have money’; or ‘We have an alliance with the health service, but subscribers are not warmly received’. Many nonsubscribers say that they put pressure on the nurse at their health centre to continue treatment at that level and postpone referral to hospital: ‘We feel bad when we have to go to hospital’.

Relationships between the insurance scheme and ‘endogenous’ mutual aid

Finally the focus groups made it possible to consider briefly the (very variable) methods of operation of existing systems of mutual aid within groups which are relatively homogeneous in terms of social (ethnic, occupational, village, etc.) identity or within community movements. To designate this very diverse group of mutual aid schemes developed by the population – but excluding networks of family solidarity, which are much more binding and more codified – we shall use the terms ‘traditional’ or ‘endogenous’.

Figure 3 Number of subscribing families over time, Bwamanda township health centre (1996) Note: the district administrator visits each health centre, on average, about twice a week for the accounting procedures of the premiums collected. In 1996, the inscription period was initially set at four weeks (the month of March 1996) and visit 11 was at the end of March. Eventually, it was decided to extend this period with 2 weeks (visits 12, 13 and 14 took place in April).
The health insurance scheme is commonly called the
*mutuelle* by the population, who have apparently adopted
this term introduced by the executive team when the system
was launched in 1986. This denomination usually designates
the agencies which run sickness and invalidity insurance in
Belgium. Its transposition to the Bwamanda context reflects
the frame of reference used by the (Belgian) doctors in the
Bwamanda executive team when the insurance scheme was
conceived. The endogenous mechanisms of mutual aid,
however, have a local name: people use the terminology
*dea-na* and *dia-na*, which in Ngbaka mean, respectively, ‘make a
family’ and ‘good family’.

The characteristics of these endogenous systems of mutual
aid were described as follows.

- The levels of contribution to be paid to the mutual aid
  fund are settled in common. The contribution frequently
takes the form of a fixed payment per family, varying
according to ability to pay; sometimes payment can be
made in kind.

- The amounts generated are modest, and are thus
  insufficient to cover high expenditures or expenditures
  concentrated in time: ‘If 10 members fall ill at the same
time the fund will be unable to meet the expense’.

- There is great flexibility in the operation of these
  systems, though the poorest people are excluded. The
  participants in one group said that they were unable to
  pay the weekly subscription of 500 Zaire (then
equivalent to 2 US cents). Moral considerations may also
  come into play in the selection of people desiring to join
  the mutual aid fund: ‘A prostitute can be accepted,
because the group can make an effort to edify her’.

- The organization is on a small scale, with great
  emphasis on social control: ‘In the mutual aid fund they
  all know each other, and if there is any
  misappropriation of funds the treasurer will be required
to make it good and he will be deprived of his post. In
  the mutuelle the members do not know each other’.

- Endogenous systems seldom cover the payment of
  the premium for the insurance (‘It will encourage laziness’).
If it does, it is only after a deliberation process in which
the social behaviour of the potential beneficiary is
examined. The following example was given: ‘If a
subscriber to the mutual aid is imprisoned for adultery
he will not be helped; but a peasant whose fields have
been burned will be’.

- In a case of illness these mechanisms are activated very
  rarely and late. In the case of a death, on the other hand,
  the money is made available immediately: a person who
gives financial aid in such circumstance gains prestige. In
the Ngbaka language the following expressions are used:
*fio kpa tulu* (‘The dead man finds his clothes’) or *fio
kpana* (‘The dead man finds his family’). Several people
expressed disapprobation with these practices: ‘They
are more concerned with the dead than with the
living’.

- Some mutual aid associations require a new member to
  subscribe to the insurance scheme: ‘Otherwise the mutual
  aid fund will have to pay out in the event of illness’.

Discussion

Insurance and mutual aid: a different logic?

As regards the relationship between the population and the
insurance scheme, a remarkable feature is the repeated use of
the idea of ‘alliance’ (expressed by the Ngbaka word *de-nase*,
which means literally ‘wish to form a family’) to designate
what, from the viewpoint of the service, is a form of contract.
A contract is an expression of modern organizations
concerned to achieve precise objectives — in this case the stable
financing of accessible hospital care — as rationally and
efficiently as possible. The contract sets out in explicit terms
the commitments of the insurance to its members and the
objective conditions for becoming a member. The rules are
uniform for all, and are applied in a framework involving
relationships that are impersonal, almost anonymous. An
alliance, on the other hand, is based on a much wider social
logic in which social relationships are more important than
technical performance. Its main objective is to establish and
strengthen privileged links between individuals and families,
which are given material form by a reciprocal exchange of
gifts. The voluntary grouping of people on the basis of social
affinities which is characteristic of the alliance is also found in
the *tontine* system (Rotating Savings and Credit Associations
or ROSCAs in the English literature), based on attitudes of
reciprocity (Lespès 1990).

The analysis of the tension between these two kinds of
systems is not new. Anthropologists for instance studied this
confrontation when comparing the use of money in different
types of medicine. On the one hand there is traditional
medicine where the use and meaning of money paid is very
much socially loaded, and on the other there is modern
‘biomedicine’ with a strictly functional and utilitarian use of
money (van der Geest 1985, 1997; Benoist 1993).

It appears that most of the frustrations expressed about the
insurance scheme are associated with features which one is
entitled to expect from an alliance but which are not
guaranteed by a contract:

- An alliance has wide scope both in good times and in
  bad, while the contract is limited, in this case to illness,
  and indeed to hospitalization.
The privileged alliance of social bonds contrasts with the impersonal and anonymous character of modern organizational logic. Fassin considers these mutual aid associations less as social insurance schemes than as 'a place of meeting and exchange which promotes the crystallization of friendly relationships which may one day be mobilized for the purpose of mutual aid' (Fassin 1992).

The alliance is prepared and negotiated, while the contract is presented on a 'take it or leave it' basis.

The alliance leaves room for feelings which may allow more flexibility of decision (e.g. an appeal for 'clemency'), in contrast to the rigidity and strict observance of regulations applying to all without exception which is characteristic of the contract.

Exchange and reciprocity are predominant features of the alliance, whereas in an insurance scheme the participant may receive nothing in return.

In the alliance, an exchange is set up between families and other homogeneous social groups, while a contract is based on the individual as a unit.

Table 3 presents the main characteristics of these two systems. We acknowledge the limitation of such a comparative table that simplifies and dichotomises, probably excessively, the features of either logic. In reality, these systems obviously interact and adopt elements from each other. Lespès, in his analysis of tontine systems in Africa, considers that the quantitative extension and qualitative diversification of these systems give rise to new practices. He thus disagrees with a too strict dualism where traditional forms of organization are opposed to modern ones. He notes, for example, that large tontines must necessarily adopt rules that go beyond the traditional form and make the tontine an institution of distinctive type (Lespès 1990). There also is interpenetration between the two systems in the interaction of savers' tontines with the official banking system, where there is a dialectic between informality and regulation. Thus a bank, in granting a loan to a member of a tontine will sometimes ask for security from the other members as a whole. In Bwamanda a number of mutual aid associations have also adopted regulations which are then fixed in written texts.

**Interaction between the insurance scheme and mutual aid schemes**

When we consider the establishment of health insurance schemes in Europe, for example, we observe that these systems had their origins in the mutual aid associations that existed towards the end of the 19th century (like for instance the mutualités in the case of Belgium, or the Krankenkassen...
in Germany). These structures were not confined to health but covered a whole series of risks, of which health care was by no means the most important. The associations were later incorporated into state-run programs. When they did not exist their formation was encouraged (Rubinow 1934).

Similarly, the first British national health insurance scheme of 1911 was based on existing mutual aid associations (‘friendly societies’), which were integrated into the national system (Gilbert 1960).

At the same time this transformation into national programs led to qualitative changes in the social relationships previously characteristic of these associations. The relationships became more formal, taking on the character of contractual obligations. Increasingly the contributions were viewed as a premium to be paid to an anonymous institution rather than a conscious and voluntary contribution to a common project. The gain in effectiveness was accompanied by a loss in the quality of the relationships between the actors involved (Rushing 1986; de Swaan 1988).

The Bwamanda hospital insurance scheme did not graft on the endogenous local dynamic of mutual aid1. In that respect, we tend to have a different view from the one suggested by other researchers who studied the Bwamanda insurance system (Ilunga et al. 1995). The Bwamanda scheme was, from the start, implemented on a large scale (i.e. the entire district). Its conception and design were guided by the health professional’s (legitimate) technical concerns and were not based on a preliminary inquiry into the modalities of operation of existing traditional mutual aid systems. This obviously does not exclude the possibility that the population gradually appropriates various elements of the mutuelle. The two systems coexist and influence each other reciprocally. We have seen that the notion of alliance characteristic of the mutual aid logic influences the population’s perceptions of the insurance. Conversely, the logic of mutual aid has adapted to the transformations of society. In many respects they too have integrated elements of the organizational logic of the contract (subscription in money terms, identical for all, even though it is negotiated in advance; adoption of regulations for the running of the scheme; prosecution for misappropriation of funds, etc.).

In Bwamanda the insurance has introduced a new and important element into the logic of mutual aid, for it was found that a number of mutual aid schemes accept as members only subscribers to the insurance. The costs of hospital treatment for a nonsubscriber to the insurance are perceived as too high a risk for the financial viability of the endogenous system. This influence of one logic on the other, however, seems unidirectional: the method of operation of the insurance has not been influenced in the course of its brief history by any features of the much older logic of mutual aid – which implicitly is a cause for criticism.

The insurance and social inequalities

Finally it may be queried to what extent the Bwamanda insurance – which works well and is well managed and effective – has aggravated social inequalities? Mutual aid schemes also provide for the exclusion of members, but in principle exclusion is based on social or moral grounds, though it seems increasingly to be linked with the ability to pay. Exclusion from the insurance, on the other hand, is ‘voluntary’: no one is excluded on the basis of social characteristics or moral image. The Bwamanda insurance was founded on a view of a well-knit and homogeneous society – a conception that has turned out to be inexact. Economic disparities presently are, or are becoming, greater than was thought; though the results of socio-economic surveys conducted in Bwamanda in 1988 and 1990 (Moens 1990; Ilunga 1992) showed few differences between subscribers and nonsubscribers.

In general, nonsubscribers fall into two groups: the ‘rich’ who are able to meet the cost of hospitalization and the ‘very poor’ that can pay neither insurance premium nor mutual aid fund contribution. The present social fabric is not always or everywhere as solid as the health service thinks. Thus the elderly women who took part in the Botuzu focus group are perceived as too high a risk for the financial viability of the

1This interpretation is largely influenced by the personal experience of BC, who worked as a general medical officer and a district medical officer in Bwamanda district in the period September 1986–July 1990.

Conclusion

The International Labour Organization (ILO) acknowledged that the organization of social security systems for the self-
employed populations in sub-Saharan Africa needs a design dramatically different from what exists for wage earners in the formal sector (Mouton & Gruat 1988). One of the options the ILO proposes is to explore the possibility of reinforcing, enlarging and formalising existing traditional systems. However, caution seems appropriate since these systems are based on a different logic. Vuarin (1993) analysed the pros and cons of ‘scaling-up’ the dynamic of mutual aid at the occasion of baptisms in Bamako, Mali, so as to transform it into some kind of baptism fund. His negative arguments clearly outweigh the positive one’s. Our study tends to support the doubts expressed by Vuarin in that a tension exists between the two types of systems (insurance and endogenous mutual aid). Objectives and expectations diverge, sometimes even conflict, and the social acceptability and technical feasibility of attempts to expand and institutionalise the logic of alliance are questionable.

A certain number of managerial implications can, however, be identified from our study. Taking into consideration the expectations and perceptions of the population – partly shaped by their own experience of endogenous mutual aid schemes – there is room for the district team to improve the acceptability and the functioning of the insurance scheme. The purpose of this investigation was to provide the District Health Team with the necessary elements to plan action. But possible reshaping of the insurance scheme—necessary from our point of view—can only be the result of (future) discussions between the Bwamanda District Health Team and the population’s representatives.

The insurance scheme is effective from a technical perspective precisely because it is rigourously managed. Organizing a system of this kind is, and is bound to be, a complex and perilous operation – all the more so in Congo, plagued for several years by galloping inflation and great difficulty in safeguarding the capital generated by contributions from subscribing families. Moreover, the relatively large scale on which the scheme has developed is necessary to enable a sufficient pooling of resources. The nature of the risks covered – hospital care – makes it necessary to mobilize sufficient resources to cover the risk of hospitalization for the subscribers. The decision to limit the coverage of risks to hospitalization and exclude care at health centre level thus seems legitimate from the technical point of view, since it is at the hospital level that the financial barrier to access is greatest. At the health centre level the endogenous systems of mutual aid could easily operate, in view of the relatively small expenditure involved. Although minor incidents present no particular problems, mutual aid associations (Carrin 1988) cannot provide satisfactory insurance against major, but less frequent, catastrophes. The popular demand for the cost of primary-level health care to be included in the coverage of risks is perhaps an expression of the expectation of greater reciprocity rather than a demand put forward because of a problem of financial accessibility at this level of care. The use of the health centre being a much more frequent event than the use of the hospital, subscribers would more easily perceive a ‘return’ on their investment; for reciprocity implies that the frequency of the occurrence of the event insured against must be sufficiently high (Debuisson 1996).

The need to achieve economies of scale, however, increases the ‘distance’ between the managers of the system and the potential beneficiaries. This is well illustrated by current experience in most state-run health insurance schemes in industrialised countries. In Bwamanda the extreme of management rigour would lead to regarding every patient as a potential defrauder trying to cheat the health service, or to measuring the success of the insurance system exclusively in terms of coverage achieved, disregarding the questions and the social transformations to which it gives rise. The Bwamanda hospital insurance scheme has become progressively institutionalised as a result of the evident success of its early years: the logic of the health service appears to have concentrated on an ambition to achieve the highest possible number of subscribers. The staff of the health service seem to have adopted an attitude in which nonsubscribers are regarded as guilty and are discriminated against, although their failure to subscribe is often due to genuine financial constraints and not to lack of interest. The fact that the health centre team has a financial interest in getting as many people as possible to subscribe to the scheme may have influenced this attitude. In this sense it is perhaps preferable to envisage fixed rates of pay for health centre staff: a measure which has the advantage of not discriminating against the staff of health centres in economically disadvantaged health areas.

The need for rigour does not mean that there is no case for changing the attitude of the health service. We think it is possible, and indeed indispensable, to achieve greater involvement of the population in the management of the insurance scheme, in spite of the complexity of the system and the highly technical nature of some of the decisions to be taken. Further involvement of the population in the management of the scheme does not, however, mean that all decisions should in future be taken by the population: such an attitude would not only risk compromising the success of the scheme but would also mean that the health service was abdicating its responsibilities. A failure to understand all the technical details does not necessarily mean that people would challenge management rigour. Care should be taken at the outset to give adequate explanations; for the view expressed in many focus groups that ‘the mutuelle is a good thing, but …’ indicates clearly the stock of goodwill on which the health service can build. The fact that the scheme was developed at district level ought, on the face of it, to facilitate
the necessary dialogue: the social nearness of the district health services and their situation at the junction between top-down planning and bottom-up planning are considerable advantages which a system managed from the central levels of the health system does not offer.

The organization of a more structured dialogue with the population cannot be delegated entirely to the health centre nurses: input from the executive team is necessary if the potential of this system of insurance as an instrument of community participation is to be realised. Thus attention should be given to the supervision of health centres in order to improve the quality of relationships between the health services and the population. What would be the benefit of improving the financial accessibility of hospital care if the reception and the psychological accessibility of primary-level care for the poorest, which form a high proportion of nonsubscribers, are unsatisfactory?

A common management structure in which discussion and agreement could take place could be established. This would provide a forum for discussing a manual of policies and procedures, mechanisms for exempting the poorest members of the community from the payment of contributions, or alternative means of organizing the subscription process. Clearly such an improvement in communication involves some expenditure of time and may indeed make management still more complex. In our view, however, there is no alternative if the Bwamanda health service wants the insurance plan to be more than a mere administrative instrument and the inhabitants of the district to become more than mere consumers of care.

The conflict between the need to achieve economies of scale in order to increase solidarity on the one hand and the fact that this extended solidarity involves becoming more remote from interpersonal relationships on the other is not unchangeable. The conflict can be resolved ‘if we bear in mind that there are stages in the build-up of a system of solidarity when the apprenticeship of the organization is under way and confidence develops’ (Demoulin & Kaddar 1993). The persisting interest of the population suggests that it is not too late in Bwamanda to rebuild the foundations of the insurance scheme in partnership with the population.

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References

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Appendix 1

Subjects for discussion in focus groups (subscribers)

1. Nowadays times are very difficult: health care is only one of people’s many concerns (finding food, paying school fees, paying for clothing, looking for water and wood, etc.) And admission to hospital is only a potential risk and not a certainty. Yet many people subscribe to the mutuelle and do it of their own free will. What do you think about this?

2. Who takes the decision on subscribing (the mother, the father, the village headman, one or more people)? How is this kind of decision taken? When? Can you tell us about this, please? We have also observed that people often subscribe only at the end of the period for subscribing. What do you think about this?

3. Sometimes families can’t subscribe to the mutuelle because they haven’t the money. What do you think about this? How do they manage?

4. Within the community there are mechanisms for mutual aid at the level of the family, the group, the clan. They operate on the occasion of catastrophic events either medical or nonmedical (for example a death or an accident). In what way are these mechanisms different from the mutuelle? And are these mechanisms unable to cover the cost of hospital treatment? Why must there be a mutuelle as well?

5. If a subscriber to the mutuelle does not receive hospital treatment but someone else does, then the first subscriber is helping to pay for the hospital treatment of the other. The other person may belong to the same family or the same village, but he may also be from another part of Bwamanda health area. What do you think about this?

6. Everyone who subscribes to the mutuelle, whether ‘rich’ or ‘poor’, pays the same premium, but not everyone can meet the cost equally well. And when subscribers are admitted to hospital they all have the same deduction from the hospital charge (paying only 20%). But some of them have greater expenses than others: for example people coming from a distance have to pay more for transport, food, etc., and they won’t always have relations in Bwamanda. What do you think about this?

7. Some people who are subscribers to the mutuelle will perhaps go more readily to the hospital for health problems which could be dealt with at the health centre or even at home. What do you think about this? How can it be limited?

Appendix 2

Subjects for discussion in focus groups (nonsubscribers)

1. Nowadays times are very difficult: health care is only one of people’s many concerns (finding food, paying school fees, paying for clothing, looking for water and wood, etc.) And admission to hospital is only a potential risk and not a certainty. Yet many people subscribe to the mutuelle and do it of their own free will. What do you think about this?

2. You have decided not to subscribe to the mutuelle. How is this decision taken? When? By whom (the mother, the
father, the village headman, one or more people)? Can you tell us about this, please?

3. If some families don’t subscribe, it is perhaps because they are short of money, or perhaps because they think the mutuelle is of no use to them. What do you think about this? How do they manage if someone falls ill?

4. Within the community there are mechanisms for mutual aid at the level of the family, the group, the clan. They operate on the occasion of catastrophic events either medical or nonmedical (for example a death or an accident). In what way are these mechanisms different from the mutuelle? And are these mechanisms unable to cover the cost of hospital treatment? Why must there be a mutuelle as well?