Original Research Article

Management of a Mutual Health Organization on the accessibility of members to medical care

ABSTRACT

Introduction: The management of a mutual health insurance company presents many challenges. The implementation of effective strategies is essential for its proper functioning. The Bishop Grison Centre and the Saliboko Primary were the subject of this investigation, which aimed to identify the major management problems of mutual health insurance that prevent it from functioning properly, to determine the consequences of the dysfunction of mutual health insurance on members' access to care and to identify strategies to be put in place for good medical care thanks to the mutual health insurance.

Methodology: We opted for a descriptive method with a cross-sectional focus which involved 50 member organisations of the two mutual health organisations studied, selected according to the LYNCH formula, and two key informants. The interview is the technique that enabled us to collect the data.

Results: With regard to the problems related to the management of the Mutual Health Organisations, 46% of the respondents made a judgement on the low income, 38% of the subjects mentioned the poverty that characterises the leaders of the Mutual Health Organisation and 58% of the subjects stated that the management is done within the institutions. In addition, 54% of respondents said that bills are paid by the head of the Mutual Health Organisation, characterised by mistrust (48%), refusal to contribute is linked to the poor access to medical care of members (64%) and 44% over-billing by the health care provider is the main reason for the dysfunction of the Mutual Health Organisation in terms of access to care. As strategies to be put in place for better management of the Mutual Health Organisation, 64% of respondents proposed a re-explanation of the rationale for the Mutual Health Organisation and 22% wanted recourse to donors.

Conclusion: The chaotic and non-transparent management of Mutual Health Organisations does not favour accessibility to health care for their members. This situation deserves to be treated with great consideration in order to promote the accessibility of the population to health care. Thus, the unfailing support of the government is indispensable.

Key words: Management, Mutual Health Organisation, Accessibility, Medical care.

UNDER PEER REVIEW

1. INTRODUCTION

The managerial management of a company and the issues at stake in its human resources strategy are extremely dependent on the economic context of its activity and the changes that it records [1].

Achieving universal health coverage (UHC) requires, among other things, the development of equitable and efficient health care financing mechanisms [2]. Maotela, et al [3] identify three main groups of financing sources: government, health insurance (voluntary or mandatory) and direct payment by households. Funds are raised through taxes, contributions, direct payment for care, donations, etc.

Any mutual organisation must be able to cover risks, both current and exceptional, in order to fulfil its commitments to its members, whatever the circumstances. Mutual health organisations are the leading private player in preventive health care. They set up prevention programmes with the aim of delaying the onset or aggravation of certain health problems: prevention of cardiovascular risks, memory workshops, nutrition, etc. [4, 5].

Third-party payment contributes to better access to care for members by removing the financial obstacle of having to pay in advance. In the context of the generalisation of third-party payment, mutual health insurance companies have developed a joint service with other complementary health insurance companies. The aim is to allow their members to benefit from third-party payment of the part reimbursed by the mutual insurance company [6].

In France, about 81% of the contributions collected by mutual health insurance companies in the framework of health coverage contracts are redistributed to members in the form of reimbursements for care (medical consultations, hospitalisation, etc.) and equipment (glasses, hearing aids, etc.) [7].

In Africa, this participatory strategy involves the development, on the one hand, of community health mutuals (autonomous, non-profit, voluntary and supportive organisations based on members' contributions) [8] and, on the other hand, of management committees for primary health centres. Indeed, a key characteristic of these mutuals is that "the community is involved in the conduct of its establishment and management" [9].

However, despite the momentum observed in the development of mutualist systems nearly three decades ago [10,11], numerous studies have highlighted the difficulties encountered in the effective implementation of user participation, in particular the low contributory capacity of the population, resulting in a low membership rate and very limited premiums; the very unequal consideration of beneficiaries' needs (variability of the care covered, insufficient quality of care, tensions between mutual schemes and health service providers); limited benefits for the poorest, who are not involved; the

UNDER PEER REVIEW

voluntary nature of membership and the amateurish nature of management [12,13,14,15].

The financing of health care has always been a major concern for people. Even in traditional Africa, the remuneration given to health care providers was relatively important. It is simply well organised now with the development of Western medicine in Africa. It is much more expensive with standard payment mechanisms that obey economic laws rather than social considerations. Thus the amount to be paid depends on the type of care and its cost and not on the user's ability to pay. There is also a tendency to apply to it the basic principles of the market economy which sets the rules of the exchange process. There are three main actors involved: the provider, the user and the payer [16, 17].

The progressive development of modern medicine in African countries, combined with the increasing demand for modern quality health care, has highlighted all the deficiencies linked to the lack of effective health coverage in these countries. The breakdown of traditional social structures such as clans, the group or the extended family, which constituted the space where all individual difficulties, including economic difficulties, of access to expensive care were managed, aggravated the situation [18].

In most African states, governments do not have the means and in any case cannot guarantee health to all at all times. The poor citizen cannot take care of himself. The traditional mechanisms of solidarity within groups cannot provide for everyone or no longer work. Other modern, transparent mechanisms must be found that engage the responsibility of each individual. This partly explains the enthusiasm with which poor people have jumped on mutual health insurance [19].

Mutual health insurance is nowadays an appropriate response to the dilemma of the exclusion of the poor from quality health care services. It is essential in supporting this explosive movement in the poorest strata to study all the factors likely to help such an undertaking succeed. In this context, it will be necessary to progressively identify the positive aspects to be magnified in order to encourage their development and also the negative aspects to be controlled early on in order to increase their effectiveness and success [20,21].

During our observation of the Saliboko Primary School and the Bishop Grison Centre Health Mutual, we raised the following respective problems:

At the level of the Saliboko Mutual Health Organisation, the following problems emerged: lack of understanding of how a mutual health organisation works, members often confuse an NGO with an NGDO (they believe that there is a subsidy from a donor, from which members no longer contribute), conflict of roles between the school management committee and the Mutual Health Organisation; it is the same team that manages the school and the mutual health organisation at the same time

UNDER PEER REVIEW

The evidence shows that financing arrangements that remove barriers to access to quality basic care for the whole population mutualise the health risk better than those based on direct payment. Pooling resources through a robust health system not only allows for a better distribution of risk but also reduces catastrophic spending and sometimes subsidises access to care for the most vulnerable.

On the other hand, at the Monseigneur Grison Centre, there was a problem linked to the distrust that arose between the Mutuelle de Santé and the support structure, because the mutualists thought that their money was managed by the support structure.

In view of the above, some concerns deserve to be clarified: What are the major management problems encountered by the Mutuelles de Santé of the Bishop Grison Centre Health Mutual and the Saliboko Primairy School in Kisangani? Do the difficulties encountered have consequences on the accessibility of health care for the members of these mutual health insurance schemes? What are the strategies adopted by these Mutual Health Organisations for better management?

Specifically, the study aims to identify the major management problems of mutual health insurance which prevent the smooth functioning of the mutual health insurance schemes concerned by the survey; determine the consequences of this dysfunction on the accessibility to health care of the members of the said mutual health insurance schemes and identify strategies to be put in place for better management.

2. METHODOLOGY

2.1 Field of research

The study was carried out simultaneously in two different sites, namely the Bishop Grison Centre Health Mutual and the Saliboko Primairy School, each of which has a mutual health insurance scheme, all of which are located in Kisangani, in the Communes of Makiso and Tshopo respectively, in the Democratic Republic of Congo.

2.2 Study population

The study population is made up of the total number of members of the two Mutuelles de Santé under study, i.e., the Bishop Grison Centre Health Mutual and the Saliboko Primairy School, made up of titular family members and dependents, whose total number is 159 members, among whom we identified 50 titular families.

Thus, the target population of this study is made up of 50 titular family members, of which 30 are from the Centre Monseigneur Grison and 20 from Saliboko Primary School.

2.3 Sampling

2.3.1 Sample size

UNDER PEER REVIEW

We used the LYNCH formula to determine the sample size, since the prevalence is unknown, so we consider 50%.

$$n = \frac{NZ^2 \; x \; p \; x \; q}{Nd^2 + Z^2 \; x \; p \; x \; q}$$

Legend :

- n : Sample size ;
- N: Study population;
- q: constant for error reduction (1-p);
- p: is 50% because prevalence is unknown;
- Z: value of standard variation 1.96 ;
- d: margin of error 0.05.

Based on LYNCH's formula, n = 44; plus 4 key informants (four health workers from contracted facilities) and 2 managers respectively.

2.3.2 Sampling technique

To select the study sample, we used non-probability sampling of the occasional type, given that only the regular members of the families available at the Bishop Grison Centre Health Mutual and/or the Saliboko Primary School participated in this study.

2.3.3 Inclusion and non-inclusion criteria

The random selection criterion allowed access to the sample. The aim was to include one part of the population and exclude another in an unbiased manner.

1) Inclusion criteria

To be selected for the survey, it was necessary to have fulfilled certain conditions; firstly, to be a member of the Bishop Grison Centre Health Mutual or of the Saliboko Primairy School regularly registered; secondly, to be a full member as a family representative; and finally, it was necessary to have used the health care services offered by the Mutuelles du Centre Monseigneur Grison and/or the Ecole Primaire Saliboko as well as by the contractual structure at least twice.

2) Criteria for non-inclusion

Excluded were those who were non-members and those who had never used the services of the Bishop Grison Centre Health Mutual or The Saliboko Primary School Mutual health insurance.

2.4 Type of study

The design is descriptive of the cross-sectional type based on the questionnaire. It is a perception survey among users of health services affiliated to the Mutual Health

UNDER PEER REVIEW

Organisation. The study was carried out at the Bishop Grison Centre Health Mutual and the Saliboko Primary School from 1 January to 31 December 2021.

It is cross-sectional as it will be undertaken during a specific period of the year 2021 and in space (Bishop Grison Centre Health Mutual and Saliboko Primary School). This study focuses on the quantitative and qualitative approach, as it will use quantitative data with the survey questionnaire as a tool and non-quantitative data with the interview guide as a tool.

2.5 Data collection method, technique and tools

2.5.1 Data collection method

We used both quantitative and qualitative methods to collect numerical and non-quantifiable data such as the opinions of key informants on the accessibility of health care for members of the Bishop Grison Centre Health Mutual and the Saliboko Primary School.

2.5.2 Data collection technique

2.5.2.1 Unstructured interview technique

This technique allowed us to engage in a verbal exchange with key informants (two managers of the Mutuelles de santé of the Bishop Grison Centre Health Mutual and/or the Saliboko Primary School and four health workers from contractual health structures) in order to collect information from them.

2.5.2.2 Questionnaire technique

This technique was more useful to us because it allowed us to go into the field in the study locations to collect the necessary information from the target population.

2.5.2.3 Data collection instrument

The instrument that allowed us to collect quantitative and qualitative data was the semi-structured survey questionnaire, which is the type of questionnaire that contains part open-ended and part closed-ended questions but also an interview guide for the opinions of key informants.

2.6 Data processing and analysis

We entered the quantitative data into SPSS software, version 20. This software allowed us to carry out the coding for statistical analysis of the data. These data are then put into frequency tables for clear presentation and interpretation.

2.7 Ethical considerations

Research ethics requires that there be free and informed consent from the participants, but that the anonymity of the statements be guaranteed. To this end, the

UNDER PEER REVIEW

purpose of the study was explained to the respondents beforehand to enable them to give their free and voluntary consent. The administration of the questionnaire was individualised and the respondent was free to choose when to answer the questions.

2.8 Limitations of the study

We did not have access to information on the amounts of contributions paid by the members in order to get an effective idea of the financial difficulties faced by mutual health insurance companies in their daily management.

3. RESULTS

3.1 Data relating to the identification of subjects

Table 1: Distribution of study subjects according to identification elements (*N=50*)

Socio-demographic information	f	%
Age		
20 – 35 years	17	34
36 – 51 years	19	38
52 years and plus	14	28
Sex		
Male	33	66
Female	17	34
Education level		
Primary	0	0
Secondary	45	90
Higher and university	5	10
Duration of membership in the Mutual Health Organization		
0 – 5 years	40	80
6 – 10 years	10	20

The table shows that 19 (38%) respondents were between 36 and 51 years of age, the majority of whom were men (66%) with secondary education (90%) and the vast majority of whom, i.e. 80%, had been in the mutual health insurance scheme for no more than five years.

3.2 Problems related to the management of the Mutual Health Organisation

Table 2: Distribution of respondents according to problems related to the management of the Mutual health insurance scheme (*N=50*)

Problems related to the management of the Mutual health	f	%
Factors for low membership fees		

UNDER PEER REVIEW

Low income of members	27	54
Care not proportional to the amount of the contribution	10	20
Lack of transparency in the management of mutuals	13	26
Factors associated with financial mismanagement		
Desire to get rich quick	22	44
Unwillingness of managers	19	38
Desire to make members suffer	9	18
Management of members by the Mutuelle de Santé		
Management is done through their respective institutions	28	56
Management is done through associations	16	32
Management by partner NGOs	2	4
Management is done within the families of the members	4	8

The data in Table 2 indicate that 54% of respondents justified the absence of member contributions by the low income of the member-members, the lack of transparency in the management of mutual health insurance (26%) and the non-proportionality of care in relation to the amount of the contribution (20%). Furthermore, it should be noted that 44% of respondents had indicated the desire to get rich quickly by the managers of mutual health insurance companies, the unwillingness of the managers (38%) and the desire to make member members suffer (18%), as the main reasons for the poor management of the finances of mutual health insurance companies.

Finally, 56% of the respondents indicated that the management of the members of the Mutual Health Organisation is done within the respective institutions, while 32% indicated that the management is done within the associations.

3.3 Consequences on accessibility to health care for members of the mutuals

Table 3: Distribution of study subjects according to consequences on accessibility to health care for mutual health insurance members (*N=50*)

Consequences on the accessibility of health care for mutual insurance members	f	%
Payment of health care bills		
By the head of the mutual insurance company	27	54
Through a medical adviser	9	18
Individually	7	14
Collectively	7	14
Major difficulties in accessing care		
Mistrust of managers	24	48
Refusal of a hearing by managers	18	36
Managers' demand for tips	8	16

UNDER PEER REVIEW

Consequences of members not contributing		
No access to medical care	32	64
Bankruptcy of the Mutual Health Organisation	11	22
Exclusion from the mutual insurance company	7	14
Reasons for dysfunction in mutual health insurance		
Overcharging for services by health care providers	22	44
Poor management of finances	16	32
Lack of transparency in the management of the Mutual Health Organisation	12	24

Table 3 shows that 54% of the respondents considered that the bills for health care were paid by the head of the mutual health insurance fund.

With regard to the major difficulties encountered prior to medical care in contractual health structures, 48% of respondents recognised the mistrust of managers of mutual health insurance companies, the refusal of audience (36%) and the demand for tips by managers (16%).

With regard to the consequences of members not contributing, the analysis of this table shows that 64% of respondents stated that members not contributing leads to inaccessibility to medical care.

Finally, the data recorded in this table show that 44% of respondents stated that overcharging for services by health care providers is the main reason for the dysfunction of mutual health insurance schemes, while 32% of respondents spoke of poor financial management and 24% indicated the lack of transparency in the management of the scheme.

3.4 Strategies to be adopted for better management of mutual health insurance

Table 4: Distribution of topics according to strategies to be adopted for better management of mutual health insurance

Strategies	**f**	**%**
Re-explain the rationale for Mutual Health Insurance	32	64
Use of donors	11	22
Financing from the treasury of the respective institutions	7	14
Total	**50**	**100**

Analysis of this table shows that 64% of respondents suggested that the rationale for the Mutual Health Organisation should be re-explained at the general meeting in terms of a strategy for better management, 22% suggested that donors should be approached and 14% suggested that the fund of the founding institution should be used to finance the Mutual Health Organisation.

UNDER PEER REVIEW

4. DISCUSSION

4.1 Identification of respondents

The results of this survey show that 66% of the respondents were male, while 34% were female. In Kinshasa (DR Congo), Kebela [9], found that men predominated in the various mutual health insurance schemes in a proportion of 75.3%. On the other hand, Karafuli [22] found a female predominance of 69.5%.

We believe that the predominance of male respondents can be explained by the number of staff working in the two structures under study, i.e. the Monseigneur Grison Centre and the Saliboko Primary School. The criterion of parity between the two sexes is not respected in the staff recruitment process.

With regard to the age of the respondents, we found that the 36 to 51 age group was the most represented with 19 respondents, or 38.0%. A study carried out in Rwanda, specifically in Kibuye, by Musango and Inyarubuga [23], states that the majority of mutualists were in the 30 to 45 age group, i.e. 62.4%; and Karafuli in Karisimbi found 53.5% of subjects whose age varied between 35 and 40 years [22].

We believe that the dominant age group is composed of people who are active and concerned about ensuring health for themselves and their families.

In addition, it appears from this study that 90% of the respondents had a secondary education. The same finding was made by Karafuli [22] who found 83.5% of respondents with secondary education.

We believe that the level of education of the respondents is a consequence of the hiring criteria set up by the managers of the two mutualist structures, who advocate employing a large but less qualified workforce.

Finally, the study shows that 40 respondents, i.e. 80%, have been with the Mutual Health Organisation for 0-5 years. Furthermore, in the commune of Ngaba in Kinshasa (DR Congo), Kebela [19] found the same result as us, according to which more than half of the mutualists, i.e. 65.1% of the respondents had been with the Mutual Health Organisation for 1-5 years. In Burkina Faso, Yameogo [24], found that most mutualists (56.3%) had an average seniority of no more than 10 years.

We believe that the duration of a member's membership in a mutualist organisation would depend on the size of the contributions and participation in meetings, given that all members of the Mutuelle de Santé are agents at the Centre Monseigneur Grison and the Ecole Primaire Saliboko.

4.2 Management difficulties encountered by mutual health insurance

UNDER PEER REVIEW

Several difficulties were indicated by the respondents with regard to the management of mutual health organisations, notably the low level of members' contributions, the poor management of the finances of the Mutual Health Organisation and its members.

With regard to low membership fees, we noted that 54% of respondents justified the absence of membership fees by the low income of the members, the lack of transparency in the management of the mutuals (26%) and the non-proportionality of care in relation to the amount of the membership fee (20%). In Kinshasa, Kebela [19] made the same observation in his study, where the subjects recognised the low income made available to the mutuals (45.3%) and the poor management of funds allocated to the mutual (37.5%). According to a study carried out in 2017, Kotoh et al [25] indicated that there are many disincentives to membership: dissatisfaction with the behaviour of health professionals, insufficient control of adverse selection by scheme managers, poor management of health care claims, delays in reimbursement, poor control by supervisors over the actual performance of procedures, insufficient control by users over these procedures. Several avenues for improvement were proposed.

Regarding to the poor management of the finances of the Mutual Health Organisation, it was observed in this study that 44% of respondents indicated the desire of the managers of the Mutual Health Organisations to get rich quickly, the unwillingness of the managers (38%) and the desire to make member members suffer (18%), as the main reasons for the poor management of the finances of the Mutual Health Organisations.

Concerning the management of members of the Mutual Health Organisation, 56% of respondents indicated that the management of members of the Mutual Health Organisation is done within the respective institutions, while 32% indicated that the management is done within the associations. In Burkina Faso, Yameogo [24] indicated that one of the difficulties observed in the management of volunteers is the statutory prohibition for administrators to receive remuneration. Although the administrators of the Mutual Health Insurance for Fiscal Workers (MHIFW) generally accept this condition as an ideological choice, it is nonetheless true that this prohibition can be an obstacle to recruiting a sufficient number of qualified and motivated administrators to manage the mutual. Thus, a certain "loss of dynamism" in the bodies responsible for the administration and management of MHIFW can be observed nowadays.

The difficulty linked to the poor management of the Mutual Health Organisation was also highlighted in the study by Maria-Pia and Bart Criel [17], which showed that 56.8% of Mutual Health Organisations are poorly managed. The same is true of the study by Ramanana and Barthes [17], who indicated that the poor management of the Mutual Health Organisation was mentioned by almost all (89.5%) of the respondents.

The low level of income observed by mutualists in our region is a real fact and therefore constitutes a major challenge to be met in the management of mutual health insurance. This could be attributable to the socio-economic conditions of the members,

UNDER PEER REVIEW

which are a consequence of the country's economic situation. We live in one of the low-income countries which is also characterised by low per capita income.

In the management of social mutuals, the leaders must be animated by a spirit of voluntary work. This can promote the autonomy of the mutuals in the sense that management can be carried out without the assistance of external parties. Volunteers combine their professional tasks with those of managing the mutuals. This means that their workload is very high, and they are generally not motivated.

This is not the case in Burkina Faso, where Yameogo [24] specifies that in the management of social mutuals the leaders are volunteers. Volunteering can thus promote the autonomy of mutuals in the sense that management can be carried out without the assistance of outside parties. The volunteers combine their professional tasks with those of managing the mutuals. Their workload is therefore very high, and they are generally not motivated.

We have not presented the financial aspect in this study. The Mutual Health, like other mutualist organisations, must comply with the internal regulations and statutes certifying their creation. We believe that the poor management decried by mutualists is a hindrance to the smooth running of the Mutuelle de Santé.

Contrary to our study, Bayege [27] specified that the management of mutual health insurance is distinct from that of mutualist organisations.

We believe that for the Mutual Health Organisation to function properly, it would be desirable and essential to designate leaders in accordance with the internal regulations and the statutes in order to avoid any misunderstanding in the management, which is a source of misunderstanding and dislocation.

4.3 Consequences on access to health care for members of mutual health insurance schemes

In this study, we noted several consequences on the accessibility of mutual health insurance members to health care, notably the payment of health care bills, the difficulties observed in accessing health care, the consequences linked to the non-contribution of members and the reasons for dysfunction in mutual health insurance.

With regard to the method of payment of health care bills, 54% of the respondents considered that health care bills were paid, in the majority of cases, by the head of the Mutual Health Organisation. We also believe that the internal regulations and statutes governing the Mutual Health Organisation should effectively determine the method of payment of bills for care provided to mutualists. Strict compliance with the texts governing the financial management of the Mutual Health Organisation would be a strong point characterising its smooth running.

UNDER PEER REVIEW

Regarding the major difficulties encountered before medical care in the various hospitals, it was noted that most respondents, i.e. 48%, recognised the mistrust that characterises the managers of the Mutual Health Organisations.

Faced with this situation, we believe that this could justify the disinterest of the members in belonging to a Mutual Health Organisation, especially since the mutualists feel that they are not treated properly and with much esteem, contrary to the statutes governing their mutualist organisation.

When asked about the consequences of non-contribution by members, 64% of respondents said that non-contribution by members leads to inaccessibility to medical care. In Burkina Faso, Yameogo [24] specifies that the technical and financial partners of social mutuals are diverse in supporting mutual health insurance. They include: the National Alliance of Christian Mutual Societies of Belgium, the Socialist Mutual Society of Belgium, the French Cooperation, the Dutch Embassy, SNV, Børnefonden, UNICEF, and WAEMU. These international or sub-regional partners accompany the support structures and encourage the establishment of social mutuals.

In Rwanda, Musango [28], in his study, indicated that the low level of members' contributions leads to the dysfunction of mutual health insurance.

The major part of the financial resources of the Mutual Health Organisation comes from the membership fees. It is inconceivable that the latter no longer fulfil their obligation towards the Mutual Health Organisation, which is to contribute regularly, because without the consequent financial resources, the Mutual Health Organisation cannot function properly, with the consequence of suppressing access to care.

In its book entitled "Improving access to health care services in Rwanda, the role of insurance", the Ministry of Health of the Republic of Rwanda in 2004, indicates the importance of supporting mutual health insurance in order to promote access to health care for the population [29].

Created with the aim of giving mutualist members access to health care, we believe that mutual health insurance would benefit from support from the public authorities in order to respond in one way or another to the health constraints of the population, by having a say in the management of these mutual health insurance schemes.

The result of this study also shows that 44% of respondents stated that overcharging for services by health care providers is the main reason for the dysfunction of mutual health insurance schemes, while 32% of respondents spoke of poor financial management and 24% indicated the lack of transparency in the management of the scheme.

In contrast to our study, Bayege [27] emphasises that medical care was insured and provided for 75%, leaving the rest to be paid for by the members.

UNDER PEER REVIEW

The main objective of Mutuelle de Santé is to provide health care at a lower cost, in order to allow members to have access to it. In our opinion, overcharging is linked to the lack of financial resources made available to the Mutuelles de Santé or to the delay in the payment of contributions by members.

In their 2009 study, Ramanana and Barthes [26] made the same observation, where 75.3% of the members of mutual health insurance in Kasai Occidental in the Democratic Republic of Congo expressed the desire to stop contributing, complaining about the poor management of funds made available to the mutual health insurance.

Several factors can be associated with the poor management of the funds decried by mutualists, notably the low level of education of the managers, the failure to respect the texts governing the mutual health insurance scheme, etc. Poor governance is the cause of a lack of confidence of member members in the management. Members, often confronted with unfortunate experiences, do not hesitate to question the skills of managers. This further weakens the management mechanisms already in place.

4.4 Strategies to adopt for better management of mutual health insurance

A variety of strategies to overcome the problem of non-contribution by mutual members were mentioned in this series, including re-explaining the rationale for the Mutual Health Organisation (64%), recourse to a donor (22%) and financing from the fund of the founding institution of the Mutual Health Organisation (14%).

The collection of contributions is one of the major difficulties faced by the majority of social mutuals. Despite the strategies put in place, the collection of contributions is not an easy task. Mutuals are always experiencing delays in payment and sometimes problems of non-payment. These difficulties are particularly acute in rural areas where household financial resources are seasonal.

CONCLUSION

This study focused on the management of a mutual health insurance scheme and its members' access to care. It concerned respectively the workers of the Bishop Grison Centre Health Mutual and the teachers of the Saliboko Primary School of Kisangani in The Democratic Republic of Congo.

In approaching this study, we set ourselves three specific objectives, namely: to identify the major problems of mutual health insurance management that prevent the proper functioning of mutual health insurance, to determine the consequences of the dysfunction of mutual health insurance on members' access to health care, and to identify strategies to be put in place for good medical care through mutual health insurance.

In our methodological approach, we opted for the descriptive method with a cross-sectional aim, with a non-probabilistic sampling of the occasional type; concerning 50 members of the two mutual health insurance companies studied, selected according to

UNDER PEER REVIEW

the LYNCH formula, and 2 key informants. The interview is the technique that enabled us to collect the data.

At the end of our analyses, we arrived at the following results:

1) Difficulties in accessing care : 46% of respondents made a judgement about low income; concerning the management of finances, 38% of subjects had mentioned the poverty that characterises the leaders of the Mutual Health Organisation; 58% of the subjects affirmed that the management is done within the institutions.

2) In relation to the consequences on the accessibility to health care for members of the Mutual Health Organisations: 54% of respondents said that the bills are paid by the head of the Mutual Health Organisation, 48% mentioned the mistrust characterising the managers; 64% declared that the refusal to contribute is linked to the poor access to medical care for members and 44% of respondents affirmed that over-billing by the health care provider is the main reason for the dysfunction of the Mutual Health Organisations in terms of accessibility to health care.

3) As strategies to be adopted for a better management of mutual health insurance: 64% of respondents proposed a re-explanation of the rationale for mutual health insurance and 22% wanted to have recourse to financial backers.

In view of these results, we believe that the objectives pursued in this series have been achieved. To this end, we recommend that the Ministry of Public Health provide financial support to the Mutual Health Organisations to ensure that they function properly and that they pursue their objectives.

References

1. Catinchi. Mutuals, which management to respond to which challenges? In Regards, 2016(49);173-182.
2. Ridde, Belaid, Samb, Faye. Health system revenue collection in Burkina Faso from 1980 to 2012. Sante Publique 2014, 26: 715-725.
3. Maotela et al. Analysis of health care financing arrangements in the Democratic Republic of Congo: a systematic review. Ann. Afr. Med, vol. 12, no. 2, March 2019.
4. Atim. Contribution of mutual health organizations to financing, delivery, and access to health care; synthesis of research in nine west and central African countries, Washington, 2018.
5. Letourmy. Guide to the management of mutual health organizations. World Bank, 2006.
6. Basaza, Criel et al. Community health insurance in Uganda: why does enrolment remain low? I view from beneath, health policy. 2008.
7. Nyssens and Marthe. Les défis des mutuelles de santé, Echos Sud, 2009.

UNDER PEER REVIEW

8. Criel and Waelkens. Evaluating the performance of health systems: Mutual health insurance in sub-Saharan Africa; status report and reflections on a research agenda, World Bank, Washington. 2003
9. Mathauer, Mathivet & Kutzin. Community based health insurance: How can it contribute to progress towards UHC? WHO. 2017
10. Criel, Atim, Basaza, Blaise & Waelkens. Editorial : Community health insurance (CHI) in sub-Saharan Africa : Researching the context. Tropical Medicine & International Health, 2004;9(10),1041-1043. doi: 10.1111/j.1365-3156.2004.01315.
11. Ndiaye, Soors & Criel. Editorial: A view from beneath: Community health insurance in Africa. Tropical Medicine & International Health, 12(2), 157 161. https://doi.org/10.1111/j.1365-3156.2007.01814.x
12. Alenda-Demoutiez & Boidin. Community-based mutual health organisations in Senegal: A specific form of social and solidarity economy? Review of Social Economy,2019;77(4),417-441. https://doi.org/10.1080/00346764.2018.1555646
13. Dror, Hossain, Majumdar, Pérez Koehlmoos, John & Panda. What factors affect voluntary uptake of community-based health insurance schemes in low- and middle-income countries? A systematic review and meta-analysis. PLoS ONE, 2016;11(8), e0160479. https://doi.org/10.1371/journal.pone.0160479
14. Ridde, Haddad, Yacoubou, & Yacoubou. Exploratory study of the impacts of mutual health organizations on social dynamics in Benin. Social Science & Medicine, 2010;71(3), 467-474.
15. Waelkens, Coppieters, Laokri & Criel. An in-depth investigation of the causes of persistent low membership of community-based health insurance: A case study of the mutual health organisation of Dar Naïm, Mauritania. BMC Health Services Research, 2017;17:535. https://doi.org/10.1186/s12913-017-2419-5
16. Criel and Blaise. Mutual health insurance in Africa and quality of care in services: a dynamic interaction, World Bank, Washington, 2009. [16]
17. Maria-Pia and Bart Criel. Mutual Health Organisations in Sub-Saharan Africa: State of Play and Reflections on a Research Agenda. Health, Nutrition and Population (HNP) Discussion Paper - The World Bank. Washington, D.C., 2004.
18. Criel, Barry and Von Roenne. The PRIMA project in Guinea Conakry, an experience of organising mutual health insurance in rural Africa. Medicus Mundi, Brussels, 2009.
19. Kebela. Health for all: identification of the factors explaining accessibility to health care in the commune of Ngaba, Kinshasa-DRC, 2004.
20. Götz, Jürgen and Kirsten. Mutuelles de santé: 5 years of experience in West Africa; Debates, controversies and proposed solutions, 2003.
21. Couilbault, Eliashberg & Latrasse: Les grands principes de l'assurance santé. L'Argus Editions, 2019(2);87-96.
22. Karafuli. Investigation into the establishment of a mutual health insurance scheme in the Karisimbi Health Zone, Goma-DRC, 2005.
23. Musango and Inyarubuga. Mutual health insurance in the Province of Kibuye: Feasibility study of the establishment. Kigali, Rwanda, 2004.

UNDER PEER REVIEW

24. Yameogo. Analysis of the functioning of the mutual insurance company for tax workers (Mutraf): difficulties and suggestions. Master's thesis in Economics and Management of Social and Solidarity Economy Enterprises. University of Ouagadougou 2. 2015
25. Kotoh, Aryeetey & Van der Geest. Factors that influence enrolment and retention in Ghana' national health insurance scheme. The International Journal of Health Policy and Management, 2017;7(5),443-454. https://doi.org/10.15171/ijhpm.2017.117
26. Ramanana and Barthes. Health Purchasing Funds in Kassaï Occidental, 2009 (Online) at http://www.memoireonline.com, accessed 22 July 2021.
27. Bayege. Contribution des mutuelles de santé à l'accessibilité de la population aux services de santé. National University of Rwanda/School of Public Health. Master's degree. Kigali, Rwanda, 2004.
28. Musango. Organization and implementation of mutual health insurance: Challenge to the development of health insurance in Rwanda. Université Libre de Bruxelles/ Ecole de Santé Publique, PhD thesis, Brussels. 2005.

UNDER PEER REVIEW