An excerpt from:
Better Health & Social Care: How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?
An International survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)
Volume 2: National Cases

For the research framework, the analysis of the national cases, and other research components, including a description of the research team members, refer to Volume 1: Report.

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GUINEA[1]

2014

HEALTH SYSTEM[2]

Population (in thousands) total: 11,451

Population median age (years): 18.53

Population under 15 (%): 42.46

Population over 60 (%): 5.03

Total expenditure on health as a % of Gross Domestic Product: 6.3

General government expenditure on health as a % of total government expenditure: 6.8

Private expenditure on health as a % of total expenditure: 71.9

According to latest estimates, 40% of the population of Guinea lives below the poverty line, on less than $300 USD per year. Only 52% have access to safe water and 55% to health services. The latter figures in themselves are achievements, however. They highlight the benefits which have been secured since the introduction of community-based health services. Still, the indicators for levels of health outcomes remain mediocre relative to other parts of the world.

Public expenditure over the decade has focused primarily on services in urban areas (particularly the capital city, Conakry), and overall has benefited the wealthier income groups. In 1994, 48% of government expenditure in health benefited the richest 20% of the population, while only 4% benefited the poorest 20%. Since that time, budget allocations have remained practically unchanged, leaving little hope for improving this situation. Expenditure for medical personnel has also focused on the capital, which explains the concentration of all categories of personnel there. More than 60% of health personnel reside in Conakry, serving only 20% of the country's total population. In fact, the health-personnel-to-population ratio (for all categories of health personnel) is less than the national average in all regions except Conakry.

Despite serious efforts to implement a low-cost, essential drugs policy since 1988 (a time when the Guinean health system was considered path-breaking in Africa), the supply system has not only remained unchanged, it appears even to have jeopardized the health system as a whole. Drugs and vaccine shortages continue to undermine service quality. In this regard, Guinea is way behind countries such as Benin and Burkina Faso, both of which have implemented efficient mechanisms of drug supply.

The poor spend less on health services and resort more frequently to self-medication. Surveys show that about 30-40% of households experience temporary inability to pay for health services, and 10-15% are permanently unable to pay for health services. Nevertheless, only a few exemptions or subsidization mechanisms are in place. Moreover, the poor are required to pay more than the official fees to compensate for the low pay scale of health personnel. In particular, service utilization by children for vaccinations and for respiratory infections remains low in rural areas. Service utilization for assisted deliveries remains extremely low in rural areas as well, despite high utilization rates for prenatal care. This is to some extent explained by the lack of personnel, but also by the perceived low quality of assisted delivery services, in spite of the indisputable relationship between maternal and child health service utilization and maternal and child mortality.

Aside from the fact that public expenditure benefits the poor segments of the population least, per capita health expenditure as well as health expenditure relative to total government expenditure is extremely low in Guinea. Health sector budget allocations invariably have been low over the past decade. They represent less than one quarter of the education sector budget allocation, when in most countries this ratio is closer to one half. While per capita public expenditure has increased in nominal terms, in real terms it has practically remained unchanged, both in GF (Guinea-Franc) and in USD.

MUTUAL HEALTH ORGANIZATIONS

On July 04, 2005, the Republic of Guinea adopted Law 014 (L/2005/014/AN) governing economic groupings of a cooperative nature, mutual organizations of a non-financial nature, and cooperatives. Accordingly, mutual health organizations (MHOs) might expect to be regulated under the second category (Articles 11-14). Unfortunately, Law 014 does not define MHOs in the usual terms. It makes no mention of rights or obligations arising from participation in an activity relating to microinsurance, as usually is the case in MHO regulations.[3]

The legal framework is thus disconnected from reality. It was in this context that, in 2012,[4] the National Organization for Mutual Support in Guinea (ONAM), in partnership with the French NGO ESSENTIAL, observed that the absence of a legislative framework specific to MHOs is a great handicap to their strategy.

Several MHOs have been created in Guinea. Difficulties (mainly in terms of management) have prevented most of these experiments from being pursued. Some MHOs continue their activity, but represent a very small numbers of members. While MHOs have the advantage of being simple and quick to set up, they eventually get integrated into the general framework of insurance.[5]

The informal sector is very important to the country, representing about 80% of the population. The extension of health insurance will not suffice to cover the majority of the population. Therefore, it is necessary to pool health risks. It will be based on community awareness, the development of income-generating activities, and training developers and providers.

In terms of awareness, specialized personnel will carry out socioanthropological studies so as to understand the needs of communities better, to articulate collective goals, and thereby address constraining factors. MHOs will be guided by certain principles: freedom of membership, solidarity between members, democracy of operation, non-profit status, and self-promotion.

In order to strengthen MHO management capacity, technical assistance will be provided. It will consist of the development of draft statutes and rules of procedure, the design of management tools, and training in MHO operation and management.

In Guinea, MHOs are usually guided by supporting entities. We managed to get information about three such entities.

- ESSENTIEL-ONAM-FMG Programme, within the framework of the Support for the National Sanitary Development Programme (Appui au Programme National de Développement Sanitaire, APDNS).

This project was set up very recently, in 2013. According to the data received, it integrates 10 MHOs from three departments. The MHOs are not yet functioning, but they have already started to enroll beneficiaries (between 47 and 300 members per organization). In fact, they have not yet reached the threshold at which support for beneficiaries becomes mandatory. The contribution is paid annually and varies between $49.75 and $62.19 USD (24,000 and 30,000 FCFA).

- ESSENTIEL-ONAM-REMUFOUD, within the framework of Health for All, Health, Social Protection, and Concentrated Dynamics (Santé pour tous, santé, protection sociale et Dynamiques concentrées.)

The first MHOs of this project were created in 2002 and the process continued up to 2013. According to the data received, it integrates 12 MHOs from three departments. The great majority of MHOs are not yet functional. Meanwhile, they are enrolling beneficiaries (between 96 and 1,135 members per organization). In fact, they have not yet reached the threshold at which support for the beneficiaries becomes mandatory. The annual contribution varies between $45.60 and $62.19 USD (22,000 and 30,000 FCFA).

- UMSGF-CIDR Programme, within the framework of MHO Support Projects (Projets d'appui aux mutuelles de santé)[6]

The Union of Mutual Health Organizations of Forest Guinea (l'Union des Mutuelles de Guinée Forestière, UMSGF) is an MHO association established as part of a project initiated in the Republic of Guinea by the Centre International de Développement et de Recherche (CIDR) in 1999. CIDR, a non-governmental organization created in 1961 and based in Autrêches, France, works in many African countries and in a variety of development sectors, such as microfinance, small business, decentralization, microinsurance, management of health services, etc.[7]

In Guinea, CIDR has chosen to organize the management and governance of health services according to the principles of mutuality, taking into consideration the strong social dynamics of the country (village cohesion and multiple mutual-aid organizations) and the absence of formal social or professional organizations which can organize the management and distribution of health products.

Since its founding in 1999, the network has experienced steady expansion. In 2005, UMSGF encompassed 21 rural mutual organizations and 7 urban mutual organizations, comprising 2,656 families and a total of 14,071 beneficiaries, nearly 100 families per MHO (the equivalent of about 10% of the target audience in the area).

To meet the demand and the financing capabilities of the target audience, MHOs had to design low-cost products ($1.60 USD per person per year in 2005), covering medical admissions and surgical procedures through the public health services.

In the space of five years, the adopted management strategy for health microinsurance enabled MHOs to constitute funds sufficient to permit product diversification ($25,206 USD over five years and a volume of $15,000 USD in annual premiums collected for the year 2004-2005). They have a security system that provides access to a contingency fund, should reserves ever diminish below a specified safety threshold. The project has set up a specialized Technical Unit

to organize monitoring and risk management functions which would be beyond the capacity of primary mutual organizations.

Growth in the number of beneficiaries is the challenge which mutual organizations and the UMSGF have to meet in order to achieve their financial independence. The sustainability threshold was established at roughly 60,000 beneficiaries. This objective can be achieved, given the maintenance of service quality by health facilities and growth in the purchasing power of the target audience.

SOURCES

[1] The data was collected with the assistance of a locally-based organization, the National Organization for Mutual Support in Guinea (ONAM). It also responded to clarifications sought by phone and e-mail. Other organizations were contacted for documentary information as well. For more information on MHOs in Guinea, please contact Mr. Diallo Alpha Oumar Korka, Executive Director, ONAM BP: 96 alphaoumarkorkaa@yahoo.fr (http://onam-guinee.jimdo.com) Tel: 628 21 75 21/662 01 01 00.

[2] No recent information has been found related to Guinea's health system. This section is extracted from a World Bank report: Taïbata Diallo, Aliou, Sall, Boubacar, Sylla, Mohamed, et al. 2006. *Guinea: A Country Status Report on Health and Poverty: Health, Nutrition and Population Inputs for the PRSP and HIPC Process*. Africa Region Human Development Working Paper Series No. 45. World Bank. Retrieved August 19, 2014 (http://siteresources.worldbank.org/INTAFRREGTOPEDUCATION/Resources/444659-1212165766431/H_CSR_Guinea.pdf).

[3] For instance, see the Law of 1996 in Mali.

[4] On the occasion of the presentation of a programme for improving access to health care for all in Guinea.

[5] This is not to suggest that they lose their traditional characteristics. To be integrated into the general framework of insurance, however, MHOs must fulfill some different financial and managerial requirements.

[6] For more details on this initiative, see Gautier, Bruno, Boutbien, Allan, and Bruno Galland. 2005. "L'Union des Mutuelles de Guinée Forestière." Groupe de Travail du CGAP sur la Microfinance Bonnes et Mauvaises Pratiques Etude de Cas no. 17. Retrieved August 19, 2014 (http://www.cidr.org/IMG/pdf/Etude_de_cas_n17.pdf).

[7] For more details about CIDR, please consult its website: Centre International de Développement et de Recherche. 2014. "50 ans d'innovation et de partenariat." Retrieved September 11, 2014 (http://cidr.org/).