The role of mutuals and community-based insurance in social health protection systems: International experience on delegated functions

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Abstract The institutional architecture for the provision of social health protection varies across countries, as do the actors and organizations involved. In some countries, mutual benefit societies and community-based health insurance organizations (CBHI) play a role in this area. In the 1990s, these were promoted particularly as a means of extending social security coverage, especially in sub-Saharan Africa. In the current context, the adoption of the 2030 Agenda for sustainable development, as well as renewed political will to

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realize universal coverage, has led to a questioning of the role of mutuals/CBHI. However, the literature on the roles they play in national social security systems remains limited. For this scoping review, 49 documents were analysed, covering 18 countries worldwide, focused on the delegation of functions to mutuals/CBHI in national social health protection systems. The results reveal the dynamics of the delegation of functions within social protection systems over time and their implementation processes. These provide areas for reflection that can inform policy processes.

Keywords mutual benefit society, social protection, health, social security schemes, health insurance, international

Introduction

Social health protection is a human right rooted in the right to social security and the right to health. It is formalized in international social security standards (ILO, 2020). It is defined as access to health care without financial hardship and guaranteed by the State across the life course, alongside income security in the event of sickness or maternity (ILO, 2020). In that regard, it contributes to the Sustainable Development Goals (SDGs) of the 2030 Agenda, in particular indicators 1.3 and 3.8 on universal social protection and universal health coverage (Bayarsaikhan, Tessier and Ron, 2022).

International standards in social health protection are not inherently prescriptive in terms of the institutional and administrative arrangements chosen by each State to implement these guarantees, provided that the arrangements respect certain guiding principles (ILO, 2020). Any system must be adapted to domestic circumstances to be acceptable and effective. In practice, the chosen administrative architecture for the provision of social health protection varies from country to country. Mutual benefit societies (mutuals) and community-based health insurance organizations (CBHI) may play an important role in this in some countries (Schremmer et al., 2009).

Historically, mutuals developed in Europe and Latin America in contexts where the public social protection system was nascent (Dreyfus, 2017). In the 1990s, mutuals/CBHI were promoted in sub-Saharan Africa as a solution to expand social health protection coverage (Schremmer et al., 2009). In a context where countries seek to realize universal coverage to achieve the SDGs, questions are raised about

the role played by mutuals in national social health protection systems. However, the available literature offers few answers on the topic, in particular regarding the functions that may be delegated to mutuals/CBHI.

This article presents the results of a scoping review to produce a global overview of the available knowledge concerning the delegation of functions to mutuals/CBHI in national social health protection systems. The article proposes areas for reflection to inform current policy processes and is structured as follows. First, the methodology of the scoping review is set out. Second, main results are presented and, in turn, those results are discussed in light of current policy debates before concluding the article.

Methods

A scoping review makes it possible to examine a body of evidence on a subject that has been little studied (Arksey and O'Malley, 2005; Belaid and Ridde, 2020; Dagenais et al., 2021). The method proposed by Arksey and O'Malley (2005) and the PRISMA system (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) (Tricco et al., 2018) have been used. This study has been conducted with the assistance of Covidence.[1]

Identification of the research questions

The research questions aimed to explore, describe and analyse experiences of delegating functions to insurance companies within social health protection systems. Two main questions were identified: i) which functions are delegated to mutuals/CBHI in national social health protection systems, and ii) how are decisions concerning such delegation arrived at.

In the absence of definitions of mutuals/CBHI and of the delegation of public service in international law or research, working definitions of these concepts have been adopted to delineate the parameters of this review while remaining within the exclusion criteria *stricto sensu*. In this context, the delegation of public service is defined, under French law, as "a contract by which a public or private legal entity entrusts the management of a public service falling within its competence to a delegate whose remuneration is linked to or substantially assured by the results of the operation of the service".[2] Mutuals/CBHI, for their part, are understood to be non-profit organizations of the social and solidarity

1. See www.covidence.org. This article is supplemented by an online Appendix developed by the authors (see Supporting Information) in which further details on the method can be found.
2. Article L.1411–1 of the French General Local Authorities Code.

economy characterized by their autonomy and their ethic of mutual assistance, solidarity, and the sharing of risks among their members (Atim, 1999).

Identification of the selected documents

The documents were identified in the following databases: PUBMED, EMBASE, CINAHL, PAIS International, Web of Science, Dimensions, Érudit, Isidore science, and Google scholar.[3] This strategy was complemented by research into the references of articles, and consultation with experts[4] and the websites of international organizations.

Selection of documents. The inclusion criteria covered any document: i) addressing the links between mutuals/CBHI and social protection policies; ii) presenting the roles and functions of at least one mutual/CBHI within the framework of at least one social protection policy; iii) without distinction as to the method; iv) for an unlimited period; and v) with a summary published in French or English. The exclusion criteria included: i) articles on the role of mutuals/CBHI in the context of additional and supplementary health insurance and complementary group insurance, as well as voluntary private insurance; and ii) articles in which the information about delegation was insufficiently detailed.

The study selection procedure was carried out in four stages (see Figure 1). The evaluation of the eligibility of documents was carried out in two stages: i) independent reading of the titles and summaries by two evaluators; and ii) comparison of the selection results, cross-evaluation of the 120 documents upon which agreement was not reached, and team discussions to arrive at a consensus.[5]

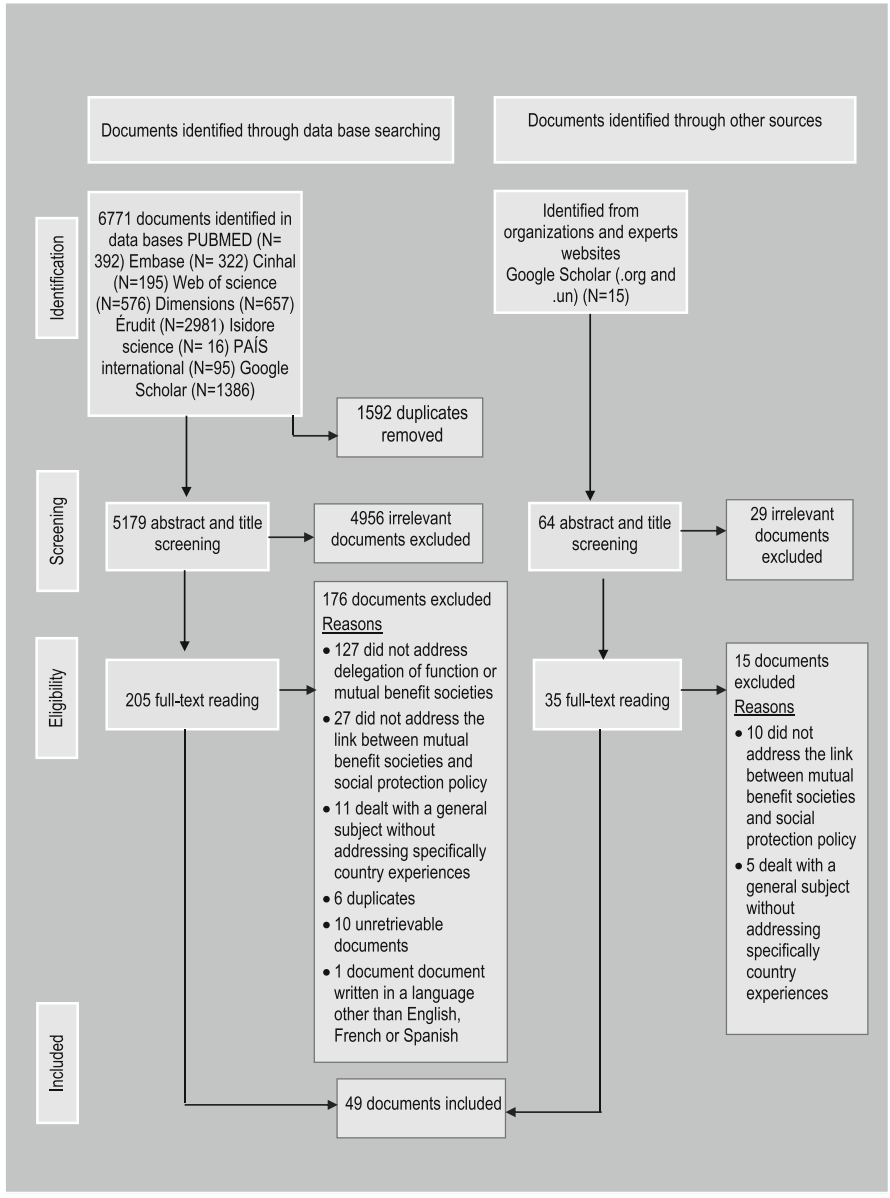
Data mapping and organization

By using the "descriptive analyses" method (Dagenais et al., 2021), the extraction and organization of data were carried out using parameters adapted to the conceptual framework of policy transfer (Dolowitz and Marsh, 2000).

1. What is meant by the term mutual/CBHI in the documents included?
2. Why are functions delegated to mutuals/CBHI?

3. This article is supplemented by an online Appendix developed by the authors and made available to readers (see Supporting Information). See Appendix, Table A1.
4. The experts are researchers and employees of national organizations (ministries of health, NGOs) and international organizations (International Labour Office).
5. This article is supplemented by an online Appendix developed by the authors and made available to readers (see Supporting Information). See Appendix, Table A1, which presents 49 documents included in this review.

Figure 1. *Diagram of the PRISMA flow for the scoping review*



Source: PRISMA, adapted by authors.

3. How are functions delegated to mutuals/CBHI?
4. What functions have been delegated to mutuals/CBHI?
5. To what extent are functions delegated to mutuals/CBHI?
6. What are the factors facilitating or restricting delegation?
7. What are the effects of delegation?

After the data extraction, a second phase of analysing and validating the preliminary results was carried out by using the main functions of social health protection systems, as derived from international social security standards (ILO, 2021a): definition of coverage parameters; awareness raising and promotion activities; registration and contribution collection; pooling of funds and risks; contracting and management of relations with health-care providers; the provision of health-care services; and participation and governance.

Results

In total, 49 relevant documents covering the period 2004–2021 were included in the review, 42 of which concerned a single country and seven of which concerned multiple countries.[6] The documents included are mainly grey literature (n=33), and 16 documents are scientific articles that use a range of methodological approaches. Table 1 summarizes the key results of the review.

What is meant by mutual/CBHI?

Some elements of the definition presented in the methods section are found in most documents: democratic governance; non-profit nature; community participation; solidarity; responsible management (Diop, Leighton and Butera, 2007; Roy and Sarkar, 2018; Soors et al., 2010). In addition, some publications refer to the federations of mutuals in accordance with the structuring of the sector at the national level (France, Morocco) (Cour des comptes, 2018, 2013).

Depending on the country, the autonomy and independent nature of mutuals/CBHI is not necessarily part of the definition, as evidenced by Ghana, Rwanda, and the United Republic of Tanzania. Similarly, the voluntary nature of membership, as well as the freedom to choose a mutual/CBHI, is sometimes mentioned, but this does not necessarily mean that membership of the social health protection system is voluntary. Several countries have mandatory registration with

6. This article is supplemented by an online Appendix developed by the authors and made available to readers (see Supporting Information). See Appendix, Table A1 (showing relevant documents covering the period 2004–2021) and Figure A1 (showing the countries included in this review).

Table 1. *Summary of the general findings from this scoping review*

Review questions	General findings
What does the term mutual/CBHI mean in the documents included?	• Absence of consensus on the definition of mutuals/CBHI. • Various uses of the term covering very different realities, particularly in terms of autonomy and voluntary membership.
Why are functions delegated to mutuals/CBHI?	• Part of a broader strategy of expanding or reforming the social health protection system and moving towards universal health coverage. • Historical process where the pre-existence or not of mutuals/CBHI largely conditions the type of role they further play within the national social health protection system.
How are functions delegated to mutuals/CBHI?	• Only a few cases of delegation would fall within the initial working definition. • In practice, there are four typical scenarios, sometimes with a continuum of change from one to another depending on the country: i Delegation contract (i.e., delegation within the initial definition): countries where there were mutuals/CBHI before the national social health protection system was developed and where these were contracted by the national body in charge of social health protection upon its creation to manage the new coverage for their members. ii Absorption: countries where mutuals/CBHI have been absorbed into the national social health protection system, including their administrative staff in some places. iii Integration: countries where the social health protection system created or structured mutual insurance companies as local public management bodies for social health protection systems. iv A final category of countries created a legal and promotional framework for the creation of independent mutual insurance companies without further contractual relationship with the national social health protection system, if any existed.
What functions have been delegated to mutuals/CBHI?	• All experiences gave mutuals/CBHI responsibilities dealing directly with front office function, i.e., the management of registration, sometimes the collection of contributions, the management of beneficiaries, local governance, administration of health-care payments in some contexts. • The situation appears to be more varied in terms of back-office functions, which tend to be centralized and seen in some countries as a prerogative and the responsibility of public bodies, in particular resources and risk pooling, decisions on coverage parameters/scheme design, and financing (including contribution rates, where applicable).
To what extent are functions delegated to mutuals/CBHI?	• Evolution and adaptation of the delegation of functions over time in accordance with the contextual realities of each country. • While some countries have opted for strong state involvement in governance through the absorption mutuals/CBHI into the national system, others retain their autonomy in operations. While in the former case there is a risk of losing the community-based and participatory character of mutuals/CBHI, in the latter case there are

(Continued)

Table 1. *Summary of the general findings from this scoping review* - Continued

Review questions	General findings
	often major challenges such as insufficient coverage and difficulties with financial viability owing to limited risk pooling.
What are the factors facilitating or restricting delegation?	• The legal and regulatory framework. • The existence of an established social health protection system. • The institutional and managerial capacities of the regulator, the delegator and mutuals/CBHIs. • Coordination with the health-care system. • Sustainability of public funding.
What are the effects of delegation?	• Contrasting effects in line with the historical conditions of the development of mutuals/CBHI and their role within the architecture of the social health protection system. • It was not possible to extract information that compared the impact of delegation of administration to mutuals/CBHI, versus the non-use of those in social health protection systems, on the reduction of financial barriers in access to care and on the provision of additional funding for health-care providers.

Source: Authors' elaboration.

the social health protection system with the free choice of a mutual/CBHI, such as in Belgium, France, and Morocco. In contrast, in Rwanda, registration with the local mutual is mandatory (Kestemont et al., 2020).

Why are functions delegated to mutuals/CBHI?

In most countries, the delegation of certain functions to mutuals/CBHI is part of a broader historical process aimed at the expansion of social health protection. The delegation of functions is sometimes part of the integration into a national social health protection system of population groups whose coverage by mutuals/CBHI preceded the creation of a national system (Belgium, France, Morocco, and Spain). In other countries, it is a matter of reforms to bring together different mechanisms to create a unified national system. In other cases, it was expected that mutuals/CBHI would make it possible to reach populations dependent on the informal economy, living in rural areas, or excluded from the social protection system (Burkina Faso, Cambodia, Senegal).

How are functions delegated to mutuals/CBHI?

The ways in which delegation is defined differ depending on whether the mutual system predated the national social health protection system. Four types of architecture can be identified, only one of which corresponds *stricto sensu* to the

working definition of delegation, and they can sometimes constitute a continuum over time.

- In contexts where certain groups were already covered by mutual insurance companies before the creation of a national social health protection system (Belgium, France, Morocco, Spain, and Uruguay), delegation took place. For example, in France, this was the result of the *Loi Morice* of 9 April 1947, which established the participation of mutual insurance companies in social security by delegating to them the management of compulsory health insurance for civil servants (Cour des comptes, 2013). In Spain, a royal decree (RD 1993/95) had established a regulation that allowed mutual societies collaborating with social security (*Mutuas Colaboradoras con la Seguridad Social – MCSS*) to collect contributions and pay benefits on behalf of the social security system (Bernal-Delgado et al., 2018). These contractual relations give rise to an agreement involving remuneration (a contribution to management costs or remuneration based on services provided to users).
- In other contexts, national health insurance organizations absorbed the mutuals/CBHI that predated the creation or reform of the national social health protection system (Cambodia, Laos, Thailand). This made it possible to affiliate the members of existing mutuals/CBHI and, in some cases, to transfer their staff. This architecture has, therefore, not yet led to management delegation agreements.
- Elsewhere, a national system has been set up and has simultaneously encouraged the creation of mutuals/CBHI or community structures for the decentralized governance of health insurance (Ethiopia, Mali, Rwanda, Senegal, United Republic of Tanzania). In this regard, two groups of countries emerge:
  - One group adopted a centralized system where the "mutuals/CBHI" are in fact public or para-public structures integrated into the institution in charge of the national social health protection system to make the system accessible by developing a network of decentralized contact points (Ghana, Rwanda, United Republic of Tanzania). In Rwanda, when mutuals/CBHI were being expanded between 2002 and 2005, local authorities were responsible for developing these at the community level (Kamwenubusa et al., 2011). This may also constitute a continuum of change where mutuals/CBHI, initially independent, have been pushed to change their status to become public or para-statal bodies for local governance integrated within the national health insurance system (Ghana).
  - The other group has put in place a legal framework allowing mutuals/CBHI to assume a certain number of functions, but in a context where the role of the State is limited to regulation (legal framework, establishment authorizations, licences) (Burkina Faso, Mali, Senegal).

In some countries, the decision to use or promote mutuals/CBHI as part of the extension of the social health protection system was taken with development

partners providing international aid (Burkina Faso, Cambodia, Ethiopia, Mali, Nigeria, Rwanda, Senegal, United Republic of Tanzania). For example, in Burkina Faso, technical and financial partners, as well as the non-governmental organizations (NGOs) supporting local mutuals/CBHI, were involved in designing the social health protection system (Kadio et al., 2018; Ouedraogo and Flessa, 2016; Conseil national de la transition, 2016).

What functions have been delegated to mutuals/CBHI in the context of social health protection systems?

The review made it possible to identify delegations or assignments of functions to mutuals/CBHI for several of the main functions of the social health protection system (ILO, 2008). It is important to note that a majority of national health insurance policies include health insurance entitlements that specify different entry points according to people's capacity to contribute and/or their employment status. There are thus contributory systems where protected persons contribute directly to the financing of the social health protection system, but where there are often subsidies for contributions where appropriate and/or exemptions from fees at the point of use for certain population groups. This diversity is reflected in the different functions that mutuals/CBHI can have (ILO, 2021b).

Definition of coverage parameters. In most cases, the parameters (benefit package, reimbursement rates and methods, contribution rate, if applicable) are defined centrally by the Government. This is therefore imposed on the mutuals/CBHI within the management delegation framework, sometimes with a certain level of participation of the mutuals/CBHI to which functions are being delegated (Ethiopia, France, Ghana, Japan, Mali, Rwanda, as well as Senegal within the framework of its departmental health insurance unit[7]). In Ghana, although the State imposed a minimum benefits package, mutuals/CBHI at the district level could define their package that would be approved by the National Health Insurance Authority (Boon, 2007). In Belgium, the tariffs and reimbursement levels for the base cover are defined through national conventions with the participation of health-care providers and representatives of mutuals/CBHI (known as *caisses de maladie*) (Gerkens and Merkur, 2020).

Awareness raising and promotion activities. In several countries (Burkina Faso, Ethiopia, France, Mali, Nigeria, Rwanda, Senegal), mutuals/CBHI conducted

7. *Unité départementale d'assurance maladie* (UDAM).

training and awareness-raising campaigns for target communities, community leaders, and political decision makers on mutuals/CBHI. In Burkina Faso, the tasks of sensitizing, mobilizing, and raising the awareness of target communities were also delegated to mutuals/CBHI or through a support network for mutual health organizations (*Réseau d'appui aux mutuelles de santé* – RAMS) (Kadio et al., 2018; Ouedraogo and Flessa, 2016; Conseil national de la transition, 2016).

In some countries, mutuals/CBHI have played a role in promotion and prevention. In France, this has taken the form of health education and increasing patient involvement with the health-care authorities (Cour des comptes, 2003), activities to combat smoking or obesity, or prevention activities (Caire, 2009).

Registration and contribution collection. Mutuals/CBHI can be assigned roles in the registration and identification of populations and in the collection of social contributions (when applicable).

In some cases, mutuals/CBHI identified poor or vulnerable households (Burkina Faso, Ethiopia, Rwanda, Senegal, United Republic of Tanzania). For example, in Senegal, under a process aimed at the decentralization of health insurance (*Décentralisation de l'assurance maladie* – DECAM), mutuals collaborated with the leaders of community-based organizations, neighbourhood and village chiefs, and local government officials to identify low-income people eligible for non-contributory membership (Ouattara and Ndiaye, 2017). In the United Republic of Tanzania, a district-level community health fund coordinator was responsible for monitoring subsidized membership, utilizing funds and reporting on the Health Solidarity Fund (Borghi et al., 2013).

In contributory schemes, two scenarios have been identified. In the first scenario, mutuals/CBHI are responsible for collecting contributions from their members (Cambodia, Ethiopia, Ghana, Rwanda). For example, in countries where health insurance was compulsory, such as Ethiopia (ILO, 2021c) and Rwanda (Kamwenubusa et al., 2011; Ouedraogo and Flessa, 2016), the committee at the level of the cell or the section was responsible for collecting and managing contributions. However, when health insurance was not compulsory (Burkina Faso, Mali, Senegal), the task of collecting contributions could be difficult for mutuals/CBHI. This calls into question the idea that mutuals/CBHI provide additional or "self-financed" resources for expanding social health insurance. In the other scenario, another centralized body handles contribution collection rather than the mutuals/CBHI. For example, in France, a social security and family allowance collection network (*Union de recouvrement des cotisations de sécurité sociale et d'allocations familiales* – URSSAF) is responsible for collecting social security contributions and distributing them to the various social protection

institutions, including the National Sickness Insurance Fund (*Caisse nationale de l'assurance maladie* – CNAM), which pays the mutuals/CBHI that have been tasked with managing the benefits (Chevreul et al., 2015).

Pooling of funds and risks. Although risk sharing and solidarity are values attributed to mutuals/CBHI, the degree to which funds and risks are pooled is poorly documented. In some countries, mutuals/CBHI seemed to have been the body responsible for pooling, while in others, this process was carried out either by a national body or at a sub-national level, with the pooled funds being returned to the mutuals/CBHI. The pooling of several funding sources creates solidarity within a broader risk-sharing scheme. In addition, it allows the cross-subsidization of health-care structures in different locations. For example, in Rwanda, the national guarantee fund for mutuals/CBHI (*Fonds national de garantie des mutuelles de santé* – FNGM)[8] subsidized an amount equal to the contribution made by the insured persons (Diop, Leighton and Butera, 2007; Kamwenubusa et al., 2011). In Colombia, funds for the care of poor and vulnerable groups were transferred to mutual associations federated into a national institution (Coheur et al., 2007). In the United Republic of Tanzania, funds were pooled at the district level through Cost Sharing and Insurance Funds (CSIFs) to enable cross-subsidization between health centres (Borghi et al., 2013; Soors et al., 2010). In Senegal, within the framework of the UDAM, the local mutual insurance company is responsible for the risk pooling for primary care, while the departmental union takes on risk pooling for hospitalization (Ouattara and Ndiaye, 2017).

Contracting and the management of relations with health-care providers. In the identified experiences, contracting with health-care providers was frequently delegated. They can have the following functions:

• Manage the signing of contractual agreements with health-care service providers and their follow-up (Belgium, Burkina Faso, Ethiopia, Mali, Nigeria, Rwanda, United Republic of Tanzania) either independently (Mali, Senegal) or as part of a national process agreed with the Government (Belgium, Rwanda). In Rwanda, in collaboration with the technical support unit for health mutuals (*Cellule technique d'appui aux mutuelles de santé* – CTAMS), the district mutual provided technical assistance to the mutual insurance sections, including training for the management and the supervision of contractual relations with health-care centres (Diop, Leighton and Butera, 2007).

8. Mobilizing partner funds, private health insurance in the country, the government and health-care establishments.

• Purchase health-care services (in most of the experiences identified). The benefit payment methods are diverse, and it is not possible to determine whether it is the mutuals/CBHI that make decisions on the method or whether these are decisions taken within the framework of the general functioning of the social health protection system. The studies mention, among other things, that in Rwanda, some mutuals/CBHI paid providers a monthly prospective capitation rate, while others paid providers on a fee-for-service basis (Diop, Leighton and Butera, 2007).

And more rarely:

• Negotiate rates with health-care providers (Ghana, Senegal).
• Monitor service use by collecting data and writing reports (Rwanda).

Some publications mention the use of third-party payments by mutuals/CBHI to facilitate access to care for users without any advance payment on their part (Belgium, Cambodia, Ethiopia, France, Spain), sometimes within the framework of broader health insurance policies at the national level (France).

Provision of health-care services. In some countries, mainly in Latin America, mutuals/CBHI played the role of health-care provider as they had their own health-care facilities (Colombia, Uruguay). Before the introduction of compulsory health insurance in Morocco, some mutuals/CBHI had both an insurance and a health-care provider role (European Economic and Social Committee, 2013). Within the legal framework for the adoption of compulsory health insurance, the functions of the compulsory health insurance manager and the care provider for compulsory health insurance beneficiaries were separated. The concerned mutuals had to create separate entities; some focused on the delegated management of compulsory health insurance, and others, which could be contracted within this framework, were in charge of the management of health-care facilities (Conseil économique, social et environnemental, 2018; Cour des comptes, 2018).[9]

Participation and governance. Community participation, through social mobilization and the commitment of the mutuals/CBHI beneficiaries to a more democratic management of the social health protection system, was only rarely addressed in the documents listed. In several countries (Burkina Faso, Ethiopia, Ghana, Nigeria, Rwanda, Senegal, United Republic of Tanzania), communities were involved in decision making in the following areas:

9. For example, the Mutuelle des unités sanitaires des fonctionnaires et agents assimilés du Maroc, the Mutuelle des oeuvres sociales et sanitaires du personnel de l'office d'exploitation des ports and the Mutuelle des actions sanitaires et sociales des forces auxiliaire.

contracting and negotiating with health-care providers; the provider payment system; registration management; the collection and management of contributions; and the management of beneficiary information.

In Nigeria, the programme managers of community-based mutuals/CBHI were responsible for helping the new participating communities set up boards of directors and for carrying out capacity-building activities (National Health Insurance Scheme, 2012).

In countries where there is no delegation of management, in the sense of the working definition, because the mutuals/CBHI are not independent entities or have been absorbed into the national system, their governance was based on consultation and community management. In Ghana, it was the National Health Insurance Authority (NHIA), responsible for the management of the National Health Insurance Scheme (NHIS) at the central level, that licensed and regulated district mutual health insurance schemes (DMHIS). The State had a significant role in the governance of these mutuals, appointing board members (Boon, 2007). In Rwanda, district and sectional mutuals/CBHI were managed at the national level by the Rwanda Social Security Board (RSSB). The State appointed the members of the board of directors by ministerial order (Kestemont et al., 2020).

Furthermore, in some countries, mutuals/CBHI could compete with private insurance companies to win management-delegation agreements with public social protection institutions (Colombia) (Coheur et al., 2007). However, these trends often have a negative impact on the capacity of non-profit organizations to play socially transformative roles in engaging and empowering their target groups and defending their rights, possibly linked to a move away from their original values and missions (Almog-Bar and Schmid, 2014; Alexander and Fernandez, 2021).

To what extent are functions delegated to mutuals/CBHI?

Analysis of the documents makes it possible to identify a typology as follows:

- **Countries where mutuals/CBHI have a high degree of independence and where there is no delegation of health insurance management in the sense of the working definition.** For these, there is an allocation of a certain role or functions to the mutuals/CBHI, alongside state intervention, which is limited to regulation and sometimes fostering the creation of insurance companies. In this case, they have all the functions of a health insurer. However, this significant level of autonomy often results in difficulties in operating and achieving a minimum level of coverage to ensure viability (initial situation in Burkina Faso, Mali, Senegal).
- **Countries where mutuals/CBHI have a delegation to administer compulsory health insurance.** These have less autonomy, limited delegated

functions, and a tight framework but have relative long-term stability (Belgium, France, Uruguay).

• **Countries where the mutuals/CBHI are public or para-public entities dependent on the national system, either since their creation** (Rwanda, United Republic of Tanzania) **or since being absorbed at the time of the creation or reform of a national system** (Cambodia, Ghana, Laos, Thailand). For these, there is no degree of delegation as such, but rather a distribution of roles between the centralized level (generally ensuring back-office functions) and the decentralized level (generally in charge of direct service delivery and local governance functions).

The experiences listed are at different stages of implementation and are liable to change significantly over time, making it challenging to offer a lasting categorization within this typology. Changes occur during the scaling up or institutionalization of the social health protection system (Ghana, Rwanda) or through the repositioning of actors over time (France). For example, in Mali, to implement universal health insurance by 2023, a process to restructure community-based mutuals/CBHI into communal mutuals/CBHI was set in motion (Ouattara and Ndiaye, 2017). In Senegal, while two different approaches were being tested (DECAM and UDAM), the State has recently decided to dissolve the communal mutuals/CBHI and reallocate the departmental units to the national level. Furthermore, the involvement of mutuals/CBHI in social protection systems is more complex than the management delegation framework mentioned in the introduction from both a historical and operational point of view.

What are the factors facilitating or restricting delegation?

Regulatory framework. The standardization of the organizational structures and financial management of mutuals/CBHI was found to have facilitated the process of their integration into the social health protection system, especially in the scaling-up process that has taken place in Ghana (Baltussen et al., 2006) and Rwanda (Chemouni, 2018).

Contractual framework and agreement. Although the clarity of the contractual framework (including the definition of delegation and the expected objectives) has been identified as a critical factor in its success, few documents address the practicalities.

In countries where mutuals/CBHI were conceived as decentralized, non-independent management structures, the centralized governance of the social health protection system was a means of better structuring delegation and the roles of each actor, as in Ghana, Rwanda (Kestemont et al., 2020) and the

United Republic of Tanzania (Borghi et al., 2013). In these countries, it has also been observed that social acceptance of decentralization and the community approach and political ownership of the delegation process have been fundamental, particularly in Ghana (Adomah-Afari and Chandler, 2018; Kestemont et al., 2020). In addition, the centralization of the risk pool at the national level has promoted better risk sharing (Kestemont et al., 2020).

Institutional and management capacities. In a dynamic of scaling up, the poor monitoring and auditing capacities of the authorities supervising and regulating mutuals/CBHI can create significant dysfunctions in the delegation. For example, in Cambodia, the Ministry of Health could not implement controls or monitor the results of the mutuals/CBHI (Annear et al., 2013).

In many countries, the State has set up national agencies in charge of social health protection systems that are responsible for the relationship with contracted mutuals/CBHI, for example, the National Agency for Universal Health Coverage (*Agence nationale de la couverture maladie universelle*) in Senegal, the National Sickness Insurance Fund (*Caisse nationale d'assurance maladie – CNAM*) in France or the Tanzanian National Health Insurance Fund (TNHIF) in the United Republic of Tanzania. The institutional and management capacities within these public bodies responsible for social health protection systems' mutuals/CBHI are identified as important factors. For example, in Senegal, mutuals/CBHI had weak operational capacities, which often resulted in dysfunctional agreements with health-care facilities, reviews of invoices, payments to facilities, and a lack of remuneration of their own employees (Daff et al., 2020; Kestemont et al., 2020). The national agency in charge of universal health coverage did not initially play a role in bearing and pooling risk at a national level, resulting in the delegation of this function to many mutuals/CBHI, none of which were necessarily professionalized, which led to significant fragmentation and little solidarity at the national level (Daff et al., 2020; Kestemont et al., 2020). The professionalization of mutuals/CBHI would appear to be a prerequisite for improving their efficiency as delegators (Rouyard et al., 2022) and for their upscaling (France, Belgium, Nigeria, Rwanda) (Boidin, 2021).

Coordination with the health-care system. The availability of the products and services included in the benefits package at the health-care facility level is essential to guaranteeing continuity and community confidence in the functions of mutuals/CBHI (Ouedraogo and Flessa, 2016). Difficulties in the functioning of health-care facilities, in terms of insufficient inputs or human resources, constitutes a considerable limitation to the proper functioning of delegation (Raheem et al., 2019).

The involvement of regional and district health officials and local authorities in raising the awareness of local communities should facilitate a better understanding of the roles of each actor in social protection and the community-based management of mutuals/CBHI. For example, in the United Republic of Tanzania, the district health committee, the health-care facility management committee, and health-care workers were responsible for encouraging membership of the community health fund and informing the community of the funds collected and how they are used within health-care facilities (Borghi et al., 2013). In some contexts, service providers and communities may have little understanding of the system and the functions delegated to mutuals/CBHI, as they are often not involved in delegation processes. This has been identified as a barrier to community buy-in and involvement (Boon, 2007) and as a disincentive to the use of health services by beneficiaries (Kadio et al., 2018).

Sustainable public financing. A lack of public funding for social health protection systems has often threatened the sustainability of delegation. Indeed, in several countries, the delegation of management to mutuals/CBHI was accompanied by public subsidies (participation in operating costs, subsidies for all or part of the contributions). In such a context, insufficient government funding and/or delays in disbursement have been a significant challenge in the implementation of the delegation of functions to mutuals/CBHI in Cambodia (Annear et al., 2013), Thailand (WHO, 2004) and the United Republic of Tanzania (Borghi et al., 2013).

Furthermore, in some lower-income countries, the transformation of the social health protection system and/or the development of mutuals/CBHI is often financed and supported technically by international donors. To fulfil their functions, mutual insurance companies mutuals/CBHI often depended on external, non-sustainable funding to fulfil their functions. In Ethiopia, for example, USAID funding enabled to increase membership and contribution collection rates, something which could not be sustained after this financial support ended (Kestemont et al., 2020).

When the collection of contributions from members is delegated to mutuals/CBHI and when the social health protection system is not compulsory or the financing arrangements (contribution rates, lack of subsidies) are not adapted, the performance of this collection function remains a significant challenge. Indeed, poor people often find it difficult to pay their contributions, a category in which workers in the informal economy are disproportionately represented (Boon, 2007; Diop, Leighton and Butera, 2007; Soors et al., 2010). For example, in Mali, the evaluation of the pilot phase of the national strategy for the extension of coverage (*Stratégie nationale d'extension de la couverture maladie – SNEM*) through mutuals/CBHI in 2015 revealed a low level of state

subsidies which had managed to mobilize only 19 per cent of the effective subsidy rates and that was accompanied by a low rate of penetration (Ouattara and Ndiaye, 2017). In contrast, in the United Republic of Tanzania, the allocation of a subsidy equal to membership fees by the Government was found to be an effective incentive for people to enrol over the long term (Soors et al., 2010).

What are the effects of delegation?

When the delegation of functions was introduced as part of the creation of a national social health protection system that sought to include pre-existing mutuals/CBHI, it made it possible to extend national coverage by integrating the members of mutuals/CBHI into a broader risk pooling system (Cambodia, France, Japan, Laos, Thailand, Uruguay).

Where the national system was created with the intention of developing mutuals/CBHI into local and participatory management mechanisms, experiences vary greatly. In Ghana, Rwanda, and the United Republic of Tanzania, a relatively centralized approach with little autonomy for community-based mechanisms has resulted in broad coverage and financial sustainability, while the professionalization of these structures has also created a less participatory structure (Chemouni, 2016; Kestemont et al., 2020). Similarly, the agreement of public service contracts with mutuals/CBHI or their absorption into national social health protection programmes has had the effect of increasing the number of community-based organizations and transforming small mutuals/CBHI into district- or department-wide entities (Adomah-Afari and Chandler, 2018; Borghi et al., 2013). Moreover, this process may have occurred alongside professionalization (Kestemont et al., 2020).

Discussion

The discussion of the results of this review is organized into six themes in which we highlight the salient observations arising from the country experiences in reviewed documents. In turn, the issues and challenges posed by the delegation of functions are also discussed to identify lessons learned from existing experiences.

Conceptual framework

The scoping review revealed a lack of conceptual clarity on the terminology used, owing to the lack of a consensus on definitions. Mutuals/CBHI are defined in different ways. This reflects a more general diversity within the social and solidarity economy, where definitions differ according to national contexts as

well as the legal framework (ILO, 2022). The lack of a clear definition and legal status can be an obstacle to the delegation of public services. At the same time, some countries have used the term "mutual" to designate decentralized public administration bodies.

Similarly, the concept of delegation is rarely used in the documents evaluated, and when it is, it is not necessarily defined as strictly as in our working definition. Little information was found on the details of the provisions of agreements between public authorities and mutuals/CBHI. This may indicate three potentially concurrent phenomena. First, the review found that in several countries the institutions in charge of the social health protection system were non-existent, in the process of being created or had little capacity. This situation could result in a division of functions with mutuals/CBHI or institutional encouragement for their creation, rather than an actual contracting process based on a clear delegation of management. Second, in other countries, the mutuals/CBHI were, in fact, state-dependent bodies with participatory governance. As such, there was no delegation in the strict sense (with the signature of a delegation agreement) as the bodies belonged to the public entity, so the arrangement did not give rise to an agreement. In a third scenario, there is an agreement, but this process did not seem to have been studied using comparative analyses that would make it possible to identify good or bad practices.

A historical process in constant evolution

The scoping review highlighted that the decision by governments in some countries to delegate certain functions relating to the implementation of social health protection systems to mutuals/CBHI is based on historical processes rather than on cost-benefit assessments of these mechanisms. Also, delegation is not systematically followed by evidence-based evaluations. In addition, little information or research has been identified on the benefits of contracting mutuals/CBHI as opposed to other mechanisms, such as direct government management. Moreover, this historical process is dynamic, and the role of mutuals/CBHI with delegated functions has evolved over time. Three types of historic "starting points" can be identified:

- In some countries, mutuals/CBHI for health and social protection were created to compensate for the absence of a national social protection system. As a result, when the system was created or expanded, the mutuals/CBHI were contracted as management delegates for the groups they already covered (France, Morocco, Uruguay) or absorbed by a new public institution to put an end to their fragmentation and to pool risks on a larger scale (Laos, Thailand), and in some cases, both processes occurred.

- When the national system is incipient or non-existent, the mutuals/CBHI can be recognized as actors in the social protection system, even when their scope remains limited. In such instance, they tend to provide all the insurance functions without any agreement with the public authorities and encounter difficulties in viability linked to a lack of funding, weak management, and limited risk pooling.
- In other countries, mutuals/CBHI were conceived as community management mechanisms of the national social health protection system at the time of its creation or reform, so the delegation of functions did not necessarily go through an agreement process, and in some cases, these mutuals/CBHI are not or are no longer independent entities (Ghana, Rwanda, United Republic of Tanzania).

Furthermore, the models adopted by some countries seem to have been taken up and adapted by others. The dissemination and scaling-up processes should be considered further in subsequent studies (Niang, 2022; Seppey, Ridde and Somé, 2020). While village-based mutuals/CBHI were struggling to develop in Senegal, Criel (1998) had already proposed the creation of district-level mutuals/CBHI and suggested scaling them up gradually. However, in a context where development actors tend to export ideas, it would be essential to understand these processes (Gautier et al., 2019). For example, the Rwandan model is frequently cited as a source of inspiration. However, Rwanda's specific political and social context may limit the transferability of public policy models (Ridde et al., 2018).

Delegation requires a well-developed health insurance architecture and strong institutions

The delegation of functions has to be part of a broader architecture of the national social health protection system and the health and social protection system, more generally, with strong public institutions. Deficits at this level affect the attractiveness, feasibility and effectiveness of delegation. This architecture requires adopting equitable and sustainable health financing, social protection governance mechanisms, and well-defined social health protection coverage parameters. For example, in Burkina Faso, although universal health insurance was launched in 2000, at the time of the study included in this review, it had not been put into operation, and there was, therefore, no operational framework for the delegation of roles and functions to mutuals/CBHI (Ouedraogo and Flessa, 2016). International social protection standards can guide the development of a robust social health protection architecture and the choice of appropriate coverage parameters (ILO, 2020).

Mutuals/CBHI are not a substitute for the sustainable financing of social health protection systems

In the countries studied, the delegation of functions is a management tool at the disposal of the public authorities, which requires remuneration or financing. In this sense, the idea that mutuals/CBHI would be a tool for generating funding for social health protection systems in a self-sufficient way does not seem to have been verified, especially when social health protection is not compulsory; the penetration rates of mutuals/CBHI are low, and contribution levels are ill-adapted without the participation of employers or the State.

In several lower-income countries, it has been noted that the delegation of functions to mutuals/CBHI is funded through international donors who often guide the structure of delegation and governance mechanisms (Ridde et al., 2022; Verbrugge, Ajuaye and Van Ongevalle, 2018). However, the lack of coordination between the various donors involved in health and social protection agencies is an important challenge in ensuring the sustainability of the delegation of functions to mutuals/CBHI. In Cambodia, for example, CBHI set up through a project has ceased to exist following the end of the project (Kolesar et al., 2020).

The selection of functions to delegate

Some functions seem to be delegated more than others or with greater success. Experiences show that responsibilities related to delivery are more often delegated, i.e., the management of registration, sometimes the collection of contributions, the management of beneficiaries, local governance, and the management of reimbursements/payments to health-care providers. In contrast, the situations seem to be more varied for decision-making functions concerning the parameters of coverage, the pooling of resources, risk sharing, financing (including contribution rates, if applicable), and relations with health-care providers at the national level (contracting, tariff negotiations). In several countries, these functions are centralized and seen as the prerogative and duty of public bodies.

Community mobilization and participation

The professionalization and centralization of certain resources and management practices, although identified as factors in the success of the delegation of management to community structures, sometimes seem to harm the community and participatory dimensions. Community participation in governance has decreased over time in countries with a long tradition of delegating functions to

mutuals/CBHI or having eventually absorbed them (Cambodia, France, Japan, Laos, Rwanda, Thailand, Uruguay). Furthermore, although the participatory structure of mutuals/CBHI is identified as an advantage of the delegation that can, in theory, lead to confidence in the social protection system and create a local democratic base, in practice, the function of social mobilization and the organization of participation does not seem to have been identified within the delegation frameworks. The impact of delegation on these aspects is not well documented either. This paradox is one of the areas for future research that has emerged from the scoping review.

Conclusion

This review has made it possible to identify publications on the delegation of functions to mutuals/CBHI in the social health protection systems of 18 countries. For several reasons, obtaining a general worldwide overview of all lived experiences was challenging. First, this subject has been little studied. Moreover, no internationally agreed definition of mutuals/CBHI or of the delegation of management or functions exists. A second challenge encountered is the dynamic nature of the experiences of delegating functions to mutuals/CBHI. It was not easy to conduct a comparative inter-country analysis, especially as comparative assessments are rare and causal challenges are significant. Some countries' experiences were not current at the time of the review, and more recent innovations had not yet been published. Regardless, the results obtained make it possible to establish a set of findings and lessons that can be used to advance knowledge on this subject, which can be used both in research and practice.

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Supporting information

Additional supporting information can be found online in the Supporting Information section at the end of this article.