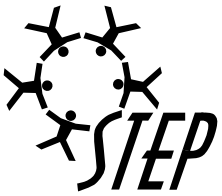
Health Micro-Insurance Schemes: Feasibility Study Guide

Volume 1: Procedure



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The programme's activities are carried out within the Social Security Department of the ILO, and particularly its Global Campaign on Social Security and Coverage for All.

STEP Programme
Social Security Department
International Labour Office
4, route des Morillons
CH-1211 Geneva 22
Switzerland
Tel: (+41 22) 799 6544
Fax: (+41 22) 799 6644
Email: step@ilo.org
http://www.ilo.org/step

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If you wish to do any comments, observations, to share the findings of your research works, or to obtain further information, please contact:

ILO/STEP
Social Security Department
4, route des Morillons
CH-1211 Geneva 22, Switzerland
Phone (41 22) 799 65 44
Fax (41 22) 799 66 44
E-mail: step@ilo.org
Internet: www.ilo.org/step

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List of acronyms

CIDR	Centre International de Développement et de Recherche
DTP1	1st dose of diphtheria-tetanus-whooping cough vaccine
HMIS	Health micro-insurance scheme
ILO	International Labour Office
ILO	International Labour Organization
INN	International non-proprietary name
MU	Monetary unit
NFCP	National Federation of Coffee Producers
NGO	Non-governmental organization
NPMC	Non-profit-making Corporation
PNC	Prenatal consultation
STEP	Strategies and Tools against social Exclusion and Poverty

Introduction

How did the Guide come about?

The vast majority of the population in developing countries and countries in transition do not enjoy any form of social protection, which means, in particular, that they have no financial coverage in the event of sickness, accident or death. The lack of social protection in health care affects nearly 80 per cent of the population in most countries of Sub-Saharan Africa and Southern Asia, and nearly half the population of Latin America and the rest of Asia.

Persons excluded from social protection systems consist, for the most part, of informal economy workers and their families. Existing social security systems are hard pressed to provide coverage for such persons. Efforts to extend social protection to them are usually carried out through new and specially adapted mechanisms.

These mechanisms are most often based on initiatives taken by the people themselves and by various civil society actors, including non-governmental organizations (NGOs), trade unions, microfinance institutions, hospitals and health centres. Among the initiatives to provide coverage in the event of sickness are health micro-insurance schemes, which have grown considerably in number.

The term "health micro-insurance" encompasses a wide variety of schemes. These include: mutual health organizations, which are autonomous associations based on the solidarity and democratic participation of their members; insurance schemes, which are organized and managed by health care providers (a health centre or a hospital may offer its users a reduction in health expenses or access free-of-charge to certain health care services in exchange for the payment of a premium); health insurance schemes set up by other actors, such as NGOs, microfinance institutions, cooperatives or trade unions.

What all health micro-insurance schemes have in common is that they operate on the basis of the insurance mechanism, which relies on the prior payment of premiums, the sharing of risks and the notion of a guarantee. The premiums of insured persons are pooled and used to cover the expenses of only those persons affected by the occurrence of a certain number of specifically defined risks. In exchange for their premiums, insured persons receive the insurer's guarantee to provide this financial compensation. They renounce ownership of the premiums they pay in and can therefore no longer lay claim to them.

In spite of their dynamic nature, health micro-insurance schemes, in general, are quite fragile. As a recent development in an environment in which such initiatives are still rare, these schemes do not possess the hindsight and experience needed for an accurate determination of the financial risks they face. The financial safeguards of such schemes – reserves, reinsurance – and their promoters' level of competence in the area of insurance are presently still limited.

Given such a context, the foundations of health micro-insurance schemes – that is, the assumptions upon which they are based – must be particularly firm. A scheme will have greater chances of surviving, and subsequently of developing, if it is well designed from the outset. Therefore, conducting a feasibility study prior to setting up a scheme or to undertaking a new phase in its development appears to be essential.

The impetus for producing this Guide grew out of two observations:

- in order to ensure the sustainability and viability of a health micro-insurance scheme, it is important to define its characteristics in terms of its particular context. The feasibility study is a key contributing factor – though not the only one – to the success of a health micro-insurance scheme;

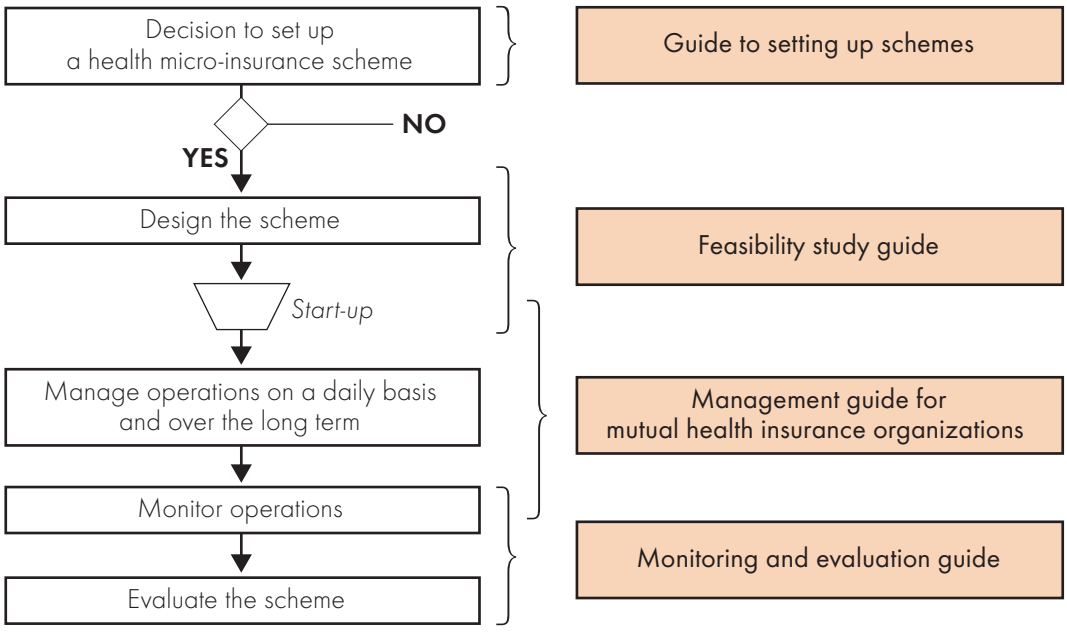
- the promoters involved must have a coherent set of methods and tools at their disposal in order to carry out this type of study.

This Guide was produced by the "Strategies and Tools against social Exclusion and Poverty" (STEP) programme of the Social Protection Sector of the International Labour Organization (ILO). For several years, STEP has been involved in efforts to strengthen the technical capacity of promoters and managers of health micro-insurance schemes and their support structures.

What are the objective and scope of the Guide?

The main objective of the Guide is to encourage and support efforts to conduct a systematic feasibility study prior to the establishment or further development of a health micro-insurance scheme. To that end, the Guide provides a set of instructions for conducting a feasibility study that consists of a step-by-step procedure in Volume 1 and methods and tools in Volume 2.

The *Health Micro-Insurance Schemes: Feasibility Study Guide* is part of a structured series of guides produced by STEP; the other guides therefore pick up where this one leaves off. In particular, the Guide neither deals with the relevance of setting up a health micro-insurance scheme, nor provides a precise and systematic explanation of how health micro-insurance functions. These two aspects are dealt with in the (soon to be published) guide to setting up health micro-insurance schemes. The *Health Micro-Insurance Schemes: Feasibility Study Guide* enables actors to design a health micro-insurance scheme and, consequently, to determine its organization and operating rules. It does not, however, provide a detailed explanation of the day-to-day management of the scheme, which is the subject of the *Guide de gestion des mutuelles de santé en Afrique* (ILO-STEP, 2003) (Management guide for mutual health organizations in Africa). For their part, the tasks of monitoring and evaluation are examined in detail in the *Guide de suivi et d'évaluation des systèmes de micro-assurance santé* (ILO/STEP and CIDR, 2001) (Health micro-insurance schemes: monitoring and evaluation guide). The following diagram illustrates the delineation of the respective scope of each Guide.



What are the limitations of the Guide?

This Guide is designed primarily for local organizations that manage a health insurance scheme. It distinguishes between schemes based on the members' active participation in management and those that do not provide for such participation. The first type of scheme includes, in particular, mutual health organizations. The second type includes, among others, schemes managed by health care providers and microfinance institutions. This distinction makes it possible to recommend methods and tools that are adapted to the main types of schemes; however, it does not allow for taking into account all the particularities of existing schemes.

The Guide deals exclusively with the establishment or the further development of a health insurance activity. It does not address the feasibility of other activities, such as health savings and health credit, nor the establishment and management of a health centre or pharmacy, which may also be set up by health micro-insurance schemes or local organizations.

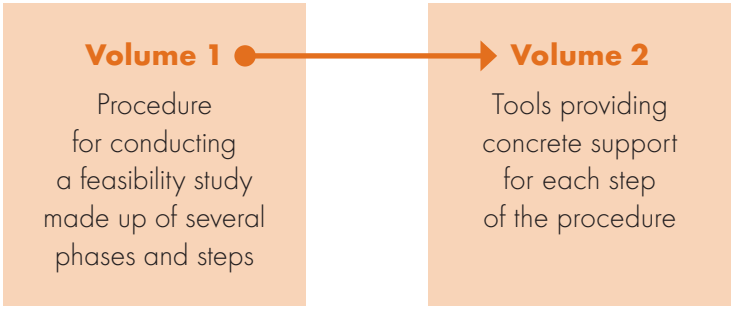
The Guide is aimed at the promoters of local schemes, regardless of their geographical location: Africa, Southeast Asia, the Indian subcontinent, Latin America. Nevertheless, the methods and tools presented in the Guide are, to a large extent, based on the experiences of the STEP programme in West Africa since 1998.

The *Health Micro-Insurance Schemes: Feasibility Study Guide* provides step-by-step instructions and useful tools for designing a health micro-insurance scheme, but is not sufficient for conducting the various operations of a scheme once it has been set up. Readers are therefore invited to refer to other guides published by ILO/STEP, in particular the *Guide de gestion des mutuelles de santé en Afrique* (ILO/STEP, 2003) (Management guide for mutual health insurance organizations in Africa) and the *Guide de suivi et d'évaluation des systèmes de micro-assurance santé* (ILO/STEP and CIDR, 2001) (Health micro-insurance schemes: monitoring and evaluation guide). Moreover, plans must be made to provide additional training or support concurrent with the start-up of operations, particularly in the areas of management, accounting and financial analysis.

The Guide does not offer a "magic formula" for successfully conducting a feasibility study. Feasibility studies depend, above all, on the creativity of the promoters of the health micro-insurance scheme. Rather, the Guide is intended to provide a basis for reflection and a toolbox that may be used to define and implement a procedure that is adapted to the particular context or situation in question.

How is the Guide structured?

The Guide consists of two volumes:



- Volume 1 provides step-by-step instructions for carrying out a feasibility study and assists actors in organizing the process of conducting the study.
- Volume 2 provides examples of supporting materials, tools, practical examples and methods of analysis and calculation, which offer concrete support for each step of the procedure. It facilitates the performance of certain technical tasks carried out during the feasibility study, such as drafting a questionnaire, utilizing the results of a survey, calculating premiums or drafting contracts or agreements.

Structure of Volume 1: Procedure

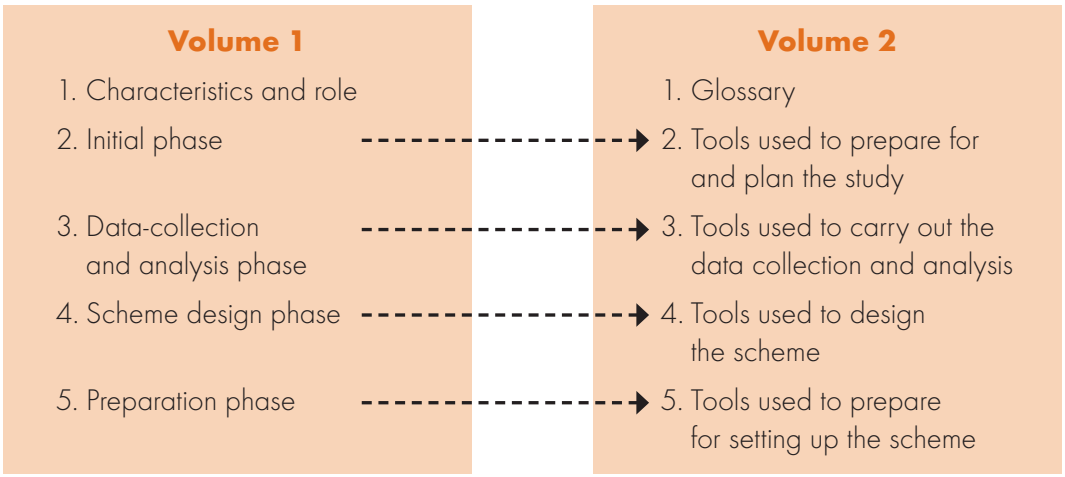
Volume 1 contains five chapters:

Chapter 1	"**Characteristics and role** of the feasibility study" provides a general description of the feasibility study, the actors involved and the role and importance of the study in terms of the viability of a health micro-insurance scheme.
Chapter 2	"**Initial phase** to prepare for and plan the feasibility study" describes the recommended procedure to follow prior to undertaking a feasibility study. It is advisable, first of all, to verify the relevance of the study, and subsequently, to prepare for the start-up of the study in terms of appointing a team, planning activities, etc.
Chapter 3	"**Data-collection and analysis phase**" proposes a method for conducting a coherent and rigorous data collection. The proposed data-collection method consists of several steps: defining the data-collection procedure (step 1), developing the data-collection materials (step 2), preparing for and carrying out the data collection (step 3), processing the collected data to produce usable information (step 4).
Chapter 4	"**Scheme design phase**" offers a step-by-step procedure for designing the scheme. This procedure consists of several steps, each of which involves the design of one aspect of the scheme: selecting health care providers, selecting the benefit/premium combination(s), determining the organization of the scheme, etc. For certain steps, the chapter suggests adopting a participatory procedure that associates various actors in the decision-making process.
Chapter 5	"**Phase to prepare for** setting up the scheme" briefly describes the feasibility study report, as well as the reference documents and tools that should be produced upon completion of the study in order to confirm all the decisions made during the scheme design phase and in order to start up operations.

Structure of Volume 2: Tools

Volume 2 consists, first of all, of a technical glossary, which defines the terms used throughout the Guide, and four subsequent chapters (Chapters 2 to 5). These correlate to Chapters 2 to 5 of Volume 1 and provide tools that are designed to be used during the various phases and steps of the feasibility study.

Chapter 1	"**Technical glossary**" defines the technical terms whose initial appearance in the text is followed by the symbol "*".
Chapter 2	"Tools used to **prepare for and plan** the feasibility study" offers guidelines for organizing discussion sessions with the target population and preparing for the feasibility study: planning, budget estimate.
Chapter 3	"Tools used to **carry out the data collection and analysis**" offers practical suggestions for defining the data-collection procedure, developing data-collection materials, calculating the size of a representative sample and transforming collected data into information that may be used during the scheme design phase.
Chapter 4	"Tools used to **design the health micro-insurance scheme**" provides data-presentation materials, materials to facilitate the decision-making process, definitions and diagrams illustrating or explaining certain mechanisms, calculation formulas and practical examples.
Chapter 5	"Tools used to **prepare for setting up the scheme**" presents document frameworks and outlines, as well as sample documents: contract, agreement, etc.



Chapters 2, 3, 4 and 5 of Volume 2 serve as support for the corresponding chapters of Volume 1.

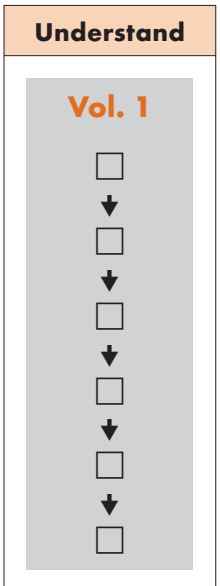
To whom is the Guide addressed and how should it be used?

The Guide is addressed to persons wishing to know what constitutes a feasibility study for a health micro-insurance scheme. Such persons may be satisfied with reading Volume 1 of the Guide, which focuses on the procedure for conducting a feasibility study.

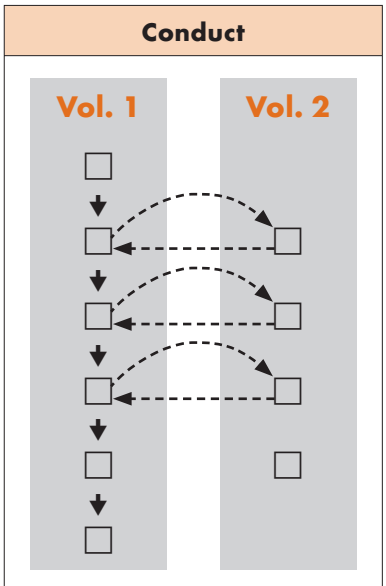
The Guide is also aimed at persons wishing actively to conduct a feasibility study for a health micro-insurance scheme, whether for the purpose of designing and setting up an initial scheme, or preparing for a new phase of development in an existing scheme through the introduction of new benefits, the re-definition of management procedures, the extension of geographic coverage, etc. Such persons are advised to use Volumes 1 and 2 simultaneously. Volume 1 helps readers to understand what needs to be done and why; it also contains numerous references to specific sections of Volume 2. Volume 2 may be seen as a large toolbox; it is not meant to be read in a linear fashion (from beginning to end), but rather to be referred to as needed in order to support certain sections of Volume 1, as indicated by the references contained in Volume 1.

Conducting a feasibility study presupposes a set of skills, all of which are rarely found in a single person. For this reason, the teams set up to conduct this type of study are often multi-disciplinary in nature and may, in addition, call upon external resources, particularly for completing certain technical tasks such as organizing a data-collection, analysing the collection results, calculating contributions or drafting legal instruments. Hence, it is difficult for a single person to follow all the recommendations contained in the Guide. Users will find it more useful to "retrieve" from the Guide the instructions and tools they need to conduct the step or steps of the study for which they are responsible.

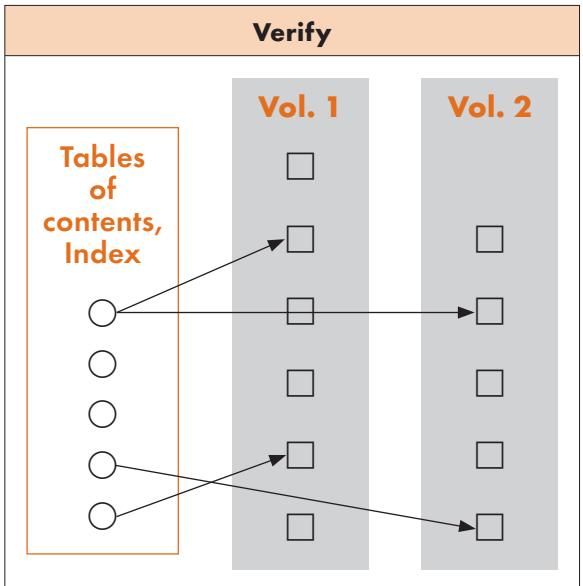
Lastly, this Guide may be used outside the context of a feasibility study as a reference tool. Readers can refer to it when they need to check a formula, draw inspiration from a sample questionnaire or contract, re-utilize a method, such as the role table, or check a line of reasoning or a definition. In such cases, users may consult the tables of contents or the index in order quickly to find the information they are looking for.



Volume 1 may be read in a linear fashion.



Volume 2 supports Volume 1, either by complementing it or by illustrating it.



The tables of contents and index enable readers quickly to find information they are looking for.

1. Characteristics and role of the feasibility study

What is a feasibility study?

A feasibility study* is the first step in any project aimed at setting up or further developing a health micro-insurance scheme*. Its objectives are to:

- test the relevance of the future health micro-insurance scheme; that is, ensure that it offers a suitable response to the problems raised, while taking into account the context in question;
- determine the characteristics of the future scheme that will encourage its development and sustain its viability;
- describe an initial situation to serve as a reference for the subsequent evaluation of the scheme's impact on the health context and on access to health care*.

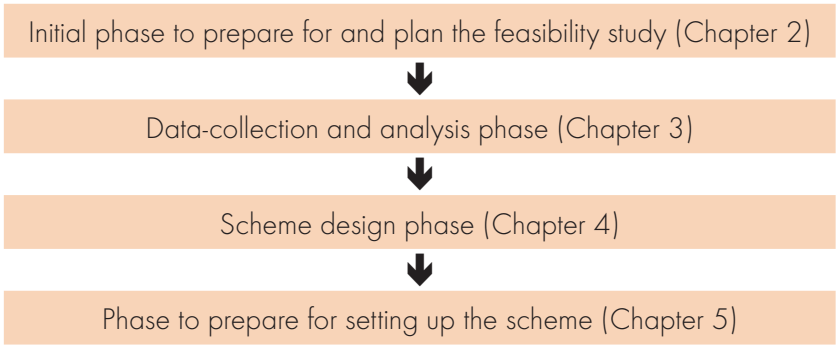
Note: In certain cases, setting up a health micro-insurance scheme may not be the best solution. For example, in a context in which there are no health care facilities* of acceptable quality, it might make more sense to improve the quality of existing health structures (or even create new ones) before setting up a health micro-insurance scheme. Likewise, in order to meet certain needs for the coverage of minor risks*, other methods of financing (prepayment*, health savings* and health credit*) may rival the effectiveness of insurance*.

For these reasons, a feasibility study should be approached with an open mind and without any preconceived notions as to what type of scheme to create or what type of benefits* to provide. Indiscriminate copying of other schemes should be avoided. The fact that a health micro-insurance scheme is operating in the country, the region or even in the next village, does not mean that it is well-suited to the needs and characteristics of the target population* or to the context of the particular micro-insurance scheme under consideration.

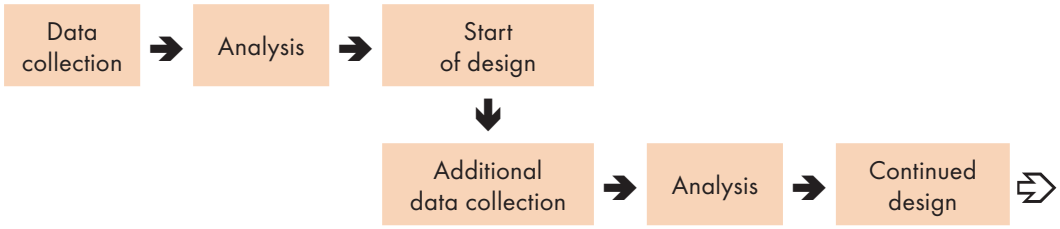
In particular, a feasibility study makes it possible to:

- highlight the problems requiring attention: difficulty experienced by the target population in meeting health expenses; problems related to the quality of existing health facilities; etc.;
- identify the causes of such problems: seasonal variations in income; inadequate income to meet certain health expenses, such as hospitalization; lack of motivation on the part of health care staff, etc.;
- validate the idea of setting up a health micro-insurance scheme;
- collect the data needed to make relevant choices and to design a sound health micro-insurance scheme;
- design the health micro-insurance scheme: services covered and levels of coverage*, organization of the scheme, operating rules, etc.;
- prepare for setting up or further developing the scheme: develop a strategy and a plan for setting up the scheme; prepare reference documents and the supporting materials and tools needed to start up operations;
- prepare for the official establishment of the scheme.

For the sake of simplicity, the feasibility study may be broken down into the following four phases:



In practice, feasibility studies are usually carried out in a more fluid fashion, alternating back and forth between analyzing the situation (based on the collection and analysis of data) and designing the scheme.



Who conducts the feasibility study?

The skills required

Conducting a feasibility study requires a particular set of skills and knowledge.

	Skills and knowledge required
Initial phase	● General knowledge of health insurance and project management ● Analytical skills ● Ability to conduct meetings, listen to others and engage in dialogue
Data-collection and analysis phase	● Familiarity with context and available sources of information ● General knowledge of health insurance ● Ability to conduct interviews, process survey questionnaires ● Computer skills needed for data entry ● Mathematical aptitude: calculation of indicators, interpretation of results
Scheme design phase	● Ability to conduct meetings, listen to others and engage in dialogue ● Technical competence in health insurance, especially as concerns the calculation of premiums* and the organization and operation of a scheme (rules and procedures) ● General knowledge of accounting and finance for establishing a budget estimate
Phase to prepare for setting up the scheme	● Ability to synthesize ideas in order to draft the feasibility study report ● Writing skills in order to draft legal documents and prepare management* tools, such as the procedures manual ● Computer skills needed to install management software, if applicable

The role of the promoter

It is usually the promoter of a health micro-insurance scheme who makes the decision to conduct a feasibility study. A promoter is an entity wishing to establish or further develop a health micro-insurance scheme. The promoter may be a local organization (such as an association*, non-governmental organization (NGO), cooperative*, microfinance institution, etc.); a health care provider* (such as a hospital); or a development agency (such as an international NGO, cooperation project, etc.), possibly working in partnership with one or more local organizations.

In some cases, the promoter can provide in-house all the skills required to carry out a feasibility study and can therefore assume responsibility for organizing and conducting it from the data-collection to the scheme design phase. When the promoter cannot provide all the skills required, it may delegate all or part of the responsibility for conducting the study to a technical support organization. For those aspects of the study for which the promoter is responsible, it supervises and guides the other actors in performing the tasks delegated to them.

The role of the target population

The target population refers to all the persons the future scheme intends to cover. It includes all potential members* and their dependents*. The target population may be defined on a geographical basis: persons residing within the radius of a health facility, the inhabitants of a rural or urban district, etc. It may also be defined on a socio-economic or socio-occupational basis: for example, the members of a trade union or cooperative, the employees of an enterprise, the members of a women's association, etc. The target population is not necessarily homogeneous. Particular importance should be given to certain sub-groups – such as women, young persons, ethnic minorities, foreigners, etc. – who may account for a large share of the target population.

The target population is directly affected by the establishment of a health micro-insurance scheme, given that the scheme will, a priori, modify its access to care.

Important. Within the target population, women usually play a predominant role in questions relating to health*, especially as concerns reproductive health, maternity care and family health. When identifying the needs of the target population and designing the scheme, it is important to encourage women to express themselves and share their opinions. Women are often in the best position to identify their own needs, and those of children, in terms of access to health care. Failure to give women a say can lead to the development of a scheme that does not meet the needs of a majority of the population.

Carrying out a feasibility study also requires the participation of other actors

These may include health care providers, health authorities*, local authorities or technical support organizations. The involvement of the actors most frequently participating in feasibility studies is described below.

Health care providers

These are the established public and private health care providers in the area in which the health micro-insurance scheme operates. They include hospitals, health centres, clinics, dispensaries, pharmacies, private physicians, etc.

Health care providers are directly affected by the establishment or further development of a health micro-insurance scheme, since the scheme partially changes the context in which they operate. Schemes may, for example, improve the solvency of the demand for care, introduce new standards of quality or alter the mechanisms used to pay for health services*.

As long as health care providers are not themselves promoters of the scheme, it is advisable for them to participate in certain phases of the feasibility study, as this will facilitate the scheme's subsequent relations with them. During the data-collection phase, health providers may, for example, provide information on the services available, the medical care consumption of the target population, etc.

However, when promoters plan to select one or more health care providers with which to conclude partnership agreements, care must be taken not to allow existing providers to become too closely involved before this selection is made.

Health authorities

These are the regulatory bodies and, in some cases, the real decision-makers of the health facilities. The health authorities include provincial, regional and national health departments.

The establishment of a health micro-insurance scheme may produce changes in the way in which health facilities function: new methods of payment, new standards of quality, new fees, etc. Generally speaking, such operational changes may be undertaken only with the authorization of the health authorities.

Local authorities

These refer to local administrative, religious and traditional authorities, as well as all local leaders. Among others, they include provincial administrators, district mayors, leaders of established religious communities, traditional chiefs, etc.

The establishment of a health micro-insurance scheme produces a change in the health and social context. Such changes may be facilitated by the approval and support of local authorities. In addition, the support offered by certain traditional or religious authorities can facilitate the enrolment of the target population in the scheme.

Local authorities must therefore be informed of the fact that a study is being conducted, as well as of the purpose of both the study and the future health micro-insurance scheme. Local authorities may provide useful information for understanding the socio-economic context or identifying other key stakeholders, such as active civil society organizations.

Support organizations

These are local, regional, national or international bodies capable of offering methodological and technical support to the scheme's promoters. Technical assistance may be provided by the decentralized departments of the State, private organizations (NGOs, consultancy firms), bilateral or multilateral technical cooperation programmes, unions* or federations* of health micro-insurance schemes, cooperatives, etc.

The promoters of health micro-insurance schemes do not always have the capacity to carry out all the necessary elements of a feasibility study. That presupposes technical know-how

and the use of specialized tools and methods. Technical support organizations may, within the framework of the feasibility study:

- provide methodological support: know-how for project management, facilitation, data collection, etc.;
- provide technical support: transfer of skills, methods and tools for data collection and analysis, statistical calculation, use of tailored softwares, etc.;
- provide financial support: financing for training programmes or for equipment, funds for the start-up of operations (reserve fund*, short- or long-term premium subsidies, etc.).

As stressed in Chapter 2, "Initial phase to prepare for and plan the feasibility study", it is advisable for the participation of all actors in the feasibility study to be coordinated by a steering committee*.

When should the feasibility study be carried out?

A feasibility study should be carried out before the start-up of a new scheme

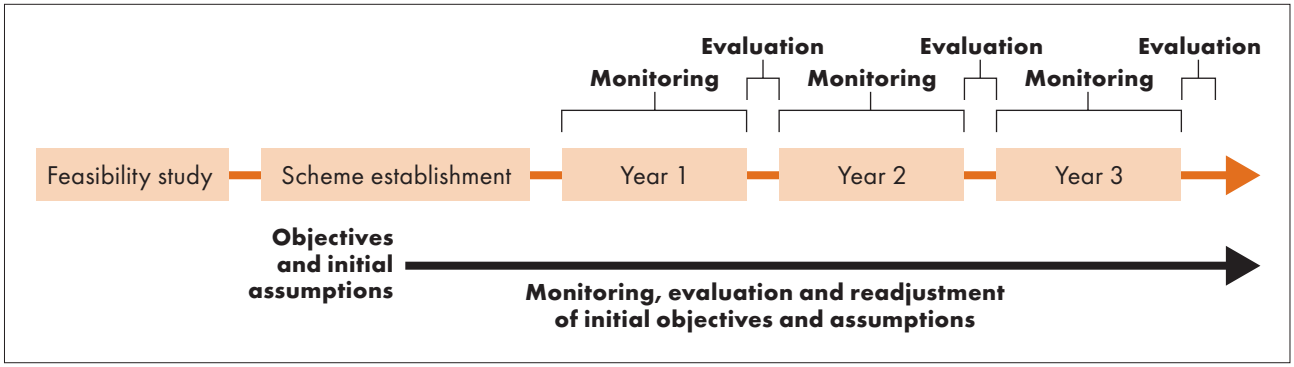
The establishment of a new health micro-insurance scheme is based on the conclusions of the feasibility study, and particularly on the selection of:

- the benefit/premium combination(s) *;
- the scheme's organizational framework;
- a set of operating rules.

These conclusions may be adjusted following the first few accounting periods*. In this respect, monitoring and evaluation play a crucial role by enabling adjustments to be made to the initial scheme design on the basis of experience.

In any case, feasibility studies permit schemes to get off to a good start and to avoid being confronted later on with regular upheavals that could discourage new members and eventually lead to the scheme's failure.

The following diagram illustrates the role of the feasibility study in defining the initial objectives and assumptions of the scheme, and the role of monitoring and evaluation in their ongoing readjustment.



A feasibility study must be carried out before each new phase of activity

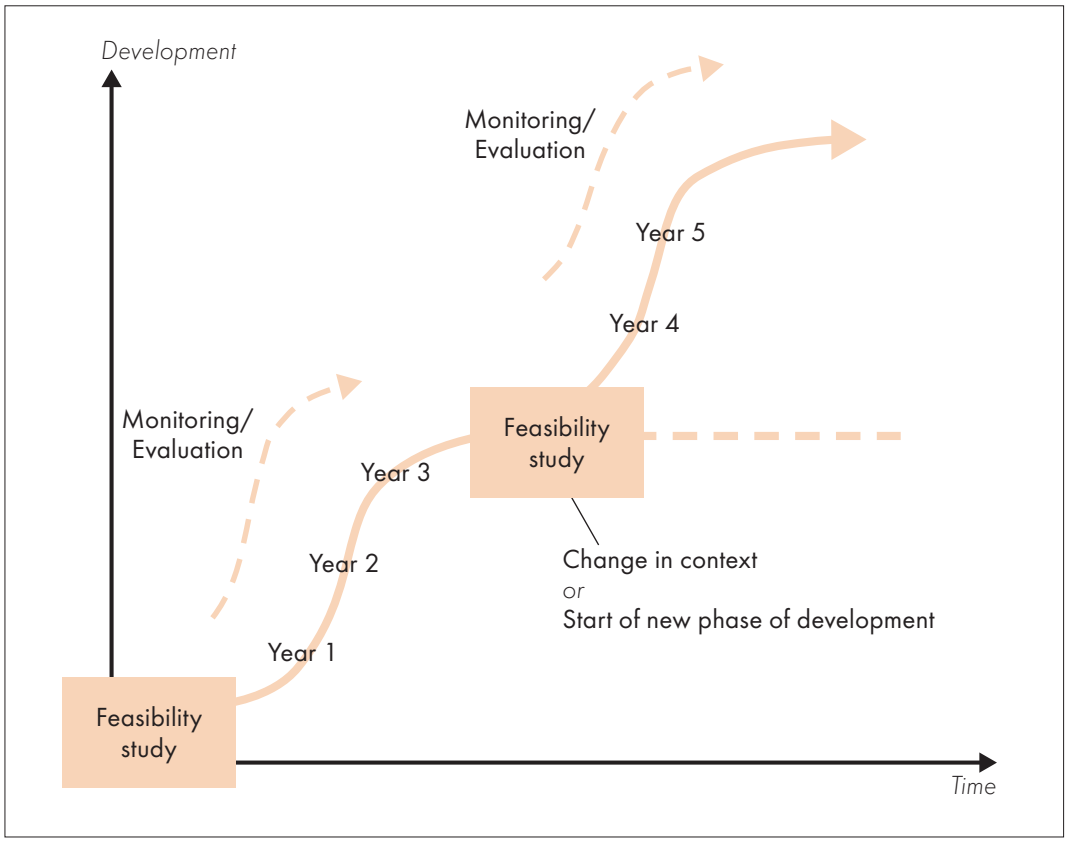
The development of a health micro-insurance scheme over the years usually consists of several phases. A set of objectives corresponds to each phase. When the objectives of a particular phase have been reached, the scheme may either maintain its "cruising speed" or begin a new phase of development in its operations: widen the scope of persons covered, offer new benefits, introduce new services, conclude agreements with new health providers, etc. Prior to the start of a new phase, it is important to carry out a new feasibility study.

It is also possible that, during a new phase of development, changes may occur in the data corresponding to the scheme's context, thus requiring certain features to be re-designed. It is important to carry out a new feasibility study in such cases as well.

Example: Following the enrolment of members of a large trade union, whose needs differ from those of the original target population, a scheme may decide to offer a new benefit plan* that is better suited to the needs of the new members.

These new feasibility studies enable promoters to verify the relevance of the developments or changes contemplated, and to define precisely the characteristics or activities of the scheme, while ensuring that they do not jeopardize the scheme's efficiency or viability.

The following diagram illustrates the recurring role of the feasibility study in determining the objectives and assumptions of each new phase of activity of a health micro-insurance scheme.



2. Initial phase to prepare for and plan the feasibility study

Introduction

Objective of the initial phase

The objective of the initial phase is to prepare for the feasibility study, in particular to:

- ensure that the preconditions for establishing a health micro-insurance scheme or further developing an existing scheme have been met, and to confirm the start of the feasibility study;
- set up a steering committee to be charged with conducting the feasibility study;
- plan the execution of the feasibility study and prepare its budget estimate.

Note: If certain preconditions have not been met, other solutions to the problems identified – besides a health micro-insurance scheme – may be envisaged. Conversely, the fact that all preconditions have been met does not guarantee the success of a health micro-insurance scheme. At this point, it is important to bear in mind that starting or further developing a health micro-insurance scheme is not necessarily the best response to the needs identified in a particular context.

The initial phase also marks the start of a process of information, education and communication with the target population and the other actors: health care providers, civil society organizations, health authorities, local authorities, etc. This process will be continued throughout the existence of the scheme.

Chapter contents

Chapter 2 offers an approach to implementing the initial phase that consists of the following actions:

- Verify that the preconditions have been met (action 1);
- Confirm the possibility of establishing a health micro-insurance scheme and begin the feasibility study (action 2);
- Set up the steering committee (action 3);
- Plan the feasibility study (action 4);
- Prepare the budget estimate for the feasibility study (action 5);
- Enter into dialogue with the target population and the other actors concerning problems related to health and access to health care (ongoing action).

The order of these actions is provided for information purposes. In practice, some of the actions may overlap, be repeated or be carried out in a different order.

For information on how to implement these actions, please consult the tools provided in Volume 2, Chapter 2:

▶ Useful tools

2.1 – Discussion sessions (page 27).

2.2 – Planning the feasibility study (page 31).

2.3 – Preparing the budget estimate for the feasibility study (page 33).

Action 1: Verify that the preconditions have been met

Prior to beginning a feasibility study, it is important to verify that setting up a micro-insurance scheme will address the problems identified and that a certain number of factors for success are present. These preliminary verifications are all the more necessary given that conducting a feasibility study sometimes entails a considerable commitment of resources.

Note: This is not the time to question whether the establishment of a health micro-insurance scheme is the best solution to the problems encountered in a particular context. The question of the pertinence and selection of a particular solution from among several options (expanding formal social security* schemes, setting up social assistance schemes or establishing community-based social protection* schemes) will be dealt with in the guide to setting up micro-insurance schemes.

▶ *Guide to setting up micro-insurance schemes*, soon to be published by ILO-STEP.

At this point, an effort should be made to check whether the following preconditions have been met:

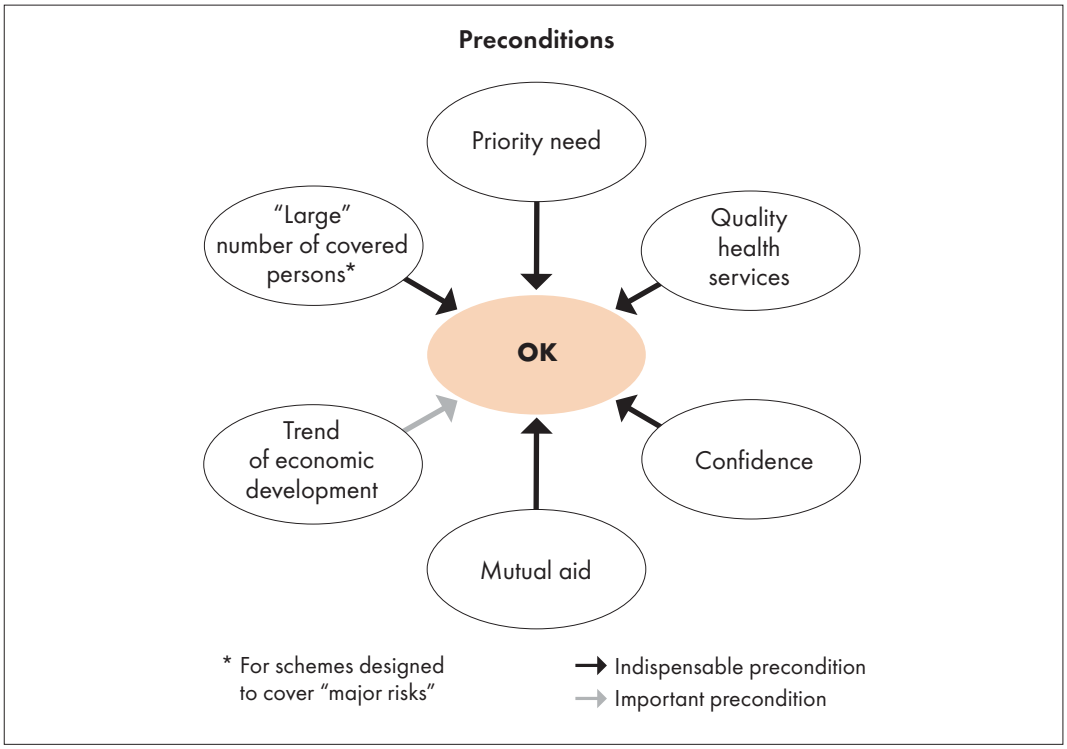
Precondition 1	A priority need exists for protection against the financial risk* associated with sickness and maternity
Precondition 2	Health services of acceptable quality are available
Precondition 3	The target population has confidence in the promoters of the scheme and in the other persons involved
Precondition 4	Traditions of mutual aid exist within the target population
Precondition 5	A trend of socio-economic development exists

And for schemes designed to cover major risks*:

Precondition 6	The potential number of covered persons* is sufficiently high as from the first year

The first four preconditions are indispensable. If one of these is not met, the process of setting up a health micro-insurance scheme may be halted, or reoriented towards another project, such as setting up a health care facility, a prepayment scheme, etc. The fifth precondition is important, but not indispensable.

The sixth precondition is introduced, particularly when the scheme plans to cover major risks – that is, risks that are particularly costly and unpredictable, such as hospitalization, surgical operations, caesarean deliveries, etc. In all cases, it is in the scheme's best interest to cover a relatively large number of beneficiaries* in order to reduce the burden of its fixed expenses.



The analysis of the preconditions is based primarily on information gathered during exchanges with the various actors. This includes information concerning the risk of sickness, the quality of health services, the strength of the local economy, traditions of risk management* and mutual aid, and the success or failure of past projects to pool resources. The analysis of the preconditions may also be based on documents relating to the health situation in the region, the strength of community-based efforts, etc.

For examples of topics of discussion, please refer to:

▶ **2.1 – Discussion sessions,** § *Sample topics of discussion,* Volume 2, Chapter 2, page 28.

Precondition 1: A priority need exists for protection against the financial risk associated with sickness and maternity

A health micro-insurance scheme makes it possible to meet the expenses associated with an episode of illness* or maternity. These include medical expenses, related expenses – such as transport to the hospital, accommodations for accompanying persons, food for the hospitalized patient* – and lost earnings, if the patient or the persons accompanying the patient must stop working.

Setting up a health micro-insurance scheme is worthwhile only if the financial risk associated with sickness and maternity is, in addition to being real, perceived by the target population as considerable, if not of priority concern. Although the need for protection in a context of free health care is certainly less significant than in a fee-based context, other health-related expenses, such as transport charges for travel to health facilities, may pose a problem for the population. If health care is fee-based, but the population has other needs – such as food or housing – that it considers more important, the establishment of a health micro-insurance scheme may not be perceived as a priority need.

THE REPERCUSSIONS OF THE FINANCIAL RISK ASSOCIATED WITH SICKNESS

Impact on health status

The fear of not being able to meet health expenses, or of having to interrupt an income generating activity during a course of treatment, sometimes compels individuals to postpone obtaining care at the risk of aggravating the state of their health.

Families must employ a variety of strategies in order to meet certain elevated health expenses and indirect costs. These include liquidating their savings, selling their possessions, requesting assistance from relatives, applying for credit, etc. This search for money takes time and is another factor that delays access to treatment.

When the amounts collected are not enough to pay for the quality of care that patients need, their complete recovery may be compromised.

Impact on standard of living

Among the strategies employed by families is that of liquidating their assets. Such a strategy can lead to the family's long-term impoverishment if it sells off its means of production. It can also increase the family's vulnerability if the family has no savings left to cover other major contingencies that may arise in the future.

A sick person's interruption of work leads to a loss of earnings and may be accompanied by unsound decisions as far as the future is concerned, such as taking children out of school and placing them in the job market.

When patients receive specialist treatment*, the expenses they incur may be considerable. The contingencies involved in this case are referred to as major risks. Conversely, when patients utilize primary health care*, the contingencies involved are referred to as minor risks.

Precondition 2: Health services of acceptable quality are available

The function of a health micro-insurance scheme is to assume total or partial responsibility for the expenses incurred in connection with the utilization of health services delivered by health centres, hospitals, private health professionals, pharmacies, etc.

No consideration can be given to establishing such a system unless a range of health services is available to respond to the principal needs of the target population, and unless the target population actually wishes to use those services. If the latter are of poor quality or are perceived to be inferior, the prospect of a health micro-insurance scheme will seem less attractive.

The existing health services must therefore be able to meet the principal health needs of the target population, be available nearby, present an acceptable level of quality and be well-regarded by the target population.

When the health care supply* does not meet these criteria, three solutions may be envisaged:

- the project to establish a health micro-insurance scheme may be abandoned;
- within the context of the project, a component aimed at improving the quality and availability of health services may be introduced. The quality of health services may be improved or the range of services offered may be expanded through agreements concluded between the scheme and the health care providers;
- an additional health care supply structure (health centre, for example) may be established. This is a relatively heavy task. Since it does not fall within the category of insurance, it will not be covered in this Guide.

When health care facilities are of acceptable quality, the establishment of a health micro-insurance scheme may – by improving the solvency of demand – increase the frequentation* of such facilities. This, in turn, may overburden health facilities and give rise to waiting lines, overworked staff, and medicine stock shortages. Thus, it is possible for a scheme to contribute to deteriorating the quality of care offered. For this reason, it may be useful, along with the establishment of a scheme, to encourage an optimum utilization of existing health facilities. This may include using compulsory referral mechanisms* to transfer patients from one level* of the health pyramid* to the next, or helping to increase the patient capacity of health facilities whose services are covered by the scheme.

Precondition 3: The target population has confidence in the promoters of the scheme and in the other persons involved

The existence of a health micro-insurance scheme presupposes the regular payment of premiums, which are then pooled to pay for the health care expenses of covered persons who require medical treatment.

The target population cannot easily be persuaded to pool its premiums when it lacks full confidence in the promoters and the other persons involved in the project. Its relationships with these parties must therefore be taken into account. The attitude of the local authorities is also important because their support is interpreted as an endorsement of the promoters and the other persons involved in the project.

Nor can the target population easily be persuaded to pool its resources when its experience with "collective" projects (service cooperatives, savings and credit funds, etc.) consists of projects that ended in failure. These experiences must also be taken into account when assessing the possibility of establishing a health micro-insurance scheme.

Precondition 4: Traditions of mutual aid exist within the target population

It is sometimes difficult for people to agree to the regular payment of a premium because its benefits are intangible so long as members and their dependents remain in good health. They may have the impression that they are paying premiums for the benefit of others who succumb to illness.

Understanding and acceptance of the insurance mechanism is facilitated when traditions of mutual aid exist within the target population. This spirit of mutual aid may arise from a number of situations: the fact of being residents of the same village or neighbourhood, co-workers of an enterprise, members of a social movement*, etc.

When such traditions do not exist, other mechanisms may be used to finance health expenses – such as prepayment, health savings or health credit – which are not based on resource pooling, but rather on individual financing. Since these mechanisms do not fall within the category of insurance, they will not be dealt with in this Guide.

Precondition 5: A trend of socio-economic development exists

It is difficult for households to make regular premium payments when they have other priority needs that strain their budgets, such as the need for food or housing. It is also difficult in a context of sluggish monetary circulation. Conversely, it is easier to agree to regular premium payments when a trend of socio-economic development exists.

This is an important precondition. Nevertheless, even if family incomes are low and do not always permit families, individually, to meet health care expenses, the pooling of premiums makes it easier, collectively, to meet the expenses of persons requiring medical treatment. This is what is known as risk pooling* or the sharing of risks among sick persons and those in good health.

Precondition 6: The potential number of covered persons is sufficiently high as from the first year

This precondition is particularly applicable to schemes designed to cover major risks. Major risks are rare contingencies that entail considerable expense, such as hospitalizations, dystocic deliveries, surgical operations, evacuations to other countries, etc.

Premiums provide coverage* for the health expenses of persons protected by the scheme. The calculation of premiums is usually based on estimates of the target population's average expected consumption of health care. When real consumption is greater than average consumption expected, the financial equilibrium of the scheme may be jeopardized.

Example: A survey of a sample of 350 households reveals that, on average, the risk of hospitalization per year for this sample is four out of every 100 persons. In the case of a health micro-insurance scheme that plans to cover hospitalizations, it may happen that the number of persons actually hospitalized in the first year is equal to the forecasted figure, that is, four out of 100 persons. It may also happen – and this is more likely – that the number of persons actually hospitalized is either lower or higher than the forecasted figure. If the scheme based its calculation of premiums on an average figure, the fact that the actual figure is higher than the forecasted figure may pose difficulties for the scheme.

According to the theory of probability*, deviations from the average are higher if the protected population is small and the covered risk is rare. Conversely, as the population increases in size and covered risks become more common, these deviations tend to decrease.

	"Small" number of covered persons	**"Large" number of covered persons**
Infrequent risk (ex: hospitalizations)	Deviation +++	Deviation +
Frequent risk (ex: consultations)	Deviation +	Deviation ≅ 0

A number of techniques may be used to take the impact of these deviations into account in calculating premiums; these techniques will be explained in the section on calculating premiums. However, when the number of covered persons is "too" small, it is difficult effectively to protect the scheme against the financial consequences of deviations from the average.

Consequently, when the target population is small (for example, the population of a village of 1,500 inhabitants) this usually results in a relatively low number of covered persons in the first year, making it unwise to set up a health micro-insurance scheme that covers major risks.

Action 2: Confirm the possibility of establishing a health micro-insurance scheme and begin the feasibility study

If the preconditions have been met, then the establishment of a health micro-insurance scheme may be considered a possible solution to the problems of access to health care encountered by the target population. At that point, the officials of the organization promoting the scheme may decide to begin a feasibility study. The launching of the feasibility study may be announced in the course of discussions with the target population, managers of health facilities and local authorities.

Action 3: Set up the steering committee

The steering committee is the team charged with conducting the feasibility study. It is usually comprised of between five and 10 persons, but may be bigger, especially when the study is being carried out simultaneously in several geographic areas. If there are too many members, the committee may not be able to function properly. Conversely, if there are too few members, the committee may not be representative of the target population and the main actors. The functions of the steering committee begin with the preparation of the feasibility study and end with the official establishment of the health micro-insurance scheme.

The steering committee also acts as an interface between the officials of the organization promoting the scheme and the target population, whose members, for obvious reasons, cannot all participate in carrying out the study.

The functions of the steering committee include:

- Conducting the study. The steering committee must plan and organize the various phases of the study. It must direct the study, monitoring the progress of each phase; perform any necessary adjustments – such as collecting data in an additional area; and make necessary operational decisions – such as recruiting a researcher.
- Conveying information to the target population and to the other actors; providing information concerning the feasibility study; identifying needs; and gathering opinions, experiences and advice from the various actors. The steering committee organizes information meetings and discussion sessions at the start of the study and leads working groups during the scheme design phase.
- Organizing and carrying out specific tasks with the support of external resources, if necessary. The committee may organize and conduct data-collection activities. It may analyze the data collected, present the results to actors during working group sessions and provide support for the collective decision-making and scheme design processes. Lastly, it may develop the strategy and plan for setting up the scheme, and draft the summary reports, tools and supporting materials needed to start up operations.

Thus, the role of the steering committee is not to decide what type of system to set up but, by organizing discussion and working group sessions with various actors, to foster a clear understanding of the problems, assist in finding solutions and promote the gradual emergence of a design for a health micro-insurance scheme that is adapted to the context and responds to the needs of the target population.

Setting up a steering committee involves selecting its members, assessing their respective needs for training and providing them with one or more training courses in order to prepare them for conducting the feasibility study.

Step 1: Set up the steering committee

The members of the steering committee may be identified in the course of contacts with the target population and the other actors. One of the objectives of the discussion sessions is precisely to identify a number of key actors who would be capable of taking an active role in conducting the feasibility study and possibly serving on the steering committee.

For a list of the objectives of the discussion sessions, please refer to:

▶ **2.1 – Discussion sessions,** § *Objectives of the discussion sessions,* Volume 2, Chapter 2, page 27.

The members of the steering committee must collectively possess a variety of skills: technical expertise in the area of health micro-insurance; experience in project management; ability to conduct meetings and interviews; familiarity with processing questionnaires; ability to analyse data, draft documents, use spreadsheets and management software, etc. The idea is to bring together members whose skills complement one another.

The members of the steering committee are generally from the organization promoting the scheme: an NGO, cooperative, trade union, hospital, microfinance institution, etc. When the promoting organization wishes to provide for the participation of the target population in setting up or further developing a health micro-insurance scheme (participatory approach),

the steering committee will also include representatives of the target population: members of a village association, members of a women's association, etc.

It is very important that, regardless of their affiliation or skills, members of the steering committee comprise a large percentage of women. Women are often in the best position to express their needs and those of children as far as access to health care is concerned. Not to give women a say in such matters may lead to the design of a scheme that fails to meet the needs of a large segment of the target population.

In certain cases, the managers of the health facilities may serve on the steering committee. This is especially true when the organization promoting the scheme is itself a health facility, or when a single health facility has a monopoly and meets the criteria for quality and proximity. On the other hand, when the selection of health facilities is not obvious (such as when health care is delivered by several competing providers and a selection must be made), it is preferable not to include the managers of the health facilities in the steering committee. They may unduly influence the selection process and reduce the scheme's negotiating potential.

When the steering committee does not include any representatives of certain categories of actors, it is nevertheless important for the committee to consult with the representatives of such groups at various times during the feasibility study.

Examples: If the steering committee does not include representatives of the target population (as when a less participatory approach is used), it is essential that the target population be consulted regularly by means of surveys, interviews and focus groups. This will help to ensure that the scheme meets the needs of the target population and corresponds to its willingness to pay*.

If the steering committee does not include the managers of the respective health facilities, the latter must be consulted at various times in the course of the study. During the data-collection and analysis phase, these officials may provide information that helps to increase understanding of the health context and the problems surrounding access to health care, to estimate the current utilization of health services by the target population and, ultimately, to serve as an input in calculating premiums.

When the local authorities and the health authorities are not included in the steering committee, they may be invited to attend various meetings (particularly the first meeting) as observers or advisers. In any case, they should be informed of the progress being made.

When the steering committee relies upon outside sources to provide certain skills, the support organizations in question may – without being full-fledged members of the steering committee – participate in its various activities and meetings.

Step 2: Assess the need for training and provide training for the members of the steering committee

In most cases, some or all of the steering committee members will require training in order to acquire the knowledge needed to take an active part in carrying out the feasibility study.

The goal is not to transform the members of the steering committee into insurance experts; the acquisition of such skills is far too long and arduous. It is preferable and less costly to call upon external services to carry out the more technical aspects of the feasibility study.

The idea is to assess the committee members' need for training by taking stock of their skills and knowledge in order to offer them the appropriate courses. The curricula of such courses may include basic and advanced theory, followed by a visit to the offices of one or more health micro-insurance schemes.

Examples of topics covered in training modules:

Basic modules	Advanced modules
● Principles of health micro-insurance ● Benefits provided by health micro-insurance schemes ● Types of schemes and the organization and functioning of each ● Procedure for carrying out a feasibility study ● Methods of facilitation	● Data collection (procedure, execution, analysis of data collected) ● Calculation of premiums ● Criteria for selecting benefit/premium combination(s) ● Management mechanisms, tools and documents

Example of "La Concertation" (Coordination network): In Western and Central Africa, numerous international organizations and programmes are involved in efforts to support micro-insurance projects that are currently under way, and organize training workshops aimed at the promoters of health micro-insurance schemes. Since 1999, these support organizations and a large number of health micro-insurance schemes, as well as promoters have joined together to form "La Concertation entre les acteurs du développement des mutuelles de santé en Afrique de l'Ouest et du Centre" (Coordination network between actors involved in the development of mutual health organization* in Western and Central Africa). Among other activities, the "Coordination network" maintains a web site (www.concertation.org) listing support organizations that may be contacted by local promoters. The site also provides numerous bibliographical references, accounts of experiences and ongoing information on major events in the field of micro-insurance, including the organization of training courses.

Action 4: Plan the feasibility study

Before beginning the feasibility study, it is advisable to formulate a plan indicating what must be done and when and how it must be done. This plan may take the form of a reference document that describes the activities to be carried out and is accompanied by an indicative timetable for conducting the study.

Planning the feasibility study makes it possible to:

- possess, at once, a macro and a micro view of the study and the course of action to be followed, including a description of each activity and task, its expected duration and the human and material resources needed to carry it out;
- ensure that sufficient time is allotted for carrying out all the activities and tasks in favourable conditions (or, conversely, that it does not take too long to complete them);

Note: On average, a feasibility study takes between four and 12 months to complete.

- make certain that the feasibility study remains an ongoing process that is not subjected to major interruptions that could risk discouraging the actors. It is particularly important to choose the starting date of the feasibility study so that it ends at an opportune time for starting or further developing the scheme and to ensure that the steering committee members are available throughout the duration of the study.

Planning the feasibility study consists of defining its various phases; breaking down the main activities of each phase and identifying the tasks to be completed for each activity (step 1); estimating the duration of each task on the basis of the workload and resources entailed (step 2); and organizing the activities and tasks in a timetable (step 3).

For an example of planning, please refer to:

▶ **2.2 – Planning the feasibility study,** § *Practical example: The National Federation of Coffee Producers* (NFCP), Volume 2, Chapter 2, page 31.

Step 1: Identify the various phases, activities and tasks of the feasibility study

The various phases of the feasibility study generally include:

- a data-collection and analysis phase. This phase usually consists of the following activities or steps:

Activity 1: Define the procedure to be used for the data collection

↓

Activity 2: Develop the data-collection materials

↓

Activity 3: Prepare for the data collection (test collection materials, recruit and train researchers, etc.)

↓

Activity 4: Carry out the data collection (collect data from health facilities, households, etc.)

↓

Activity 5: Transform collected data into usable information

- a scheme design phase. This phase usually consists of the following activities:

Activity 1: Summarize the results of the data collection

↓

Activity 2: Prepare materials (tables, diagrams) that will be used to present the results to the persons participating in the scheme design process

↓

Activity 3: Carry out the scheme design process

↓

Activity 4: Put together a list of the decisions to be confirmed when the scheme is officially established

- a phase to prepare for setting up the scheme. This phase usually consists of the following activities:

Activity 1: On the basis of decisions taken during the scheme design phase, draft all documents and develop the necessary tools to start up operations

↓

Activity 2: Draft the feasibility study report

↓

Activity 3: Officially establish the scheme (vote on statutes* at the general assembly* for example)

↓

Start up operations

Once the phases and activities have been identified, each activity is broken down into its component tasks.

Example: The activity "collect data from households" is made up of the following tasks: "conduct surveys", "monitor the progress of the data collection", "input raw data" and "control data input".

Step 2: Estimate the length of time needed for each activity and each task

The duration of each task is estimated on the basis of the workload entailed and the resources needed to carry it out.

Example: A steering committee plans to carry out a survey of 300 households in a village. Three researchers will be assigned to the survey, and each researcher will interview 100 households. The time needed to process a questionnaire is estimated at 30 minutes, and the working day of a researcher is five hours. Consequently, it will take 10 days to complete the survey, with each researcher conducting 10 interviews per day.

Step 3: Organize the activities and tasks in a timetable

The next step is to organize the activities and tasks to be completed in a timetable. The best tool for this is the Gantt chart (work plan), which makes it possible to schedule specific activities and to monitor their completion as the feasibility study progresses.

Setting up the chart begins with organizing the activities and tasks in logical and chronological order. Next a table with two columns is drawn. The left column contains activities arranged in logical and chronological order, with a breakdown of the tasks corresponding to each activity. The right column represents the progression of time and is subdivided into months, weeks and days. For each task, the squares corresponding to the days, weeks or months allotted to completing the task are shaded in. Thus, for a task that lasts five days, five squares are shaded in. Determining the starting date of a particular task requires finding the date on which the preceding task (or tasks) to which it is linked was completed.

Example: Task "b" begins after the completion of task "a", and lasts three days. Task "a" ends on Friday of the first week. Thus, task "b" may begin the following Monday, and the squares corresponding to Monday, Tuesday and Wednesday of the second week may be shaded in.

1st column: Activities and tasks arranged in logical and chronological order	2nd column: Progression of time																					
	Week 1					Week 2					Week 3					Week 4					
	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	Etc.
Activity no. 1:																					
● Task «a»	■	■	■	■	■																
● Task «b»						■	■	■													
Activity no. 2:																					
● Task «c»									■	■	■	■	■								
● Task «d»														■	■						
● Task «e»																■	■	■			
Etc.																					

The Gantt chart may be used to estimate the overall duration of the feasibility study. It can also be used to "work backwards". Once the most favourable time for starting-up the operations of the health micro-insurance scheme has been established, it is easy to determine the date by which the feasibility study must be completed, and by working backwards, its starting date.

Important. Determining the most favourable time to start up the scheme's activities must take two factors into account: (1) premium payments must be scheduled for the time of year when incomes are at their highest, following the sale of the harvest, for example; (2) the waiting period* must not take place during a period of low liquidity. Asking families to pay premiums during this period – which is particularly difficult from both the financial and health perspectives – without being able to benefit from coverage is counter-productive and risks discouraging new enrolments.

Action 5: Prepare the budget estimate for the feasibility study

Identifying and planning the activities and tasks of the feasibility study makes it possible to estimate the resources needed and to draw up the budget estimate for the study. A feasibility study is not necessarily costly, but it does involve some expenses, such as the remuneration of researchers, travel expenses, photocopy charges, etc.

The steering committee must ensure that adequate – but not excessive – resources are assigned to the feasibility study.

Preparing a budget estimate consists of compiling and evaluating all estimated income and expenses related to the feasibility study, and verifying that a financial balance has been struck. Expenses estimate include: payroll costs (remuneration of researchers and, in some cases, members of the steering committee), training costs, travel expenses, office supplies (photocopies, supporting materials, etc.), infrastructure costs (for meeting rooms and training classes). Income estimates are provided primarily by the organization promoting the scheme and by external organizations (partner NGOs, support organizations, the State, cooperation programmes).

Once the figures for income and expenses have been calculated, they are transferred to a table with two columns. Expenses are listed in the left column and income on the right. For an example of a budget estimate, please refer to:

▶ **2.3 – Preparing the budget estimate for the feasibility study**, Volume 2, Chapter 2, page 33.

Ongoing action: Enter into dialogue with the target population and the other actors concerning problems related to health and access to health care

This dialogue is part of a process of information, education and communication that begins during the initial phase and is continued over the course of the feasibility study. It is then conducted in an ongoing fashion throughout the existence of the health micro-insurance scheme.

Such a process is crucial for generating interest in the scheme on the part of the target population and the other actors. It also contributes to the design of a scheme that will meet the needs of the target population and correspond to its willingness to pay. Ultimately, this process enables the scheme to evolve by responding to changes in the needs of covered persons or by identifying the needs of potential new members and dependents, such as the inhabitants of a new geographic area, other socio-occupational categories, etc.

The initial phase is aimed at eliciting the individual comments and opinions of everyone regarding the health context, problems associated with access to health care and the need for protection. It is also aimed at encouraging actors to examine these issues and to take steps to deal with the problems expressed.

It is important that an attempt be made to gather the opinions of the various actors (target population, health care providers, civil society organizations, health and local authorities, etc.) and of all the groups making up the target population. Efforts should be made to give consideration to the views of groups that are usually under-represented in meetings and decision-making bodies, such as women, adolescents, migrant workers and members of certain social or ethnic groups. In some contexts it may be useful to organize meetings according to homogeneous sub-groups. These meetings may be organized in a variety of ways, ranging from individual interviews to group meetings. For a description of the various ways of organizing such meetings, please refer to:

▶ **2.1 – Discussion sessions,** § *Organization of discussion sessions*, Volume 2, Chapter 2, page 28.

3. Data-collection and analysis phase

Introduction

Objective of the data-collection and analysis phase

The data-collection consists of gathering the information needed to design the health micro-insurance scheme. This information will be used to select the services to be covered, benefit/premium combination(s), partner health care providers, etc.

The information gathered may also be used to put together a description of the initial situation, which will serve as a reference for later evaluating the scheme's impact on the frequentation of health facilities, the means of treatment sought in response to illness, etc.

Ideally, the data collection will focus on essential information and will cost as little as possible. The data collection should be conducted systematically, which involves defining and then following a coherent course of action. This requirement to be systematic helps to keep a common thread running throughout the process of data-collection and analysis. It does not preclude collecting data on a repetitive basis with several successive phases of collection and analysis.

ERRORS TO AVOID DURING THE DATA-COLLECTION PHASE

Error No. 1: Collecting needless or unusable information
Experience has shown that this precaution is often ignored. A great deal of information is accumulated without being used.

Error No. 2: Producing information that is already available
Prior to launching into interviews or surveys, it is advisable to collect data that are already available: results of surveys carried out by other organizations, census findings, background studies, etc.

Error No. 3: Interviewing the same persons repeatedly
It makes more sense to decide ahead of time what information to collect from one's sources so as not to have to interview the same person several times.

Error No. 4: Implementing a procedure that is too complicated and requires the input of substantial human and material resources

Chapter contents

Chapter 3 proposes a rigorous and coherent method of data collection, consisting of the following steps:

- Define the data-collection procedure (step 1);
- Develop the data-collection materials (step 2);
- Prepare for and carry out the data collection (step 3);
- Process the collected data to produce usable information (step 4) – i.e. information that may be used in designing the scheme.

To implement each of these steps, please refer to the tools provided in Volume 2, Chapter 3:

▶ Useful tools

3.1 – Lists of information to be collected by objective (page 35).

3.2 – Sample data-collection materials (page 58).

3.3 – Size of sample for conducting household surveys (page 73).

3.4 – Examples of processing collected data to produce usable information (page 73).

Step 1: Define the data-collection procedure

The first step in conducting a data-collection is to define the procedure to be used. This involves specifying the information being sought, its purpose and the sources from which it will be collected. It also involves preparing for developing the data-collection materials and deciding upon the eventual use to be made of the collected data in designing the scheme.

To help define the data-collection procedure, two complementary charts may be drawn up:

- a chart which may be referred to as the "strategy chart";
- a chart which may be referred to as the "implementation chart".

The strategy chart is used to record the objectives of the data collection, the information sought for each objective and the sources of information to be consulted. The implementation chart is used to record the information to be collected from each source and to serve as a reminder of the use to be made of each item of information sought. These two charts actually contain the same information; they simply present it in reverse order. They are complementary. Initially, the strategy chart is used to identify the information sought, while the implementation chart organizes and categorizes this information for the sake of simplicity and in order to reduce the cost of the data collection. Efforts should be made to obtain all necessary information from each source in the fewest possible number of consultations. (For example, efforts should be made to avoid requesting information from the same person on separate occasions for the purposes of objective 1, then 2, then 3, etc.)

Action 1: Complete the strategy chart

The strategy chart contains three columns. The first column is used to record the objectives of the data collection; the second, to record the information to be collected for each objective; and the third, to record the sources of information to be consulted.

Strategy chart

Objectives	Information	Sources

First column: The objectives of the data collection

The steering committee can set one or more objectives for itself. These may vary from one promoter to the next. The principal and most frequently pursued objectives are enumerated below; however, this list is not exhaustive.

LIST OF PRINCIPAL OBJECTIVES

Objective 1: To understand the context.

Objective 2: To establish a basis for selecting the target population.

Objective 3: To establish a basis for selecting the partner health care providers.

Objective 4: To establish a basis for selecting the health services to be covered.

Objective 5: To establish a basis for determining methods of coverage: direct payment or third-party payment.*

Objective 6: To establish a basis for calculating premiums based on the health expenses of the target population.

Objective 7: To establish a basis for calculating premiums based on the operating costs of health facilities.

Objective 8: To evaluate the target population's willingness to pay.

Objective 9: To establish a basis for negotiating with health care providers, negotiating with transport operators, collaborating with prevention programmes, and obtaining information on public aid.

Objective 10: To establish a basis for defining the organization and operation of the scheme.

For more details on the various objectives and, in particular, on the types of promoters that may be interested by a particular objective, please refer to:

▶ **3.1 – Lists of information to be collected by objective,** Volume 2, Chapter 3, page 35.

CHOOSING BETWEEN OBJECTIVE 6 AND OBJECTIVE 7

Both objective 6 and 7 deal with establishing a basis for calculating premiums. There are, in fact, two basic methods of data collection that may be used for this calculation. The first method is based on the health expenses of the target population and corresponds to objective 6. The second method is based on the operating costs of health facilities and corresponds to objective 7.

In what circumstances should objective 6 be pursued? Objective 6 should be pursued when the scheme plans to cover health services delivered by a variety of health care providers (health centres, public hospitals, private pharmacies, public dispensaries, clinics, etc.).

Example: A scheme plans to assume responsibility for the cost of consultations and medicines dispensed by integrated health centres, the public hospital and various clinics, as well as medicines purchased from designated private pharmacies.

In what circumstances should objective 7 be pursued? Objective 7 should be pursued when the scheme plans to conclude partnership agreements with a limited number of health facilities and wishes to assume responsibility for the cost of, not only certain specific health services, but all services delivered by those health facilities (or by one of their branches, such as the surgical department of a hospital, for example). Objective 7 may also be pursued when the scheme plans to pay health providers using a global payment* method (a fixed, global fee per episode of illness or an annual comprehensive fee per covered person, called a capitation payment*).

Example: A scheme plans to assume responsibility for the cost of the services provided by a health centre and decides to use a subscription system. It pays the health centre an annual comprehensive fee per covered person granting the latter entitlement to "unlimited" use of the centre.

Once the objectives of the data collection have been determined, the steering committee may record these in the first column of the strategy chart, as follows:

Completing the strategy chart

Objectives	Information	Sources
To understand the context		
To establish a basis for selecting the health services to be covered		
...		

Second column: Information to be collected for each objective

Various items of information may be collected for each objective. Thus, economic, demographic, health-related and political information may be collected for objective 1, which is "To understand the context."

Determining what information to collect obviously depends upon what is available. This can vary from one country, one region, etc. to the next. Thus, in a country where health facilities

are not regularly inspected, information on the objective quality of the health care supply risks being unavailable or unreliable.

It is also advisable to sort through the identified information in order to keep only that which appears to be the most relevant, given the particular context in question.

A summary of the list of information to be collected for each objective is presented below. For a detailed list, please refer to:

▶ **3.1 – Lists of information to be collected by objective,** Volume 2, Chapter 3, page 35.

SUMMARY OF THE LISTS OF INFORMATION TO BE COLLECTED BY OBJECTIVE

Information for objective 1: "To understand the context"
Demographic, economic, political and legal information; information concerning the health care supply, the health context, certain social aspects.

Information for objective 2: "To establish a basis for selecting the target population"
Information concerning the objective quality of health facilities used by the target population (it being preferable that the selected target population have access to a health care supply of acceptable quality); access to health facilities; the trend of socio-economic development among the target population; certain social aspects; traditions of mutual aid in the event of illness; means of treatment sought in response to illness; and methods of financing access to health care.

Information for objective 3: "To establish a basis for selecting the partner health care providers"
Information concerning the health care supply; the objective and perceived quality of health facilities; the frequentation rates of health facilities.

Note: When the health care supply is inadequate, the organization promoting the scheme or a support organization may consider playing a role in setting up health services, if the latter correspond to the real or expressed needs of the target population. Examples include setting up a pharmacy, purchasing an ambulance, etc.

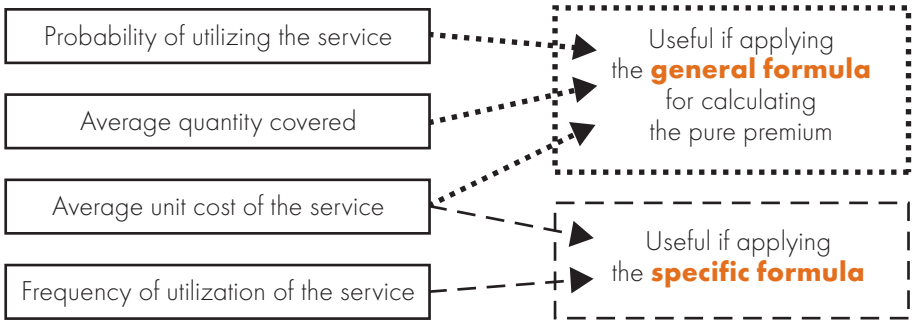
Information for objective 4: "To establish a basis for selecting the health services to be covered"
An overview of the available health services; information that may help to determine which health services are considered priorities in terms of health needs, and which services are difficult to access for financial reasons; information on the particular needs of certain sub-groups of the target population; information that may be used to identify health services that pose problems of cost recovery* and/or of financing.

Information for objective 5: "To establish a basis for determining methods of coverage: direct payment or third-party payment"
Information that may be used to identify the services for which third-party payment is considered a priority.

SUMMARY OF THE LISTS OF INFORMATION TO BE COLLECTED BY OBJECTIVE *(continued)*

Information for objective 6: "To establish a basis for calculating premiums based on the health expenses of the target population"

Information that may be used to calculate the premium and, in particular, the pure premium* for each health service: the probability of using the service, the average quantity covered, the average unit cost and the frequency* of utilization of the service.



Important. The data collected relate to the past utilization of health services by a population, which, in most cases, does not enjoy any health insurance coverage. If the data collected are used as is, the value of the pure premium thus obtained runs the risk of being undervalued. Therefore, when analyzing and processing the collected data, it is important to attempt to take into account the presumed impact of insurance coverage on the utilization of health services.

▶ **3.4.6 – Practical examples,** Volume 2, Chapter 3, page 90 and page 104.

Information for objective 7: "To establish a basis for calculating premiums based on the operating costs of health facilities"

The fixed and variable costs of the health facility; the number of users of the health facility.

Information for objective 8: "To evaluate the target population's willingness to pay"

Information on the seasonal nature of people's willingness to pay and on current premium or contribution levels, drawn from the experiences of other civil society organizations that operate on the basis of periodic premiums or contributions.

Information for objective 9: "To establish a basis for negotiating with health care providers, negotiating with transport operators, collaborating with prevention programmes, and obtaining information on public aid"

Information on the existence and content of a legal framework for concluding agreements* with health providers; identification of partners with whom to conclude future agreements; information that may be used to establish fees and quality standards to be stipulated in agreements with these providers; information that may be used to define the most suitable method of payment* of health providers; information that may be used as a basis for reaching agreements with transport operators; identification of health education and prevention programmes and the means of collaborating with such programmes; identification of existing sources of public aid and grant conditions.

Information for objective 10: "To establish a basis for defining the organization and operation of the scheme"

Methods of organization and basic rules of management of existing health micro-insurance schemes; existence and characteristics of the networks*, if any, of such schemes; main indicators: percentage of management costs, population penetration rates, etc.

Important. The **frequentation** of a health facility (see information for objective 3) is measured with the help of the frequentation rate that is calculated by dividing the number of new cases by the population size of the health facilities' catchment area:

$$\text{Frequentation rate} = 100 \times \frac{\text{Number of new cases}}{\text{Catchment area population}}$$

The new cases are the new episodes of illness or pregnancy seen for the first time. If during the same episode a patient must return several times for treatment, these new visits are not counted.

The **frequency of utilization** of the services (see information for objective 6) is the number of times the health service is utilized in the course of the year divided by the reference population.

$$\text{Frequency of utilization of the health services} = \frac{\text{Number of times the service is utilized in the course of the year}}{\text{Reference population}}$$

The reference population refers to the scope* of a health facility, which can be different from the health facilities' catchment area. The number of times the health service is utilized integrates the old and the new cases insofar as each utilization must be taken into account in the calculation of the pure premium.

Next, the steering committee may fill out the second column of the strategy chart by indicating, for each objective, the data it has decided to collect.

Completing the strategy chart

Objectives	Information	Sources
To understand the context	• Demographic information • Political information • Economic information • Information concerning the health care supply...	
To establish a basis for selecting the health services to be covered	• Overview of health services • Services considered a priority in terms of health needs (real/felt)...	
...	...	

Third column: Available and useful sources of information

For each item of information sought, the steering committee can identify one or more sources of information.

Examples: Information on existing civil society organizations may be obtained from socio-economic studies conducted by other organizations or from interviews with local authorities.

Information concerning the needs of households in terms of coverage may be obtained from health studies (real needs) and/or from household surveys (felt and expressed needs).

Information used to produce the inputs used in calculating premiums (objective 6) may be collected from various sources: household surveys; health facilities (registers, annual reports, statistics); the tracking of a sample of patients; and management information pertaining to other health micro-insurance schemes operating in the area and serving target populations similar to those of the scheme.

The use of several sources, when the latter exist, to collect a single item of information is certainly a more reliable method, but risks making the data collection long and costly. It is therefore important to make a selection from among the sources, retaining only those that are either the most reliable or indispensable, or for which it is the most simple to organize a data collection.

To identify useful sources of information, please refer to:

▶ **3.1 – Lists of information to be collected by objective,** Volume 2, Chapter 3, page 35.

The steering committee may then fill out the third column of the strategy chart by indicating, for each item of information sought, the sources of information it has chosen to use.

Completing the strategy chart

Objectives	Information	Sources
To understand the context	● Demographic information ● Political information ● Economic information ● Information concerning the health care supply...	● Socio-economic studies ● Interviews with local authorities ...
To establish a basis for selecting the health services to be covered	● Overview of health services ● Services considered a priority in terms of health needs (real/felt)...	● Fee schedules of health facilities ● Interviews with health care staff ● Household surveys ...
...	...	...

Action 2: Complete the implementation chart

The implementation chart is drawn up on the basis of the strategy chart, whose content – objectives, information to be collected and sources of information to be used – it duplicates, but in a different order. The selected sources of information are listed in the first column, the information to be collected from each source is listed in the second column and the purpose, or objective, of each item of information is indicated in the third column.

Completing the implementation chart

Sources	Information	Purpose/Objective
Interviews with local authorities	• Economic information, political information, social aspects	• To understand the context
Fee schedules of health facilities	• Overview of health services • Official rates	• To establish a basis for selecting the health services to be covered • To establish a basis for negotiating fees with health care providers
...	...	...

The implementation chart is used to group information according to source. In most cases, various items of information may be obtained from a single source.

Examples: Socio-economic studies are a source of demographic information, economic information and information on the strength of community-based efforts.

Interviews with local authorities yield economic information, health information on major pandemics or problems related to access to health care, and information on the strength of community-based efforts.

This way of grouping the information facilitates the subsequent development of data-collection materials, as well as the collection itself. The development of data-collection materials is presented in greater detail below under "Step 2: Develop the data-collection materials".

The implementation chart may also be used to group the objectives pursued for each item of information. Each item of information may, in fact, be used to attain one or more objectives.

Examples: Knowing the size of the population of a health facility's catchment area makes it possible to calculate the frequentation rate of the health facility, and thus to achieve two objectives: to establish a basis for selecting partner health care providers (objective 3) and to establish a basis for calculating premiums based on the target population's health expenses (objective 6).

Keeping in mind the purpose of each item of information collected makes it easier to analyze the results of the data collection. This analysis is described in more detail under "Step 4: Process the collected data to produce usable information".

Step 2: Develop the data-collection materials

Data-collection materials including, in particular, data-entry forms, interview forms and survey questionnaires, should be developed before starting the data collection.

Data-entry forms may be used for collecting information from documentary sources. These include: census reports; health coverage plans; socio-economic studies; health status reports; political framework (legislative texts, decrees, codes*); quality assessment* reports; and the fee schedules, registers, annual reports, statistics and accounting data of health facilities. Data-entry forms generally consist of two columns: the left column is used to record the type of information sought and the right column is used to record the information obtained.

Interview forms may be used to collect information from health care staff and managers of health facilities, health authorities, local authorities, leaders of civil society organizations, transport operators and officials in charge of prevention programmes. They contain questions that are often open-ended, which allow respondents to express their views, using examples for illustration. The responses provided during interviews consist mainly of qualitative data.

Survey questionnaires are used to conduct household and patient surveys. To the extent possible, they should contain "closed" questions, such as multiple choice questions with squares to shade in, which compel respondents to provide precise answers. This makes it possible subsequently to use the replies as a basis for quantitative calculations, such as averages, percentages, etc.

Media	Purpose	Characteristics
Data-entry forms	• To collect information from documentary sources • To track a sample of patients	Data-entry forms often have two columns: the left column contains the information sought and the right column contains the information obtained
Interview forms	To collect qualitative information from individuals	Interview forms often contain open-ended questions
Survey questionnaires	To conduct household and patient surveys	To the extent possible, survey questionnaires should contain "closed" questions

In designing data-collection materials, the steering committee may refer to the implementation chart drawn up in step 1. In fact, the implementation chart lists useful information to be obtained from each source.

Case No. 1: The data-collection medium is a data-entry form

The data-entry form may contain two columns. The steering committee lists the information sought in the left column and the corresponding findings in the right column.

Example of a "census" data-entry form

Information sought	Findings
National population	
Population in area of intervention	
Population of provincial capital	
Population of urban district	
...	...

Case No. 2: The data-collection medium is an interview form or a survey questionnaire

Each question should enable researchers to collect one or more of the items of information listed in the implementation chart.

Example of a "health authorities" interview form

1. What are the most frequent illnesses in the region?
2. Are there some periods of the year that are more difficult than others from the standpoint of health?
3. etc.

For sample data-collection materials (data-entry forms, interview forms, survey questionnaires), please refer to:

▶ **3.2 – Sample data-collection materials,** Volume 2, Chapter 3, page 58.

Step 3: Prepare for and carry out the data collection

Prepare for the data collection

Test data-collection materials

The interview forms and survey questionnaires must be tested on a small sample of persons in order to ensure that the questions are understandable and that they effectively allow researchers to collect the desired information.

Determine the population sample to be surveyed

Surveys of the target population (households, patients) and the tracking of a sample of patients must be carried out using representative samples* of the target population. A sample is representative when it has the same structure as the total population: same proportion of men and women, same proportion of young, elderly, actively employed and unemployed persons, etc. The representative sample must also conform to minimum requirements, which depend upon the size of the target population and its homogeneity. In practice, household surveys are most frequently carried out of 350 heads of family.

For examples of the minimum size of representative samples, please refer to:

▶ **3.3 – Size of sample for conducting household surveys,** Volume 2, Chapter 3, page 73.

Important. In conducting household and patient surveys, it is necessary to include a large proportion of women. Experience has shown, for example, that household surveys often question the "head" of the family, who is usually a man and who, granted, answers on behalf of the other members of his family. The fact remains, however, that women play a predominant role in issues relating to health, whether it is reproductive health, family health or maternity care. For example, they have specific knowledge about childhood illnesses and children's needs in terms of protection. As women, they also have particular health and social protection needs with which men may not be familiar and which they may not perceive as priority concerns.

If, despite having taken precautions, it appears from the data analysis that the proportion of women surveyed was too low, it is always possible to organize an additional survey of an exclusively female sample.

Assign tasks, recruit and train researchers

Depending on the situation, the steering committee may assume responsibility for the entire data collection, or it may rely upon external resources. Generally speaking, steering committee members carry out the data collection themselves on the basis of existing documents: studies, censuses, health coverage plans, quality assessments, etc. They also collect data from local authorities, health authorities, health facilities and pre-existing health micro-insurance schemes.

The steering committee often relies upon researchers to conduct surveys of the target population. Researchers must have received prior instruction in conducting the surveys and must have been informed of the content of the questions and the types of replies to be expected.

For the tracking of a sample of patients, the members of the steering committee may request the assistance of the health care staff in the health facilities concerned to complete the data-entry forms.

Carry out the data collection

Monitor the progress of the data collection

It is important to ensure that the data collection is carried out in keeping with initial plans, and that the structure of the population surveyed – in terms of geographical location, socio-occupational category, gender, age, etc. – conforms to predefined parameters. In the event of discrepancies, adjustments may be made during the data-collection process. Such adjustments include revising the objectives of the data collection, recruiting additional researchers, giving priority to certain groups of the population that are under-represented in the population segment already surveyed, etc.

Enter raw data and control data input

During the course of the data collection, it is advisable to process completed forms and questionnaires regularly (every evening, for example) and, little by little, to input the data using a computer application that facilitates their utilization (a spreadsheet programme, for example).

Step 4: Process the collected data to produce usable information

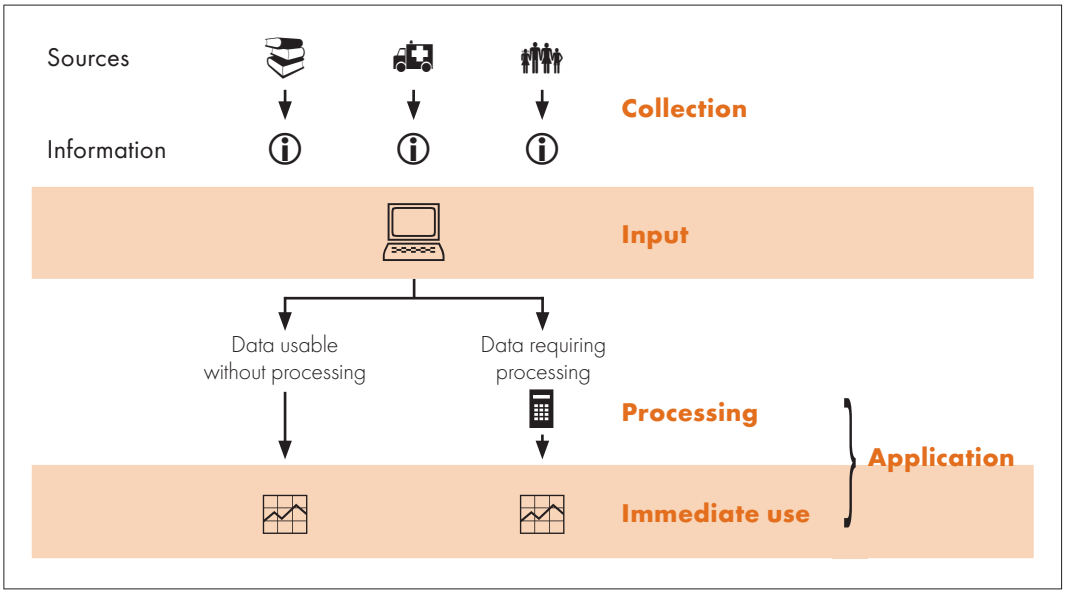
Among the data collected, some may be utilized immediately: i.e. they may be used to achieve one or more objectives without any particular processing.

Example: Demographic information contributes to a better understanding of the context (objective 1) without being processed in any way.

Other data must be processed before they can be used to achieve the objective in question. Processing consists of calculating an indicator on the basis of raw data.

Example: The size of the population of the catchment area of a health facility is collected in order "to establish a basis for selecting the partner health care providers" (objective 3). In order for this information to be usable, it must be processed. It will be used to calculate the frequentation rate, which, in turn, is used as a criterion for selecting partner health facilities.

Thus, data application involves processing (if necessary) the collected data and using them to achieve the stated objectives.



For methods of processing and utilizing collected data, please refer to:

▶ **3.4 – Examples of processing collected data to produce usable information,** Volume 2, Chapter 3, page 73.

4. Scheme design phase

Introduction

Objective of the scheme design phase

The scheme design phase consists of using the information gathered during the data-collection phase as a basis for defining the health micro-insurance scheme that will subsequently be implemented.

This involves deciding which health services to cover, selecting partner health care providers and defining the benefit/premium combination(s). It also involves ensuring that the proposed scheme is viable from the financial, social, institutional and technical standpoints, and that it offers a suitable response to the problems identified in terms of access to and utilization of health services.

SOME SUGGESTIONS FOR DESIGNING THE SCHEME

Following are some suggestions for designing a viable scheme that meets the needs of its members:

Suggestion No. 1: Consider the context

Consideration should be given to the context at various stages in the development of a health micro-insurance scheme, including when determining the scheme's organization, establishing its operating rules, deciding which services to cover, selecting partner health care providers, etc.

Suggestion No. 2: Involve the main partners

Taking into account the needs of the target population, on the one hand, and the interests of partner health care providers, on the other, is essential to ensuring the proper functioning, development and viability of the scheme.

The participation of other actors, such as local authorities, health administration officials, leaders of civil society organizations and representatives of employers' and workers' organizations may also prove to be useful, particularly for encouraging partnerships between these organizations and the health micro-insurance scheme.

Suggestion No. 3: Proceed systematically

Designing a health micro-insurance scheme is a complex operation that involves making numerous decisions, conducting negotiations, developing mechanisms, calculating premiums, etc. So as not to omit certain elements that are essential to the scheme's proper functioning, a systematic and rigorous procedure should be adopted.

Suggestion No. 4: Call upon external resources to supply skills not possessed by members of the steering committee

Designing a health micro-insurance scheme requires specific technical knowledge, in terms of designing benefits* that are geared to the needs of members; carrying out various premium simulations for the purposes of selecting the benefit/premium combination(s); designing operating rules that are both simple and effective; and ensuring that the proposed scheme is structured in such a way as to limit insurance-related risks. These include adverse selection*, moral hazard*, over-prescription*, fraud, abuse and the occurrence of catastrophic cases.

Chapter contents

This chapter proposes breaking down the process of designing the scheme into several steps, each of which corresponds to a necessary decision in that process:

- Select, or confirm the selection of, the target population (step 1);
- Pre-select the health services to be taken into account in the various benefit plans (step 2);
- Select the partner health care providers (step 3);
- Select the services and health care providers to include in a third-party payment mechanism (step 4);
- Select the benefit plans and calculate the corresponding premiums (step 5);
- Prepare negotiations or agreements with partner organizations, particularly with health care providers (step 6);
- Define the scheme's organization (step 7);
- Define the scheme's methods of operation (step 8);
- Prepare the scheme's budget estimate (step 9).

This breakdown is provided for information purposes; in practice, the design of a scheme is a more fluid process in which the same step may be repeated several times at various stages, and in which decisions made during one step may call into question those made previously.

Example: The calculation of premiums and the establishment of the benefit/premium combination(s) (step 5) may call for modifying the list of health services to be covered, a preliminary selection of which was made in step 2. Similarly, certain operating rules established in step 8, such as those concerning membership, may have an impact on the calculation of premiums (step 5).

Only the steering committee will be able to conduct certain steps – such as step 1, which involves selecting the target population. This chapter suggests that a participatory approach, whereby the steering committee involves various actors in the decision-making process, should be used for the other steps. For the most part, these actors are representatives of the target population and, depending upon the meeting in question, other actors concerned with setting up the scheme, such as managers of health facilities, local authorities and leaders of civil society organizations.

Regardless of whether or not a participatory approach to decision-making is adopted, it is advisable to adopt the following procedure for each step:

1. Summarize the findings of the data collection: analysis of data collected, calculation of indicators.
2. Prepare materials to facilitate decision-making: comparative tables, graphs, etc. When a participatory approach to decision-making is used, such materials should enable the data needed for decision-making to be presented clearly to the persons concerned (these materials may propose a number of options from which decision-makers are requested to choose).
3. Proceed to making decisions. When decision-making is participatory, the steering committee organizes working groups, composed of persons participating in decision-making, and facilitates working group sessions to that effect.
4. Put together a list of the decisions to be confirmed when the scheme is officially established.

This chapter proposes a procedure for each step in the scheme design process and describes the principal decision-making criteria. For details concerning certain methods of premium calculation or samples of data-presentation materials, please refer to Volume 2, Chapter 4:

▶ **Useful tools:** One or more tools in Volume 2 corresponds to each step. Thus, tool 4.1 corresponds to step 1, tool 4.2 corresponds to step 2, etc.

WORKING GROUP SESSIONS

The use of a participatory approach to designing the health micro-insurance scheme allows for:

(1) Continuing the process of information, education and communication began during the initial phase to prepare for the feasibility study and consisting, in this case, of:
- presenting the results of the data collection, which will serve as a basis for decisions relating to the design of the scheme;
- consulting the various stakeholders in the future scheme – mainly the target population and the health care providers – by gathering their points of view;
- guiding the actors in their deliberations on the various aspects of the scheme design process;
- transmitting knowledge concerning the functioning of insurance.

(2) Involving the various actors in the design and subsequent establishment of the scheme, thereby promoting the scheme's proper functioning and development.

For suggestions on conducting working group sessions, please refer to:

▶ **4.0 – Working group sessions,** Volume 2, Chapter 4, page 120.

Step 1: Select, or confirm the selection of, the target population

In many cases, the selection of the target population is determined by the organization promoting the health micro-insurance scheme.

Example: If the promoting organization is a trade union, the target population will consist primarily of trade union members and their families. Similarly, if it is a microfinance institution, the target population will consist primarily of the institution's clients and their families.

When the health micro-insurance scheme is promoted by a support organization that must choose in which villages or in conjunction with which civil society organization (trade union, cooperative, etc.) the scheme will be established, this choice generally takes into account:

- the needs of the target populations, giving priority to those whose needs for coverage are greatest;
- the chances for success of the project, choosing to set up the scheme where the most factors for success are to be found.

In some cases, a compromise must be made, since it is possible for the implications of these two selection criteria to be contradictory.

The steering committee may proceed in the following manner:

1. Summarize the data collected for the purposes of objective 2 – "To establish a basis for selecting the target population".
2. Prepare a comparative table to facilitate the comparison of various "candidate" target populations. For a sample comparative table, please refer to:

▶ **4.1 – Selecting the target population,** Volume 2, Chapter 4, page 121.

3. Choose the target population that best meets the following criteria in terms of:
   - Objective quality of health facilities. It is preferable that the selected target population have access to a health care supply of acceptable quality.
   - Access to health facilities. The establishment or further development of a health micro-insurance scheme could initially be concentrated in areas where the health facility attracts large numbers of users, i.e. areas with high frequentation rates (criterion used when defining the target population on a geographical basis).
   - Favourable economic and social characteristics. Factors leading to the success of a project to set up a health micro-insurance scheme include literacy, economic vigour, the presence of persons experienced in community-based organization, the presence of persons capable of managing a scheme, the existence of traditions of mutual aid in the event of illness, etc.
   - Number of potential beneficiaries. It is preferable for the scheme to cover a large number of persons, particularly if the scheme expects to provide coverage for major risks.

Step 2: Pre-select the health services to be taken into account in the various benefit plans

Generally speaking, a health micro-insurance scheme cannot cover all health services – at least not in the first few years of its existence. Step 2 consists of identifying and making a preliminary selection of the health services to be covered by the future health micro-insurance scheme. Some of the services included in this preliminary selection may later be called into question if their corresponding premium levels exceed the target population's willingness to pay (step 5).

In making a preliminary selection of the health services to cover, the steering committee may adopt a participatory approach that allows for the involvement of representatives of the target population. This approach consists of:

1. Summarizing the data collected for the purposes of objective 4 – "To establish a basis for selecting the health services to be covered".
2. Preparing the data-presentation and decision-making materials that will be used during the working group sessions.

Examples of data-presentation materials: A comparative table that may be used to prioritize the various health services; fee schedules of health facilities that show how health services are currently being billed.

3. Convening a working group to:
   - Action 1: Pre-select the health services to be covered;
   - Action 2: Define one or more benefit plans and the services included in each;
   - Action 3: Take into account the method of invoicing used by health care providers.
4. Putting together a list of the decisions to be confirmed when the scheme is officially established.

Action 1: Pre-select the health services to be covered

The pre-selected health services may be curative, obstetrical or preventive in nature.

Note: It is in the interest of a health micro-insurance scheme to provide coverage for preventive care as a means of limiting the occurrence of illness. Coverage of prenatal consultations, for example, is aimed at preventing dystocic deliveries.

This pre-selection may also include the evacuation of patients from one level of the health pyramid to another, or the purchase of basic medical supplies, such as perfusion equipment, gloves or syringes, requested by health care staff in the case of hospitalization or obstetrical delivery.

For the list of health services usually covered by health micro-insurance schemes and a definition of major and minor risks, please refer to:

▶ **4.2 – Pre-selecting the health services to be taken into account in the various benefit plans,** Volume 2, Chapter 4, pages 122 and 124.

The health services to be covered may be pre-selected on the basis of priority criteria. These criteria may vary from one type of organization to the next. Civil society organizations or their support structures often give precedence to services that meet the real health needs of households and whose utilization may pose financial difficulties. Health care providers often give precedence to services that entail the most difficulty in terms of cost recovery or financing. Generally speaking, the main priority criteria used are the following:

- The "real" health needs of the population. Priority is given to services that contribute to reducing significantly the mortality rate and the morbidity rate of certain illnesses. In this respect, prevention and health education services may have a major impact on people's health while remaining low in cost.
- The population's "felt" and "expressed" health needs. These are the health services that people would like for the scheme to cover on a priority basis.
- The financial difficulties associated with the utilization of these services. Priority should be given to services that pose serious problems in terms of financial accessibility. Some services may, on the other hand, be removed from the list of covered services, i.e. those that constitute a small financial risk for a large share of the population.
- Problems of cost recovery and financing (from the standpoint of health care providers). Priority services are those that demonstrate the highest rates of outstanding payments or whose utilization is insufficient (problem relating to the amortization of equipment).

For a sample comparative table of health services from the perspective of these various criteria, please refer to:

▶ **4.2 – Pre-selecting the health services to be taken into account in the various benefit plans,** *§ Sample comparative table of health services*, Volume 2, Chapter 4, page 125.

Action 2: Define one or more benefit plans and the services included in each

An assessment of health needs may reveal that among the target population:

- certain health services are considered to be a priority by the entire population;
- other services are considered to be important, but not a priority;
- still others are considered to be a priority, but only by certain sub-groups of the population.

Example: The inhabitants of a village located far from a hospital may consider patient evacuation to the hospital to be a priority, while persons living in proximity to the hospital do not consider this to be a necessary service.

Such distinctions may be made by cross-referencing the replies to questions concerning the target population's felt and expressed needs, on the one hand, with the respondents' characteristics, such as age, sex, place of residence and occupation, on the other.

This situation may lead to the proposal of several types of coverage.

Example: A scheme may offer a "basic" plan that includes priority services and an "extended" plan that consists of priority services + important, but not indispensable, services. A scheme may also offer optional benefits, which would be selected only by population groups who considered those services to be indispensable.

Action 3: Take into account the method of invoicing used by health care providers

Depending upon the case, the proposed benefits may refer to:

- individual health services*;
- clusters of health services;

Example: A "Medical hospitalization" service may include the fixed daily rate, consultations and various examinations administered during the hospital stay.

- episodes of illness or maternity.

Example: Care provided for malaria cases may include all health expenses associated with an episode of malaria, regardless of the individual health services utilized in the patient's treatment.

The point is to ensure that the preliminary selection of covered services is consistent with the particular terms used by health facilities for invoicing health services.

If health facilities charge patients on a fee-for-service basis, the benefits provided by the scheme may cover each individual health service, clusters of health services or episodes of illness.

If health facilities charge a fee for a cluster of health services or a global fee for an episode of illness, the benefits provided by the scheme may not cover each health service separately. The benefits must either conform to the terms in effect or provide for broader terms.

In order to determine what method of invoicing is currently being used by health facilities, the steering committee may refer to the fee schedules of health facilities, which were collected for the purposes of objective 4 – "To establish a basis for selecting the health services to be covered".

For a sample benefit plan, please refer to:

▶ **4.2 – Pre-selecting the health services to be taken into account in the various benefit plans,** § *Sample benefit plan*, Volume 2, Chapter 4, page 126.

Step 3: Select the partner health care providers

This step consists of identifying and selecting the health care providers whose services will be covered by the future scheme. This may include health care providers with which the scheme wishes to conclude:

- a fee agreement;
- an agreement concerning patient reception procedures for insured persons or concerning treatment protocols*;
- an agreement concerning payment methods: fee-for-service* or global fee;
- and/or a third-party payment agreement.

It may also include health care providers with which the scheme does not intend to conclude any particular agreement, but whose services will be covered by the scheme. The prior identification of the health facilities whose services are covered to the exclusion of all others helps to contain the rise in costs that would occur if insured persons routinely sought treatment primarily from the most expensive health care providers.

In selecting partner health care providers, the steering committee may utilize a participatory approach that allows for the involvement of representatives of the target population. This approach consists of:

1. Summarizing the data collected for the purposes of objective 3 – "To establish a basis for selecting the partner health care providers."
2. Preparing the data-presentation and decision-making materials that will be used during working group sessions: map of the scheme's area of operation, comparative table of the various "candidate" health care providers.
3. Convening a working group to select the health care providers whose services will be covered by the scheme.
4. Putting together a list of the decisions to be confirmed when the scheme is officially established.

Select health care providers

Health care providers are selected on the basis of criteria relating to location, quality and cost.

Criteria relating to location

To the extent possible, the selected health care providers must be located in proximity to the target population. In particular, if the scheme plans to cover primary health care services, it is important for providers at this level to be located relatively close to the people.

The geographic distribution of health care providers at each level of the health pyramid may be illustrated on a map of the scheme's area(s) of establishment. This map may be used to identify the partner health care providers serving the various targeted villages or neighbourhoods. It also highlights the areas for which no health care provider has yet been identified.

Criteria relating to quality and cost

The steering committee may compare prospective health facilities on the basis of the following criteria: the health facilities' objective quality, perceived quality, and frequentation rates. Given a competitive environment, the higher the frequentation rates of health facilities, the more health services are, in principle, accessible, of good quality and well-regarded by users.

In order to choose between two providers offering services of similar quality, the steering committee may give precedence to the least expensive provider.

Often the decision is not so simple, and other factors must be taken into account: the public or private nature of the health facility, the recognition or lack of recognition given to the facility by the health administration, the transparency and cost-efficiency of practices used by health professionals, the extent to which prevention and health education are promoted by health professionals, the quality of relations between the promoters of the scheme and the managers of the prospective health facilities, etc.

A comparative table of the various "candidate" health providers may be used to facilitate the selection process. For a sample comparative table, please refer to:

▶ **4.3 – Selecting the partner health care providers,** Volume 2, Chapter 4, page 127.

Step 4: Select the services and health care providers to include in a third-party payment mechanism

This step involves deciding whether to set up a third-party payment mechanism and, if so, identifying the health care providers and services that would be included under such an arrangement.

The provision by the scheme of third-party payment for all covered health services is certainly more convenient for insured persons; however, it exposes the scheme to moral hazard. It is therefore advisable to identify those services for which third-party payment is genuinely necessary.

The steering committee may adopt a participatory approach by working in conjunction with representatives of the target population and, if necessary, with representatives of the health care providers pre-selected in step 3. This approach consists of:

1. Summarizing the data collected for the purposes of objective 5 – "To establish a basis for determining methods of coverage: direct payment or third-party payment."
2. Preparing the data-presentation and decision-making materials that will be used during working group sessions, including explanatory diagrams of the third-party payment and direct payment (also known as third-party guarantor*) mechanisms, as well as a comparative table indicating the services for which third-party payment appears to be most important.
3. Convening a working group to choose the services to be provided through the mechanism of third-party payment and the health care providers concerned.
4. Putting together a list of the decisions to be confirmed when the scheme is officially established.

Choose the services to be provided through the mechanism of third-party payment

Choosing the health services to be provided through third-party payment may be based on the following criteria:

- the cost of the services;
- the degree of urgency or unexpectedness of the services: e.g. the hospitalization of a wounded person following an accident is at once urgent and unexpected.

For sample diagrams explaining the different methods of coverage (with or without third-party payment) and a sample comparative table to help identify and select the health services for which third-party payment is considered a priority, please refer to:

▶ **4.4 – Selecting the services and health care providers to include in a third-party payment mechanism,** Volume 2, Chapter 4, page 128.

Step 5: Select the benefit plans and calculate the corresponding premiums

The health micro-insurance scheme may cover the total cost of each health service or transfer part of this cost to its members (co-payment* mechanism). Co-payment mechanisms have two advantages: (1) they make it possible to reduce premium levels; (2) they help to contain moral hazard. However, the introduction of a co-payment may be strongly resented by health scheme users, particularly during periods of low liquidity. There are different types of co-payments, including percentage co-payments*; flat-rate benefits* or maximum benefits*; maximum number of days, cases or sessions*; monetary deductibles*; and numerical deductibles*. For a description of the different types of co-payment, please refer to:

▶ **4.5.1 – List of co-payments,** Volume 2, Chapter 4, page 129.

In addition, a health micro-insurance scheme may offer: (1) a single benefit plan that is common to all members; or (2) several plans from which members may choose: a basic plan, an extended plan, optional benefits, etc.

The health services to be covered under each benefit plan were pre-selected in step 2. Step 5 consists of determining, for each benefit plan (if the scheme plans to offer more than one), the levels of coverage corresponding to the services included and, if applicable, the types and levels of co-payment.

Higher levels of coverage necessarily entail higher premiums. Even if a scheme initially plans to provide a high level of coverage (80 or 100 per cent of expenses) for a certain number of health services, it is often forced to scale back this initial benefit plan, given the high premium levels entailed.

CALCULATION OF PREMIUMS, METHOD OF INVOICING AND METHOD OF PAYMENT USED TO PAY HEALTH CARE PROVIDERS

The tasks of deciding which health services to cover, defining levels of coverage and calculating the corresponding premiums are related to the way in which health care providers usually bill their patients for health services. For example, if a provider bills each health service separately, the data collected on the quantity of services consumed or on unit costs will relate to individual health services; consequently, it will be possible to calculate the pure premium (see definition below) corresponding to each service. If a health care provider charges a global fee per episode of illness, regardless of the services provided or the medicines consumed, the collected data will correspond to these terms. As a result, it will be difficult to calculate a pure premium for each health service provided.

The tasks of deciding which health services to cover, defining levels of coverage and calculating the corresponding premiums are also related to the method that will be used to pay health care providers. If a scheme plans to pay on a fee-for-service basis, premiums must be calculated for each service. When the method of payment has not yet been decided upon at this point, premiums should be calculated on a fee-for-service basis, which leaves open the possibility of using any of the various methods of payment, such as those based on clusters of health services, episodes of illness, capitation, etc. The decision concerning what method of payment to use is made in step 6 – "Prepare negotiations or agreements with partner organizations, particularly with health care providers".

A benefit plan consists of a set of covered health services and the level of coverage corresponding to each service. After defining an initial benefit plan, the premium corresponding to that plan is calculated. If the premium level is too high with respect to the target population's willingness to pay, this initial plan is adjusted by reducing levels of coverage or by removing certain services from the benefit plan. A compromise is worked out between the benefits (services to be covered and levels of coverage) and the premium levels to pay until an acceptable benefit/premium combination is found.

In deciding upon levels of coverage and calculating the corresponding premiums, the steering committee may utilize a participatory approach that allows for the involvement of representatives of the target population. This approach consists of:

1. Summarizing the data collected:
   - for the purposes of objective 6 – "To establish a basis for calculating premiums based on the health expenses of the target population". This requires first calculating for each covered service the indicators used to calculate the pure premium: the probability of using the service, average quantity covered, average unit cost of the service and/or frequency of utilization of the service; or
   - for the purposes of objective 7 – "To establish a basis for calculating premiums based on the operating costs of health facilities". This requires first calculating the health facility's estimated operating costs corresponding to each individual.
2. Summarizing the data collected for the purposes of objective 8 – "To evaluate the target population's willingness to pay". Whether or not the target population's willingness to pay has been taken into account in choosing the level and periodicity of premiums can affect the success of the scheme in terms of enrolment and the collection of premiums.
3. Preparing the premium calculation charts that will be used during working group sessions; for a sample calculation chart, please refer to:

▶ **4.5.5 – Sample premium calculation chart,** Volume 2, Chapter 4, page 148.

4. Convening a working group to:
   - Action 1: Define several scenarios. This involves defining several benefit plans. At this point, it is preferable to define scenarios together with the actors – not to present them with a limited selection of pre-established scenarios;
   - Action 2: Calculate the premium levels that correspond to the various scenarios. This step presupposes that the members of the steering committee understand the basic techniques of premium calculation. If necessary, they may call upon external technical support services;
   - Action 3: Take into account the level of the target population's willingness to pay;
   - Action 4: Choose several scenarios, i.e. several benefit/premium combinations meeting various criteria.
5. Putting together a list of the decisions that will be confirmed when the scheme is officially established.

This step may prove to be somewhat lengthy. However, experience has shown that time spent on it is a worthwhile investment since one of the main reasons for the failure of many current initiatives is a poor choice in terms of the benefit/premium combination(s).

Action 1: Define several scenarios

The first scenario generally consists of:

- the services pre-selected in step 2 – "Pre-select the health services to be taken into account in the various benefit plans";
- one or more benefit plans: for example, a basic plan that includes services considered a priority by a large majority of the population, and an extended plan that, in addition, includes services that are not considered to be a priority;
- a high level of coverage for each service (80 or 100 per cent of expenses incurred).

If after calculation (see Action 2 below), the premium level seems high, a second scenario may be defined:

- by reducing the number of services to cover;
- by reducing the levels of coverage: introducing co-payments, such as percentage co-payments, deductibles, flat-rate benefits and maximum benefits.

Action 2: Calculate the premium levels that correspond to the various scenarios

Premiums may be calculated in two ways:

- on the basis of the health expenses incurred by the target population, i.e. on the basis of the data collected for the purposes of objective 6;
- on the basis of the operating costs of the health facilities, i.e. on the basis of the data collected for the purposes of objective 7.

On the subject of deciding between these two methods, please refer to:

▶ **Step 1: Define the data-collection procedure, Action 1: Complete the strategy chart,** *§ Choosing between objective 6 and objective 7,* Volume 1, Chapter 3, page 32.

This deals exclusively with the first method. For details on the second method, please refer to:

▶ **4.5.2(b) – Calculating the pure premium based on the operating costs of the health facilities,** Volume 2, Chapter 4, page 143.

and to the practical example provided in:

▶ **3.4.7 – Example of processing the data collected for objective 7,** Volume 2, Chapter 3, page 108.

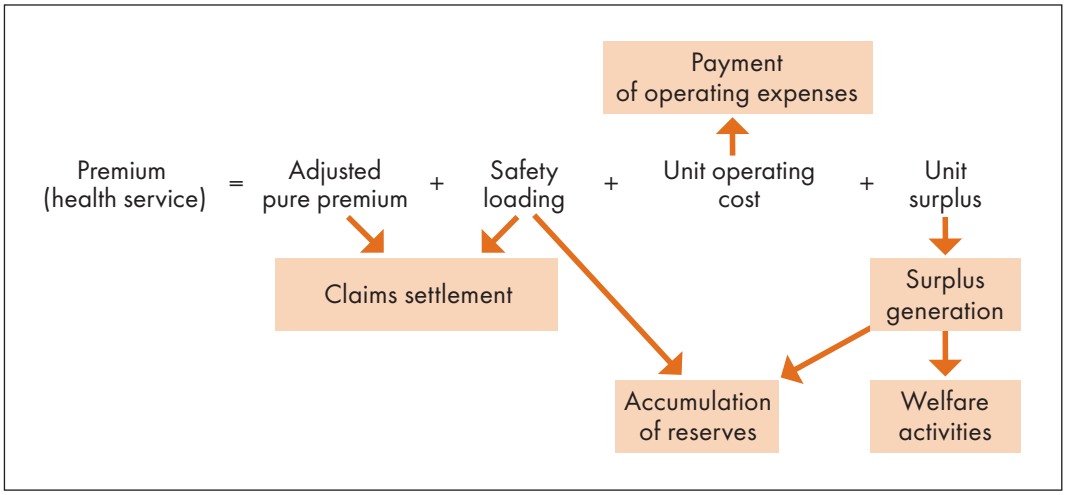
Premiums constitute the primary source of revenue of a health micro-insurance scheme. They must be able to: (1) finance the provision of services included in the benefit plans; (2) finance the operating costs of the scheme; (3) generate a surplus* in order to accumulate financial reserves and ensure the scheme's sustainability.

Premiums are calculated on a yearly basis.

Note: When these reserves are sufficient, a portion of the surplus may be used to increase levels of coverage or insure new health services while maintaining current premium levels; reduce premiums; or finance social welfare activities for beneficiaries.

In order to determine the total individual premium – that is, the premium corresponding to an individual – the individual premium for each covered health service must first be calculated. The health service premiums are then added together to obtain the total premium for an individual. The total individual premium is thus equal to the sum of the premiums calculated for each health service. The individual premium for a given health service is equal to the sum of the following elements:

- the adjusted pure premium;
- the safety loading;
- the unit operating costs;
- the unit surplus.



The following process, consisting of **six steps**, may be used to calculate premiums:

First step: Calculate the pure premium

Second step: Adjust the pure premium

Third step: Calculate the safety loading

Fourth step: Calculate unit operating costs

Fifth step: Calculate the unit surplus

Sixth step: Calculate the total premium

First step: Calculate the pure premium

The pure premium is the average cost of the coverage provided for each covered health service. It is the average expense to be assumed by the scheme for each protected person.

There are two formulas for calculating the pure premium: the general formula and the specific formula, which is a specific application of the general formula. These formulas are as follows:

General formula

Pure premium (for a health service)

=

Probability of utilizing this service ×
Average quantity covered ×
Average unit cost

Specific formula

Pure premium (for a health service)

=

Frequency of utilization of this service ×
Average unit cost

Note: In the specific application of the general formula, the concepts of "probability" and "average quantity covered" are combined in the concept of "frequency of utilization".

The comparative advantages of these two formulas are described in:

▶ **3.1.6 – Lists of information to be collected for objective 6,** Volume 2, Chapter 3, page 46.

The term "**probability**" refers to the "odds" that an individual will utilize a given health service at least once in the course of a year. It is therefore equivalent to the percentage of persons who will utilize this service at least once in the course of a year.

In most cases, the **average quantity covered** is equal to the average number of times a given health service is utilized by users of the service. For certain levels of coverage (subject to limitation in terms of a maximum number of uses per person and per year, or to a numerical deductible), the average quantity covered is less than the average number of utilizations.

Examples of limitations: A benefit that provides for a maximum of three prenatal consultations per person per year; a benefit that provides for hospitalization as of the second hospital day, meaning that the cost of the first day is borne by the member.

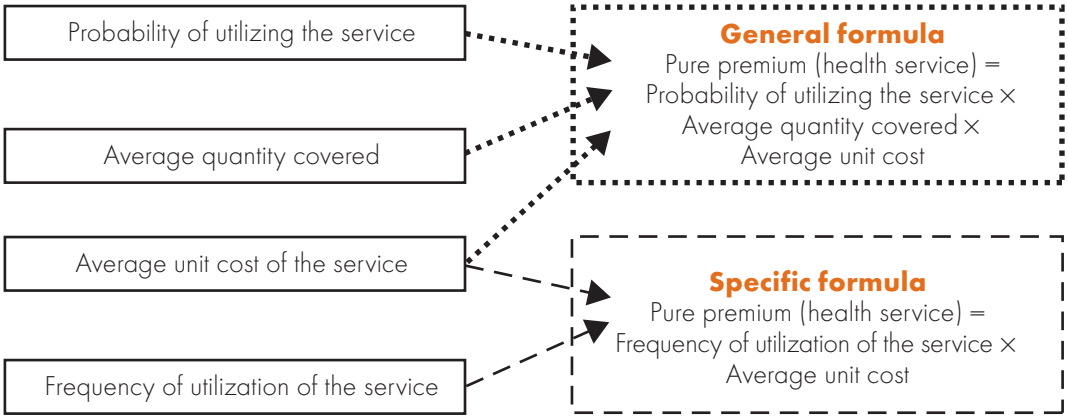
The term "**average unit cost**" of a health service refers to the average expense incurred by an individual for that service if the level of coverage is 100 per cent. In all other cases (flat-rate benefits, benefits subject to a percentage co-payment or to a monetary deductible) the average unit cost is less than the average expense incurred.

The term "**frequency of utilization**" refers to the number of times, on average, that a given health service is consumed by the total population under consideration.

For a description of the methods used to calculate these various indicators (probability, average quantity, average unit cost, frequency), please refer to:

▶ **4.5.2(a) – Calculating the pure premium based on the health expenses of the target population,** Volume 2, Chapter 4, page 131.

Once these indicators have been calculated, they are simply multiplied by each other to obtain the pure premium:



Second step: Adjust the pure premium

At this point, adjustments must be made to the pure premium to take into account factors that have a bearing on health care consumption and thus, on the level of expenses. These include individual characteristics – such as age, sex, place of residence – and the existence of certain services or methods of payment, such as third-party payment. For a discussion of the methods used to adjust the pure premium, please refer to:

▶ **4.5.3 –Adjusting the pure premium,** Volume 2, Chapter 4, page 144.

Third step: Calculate the safety loading

The safety loading is added to the pure premium to make allowances for the risk that the average real expenses per beneficiary exceed estimates.

The pure premium is calculated on the basis of estimates corresponding to a large number of persons. When the number of persons is small, this may give rise to considerable statistical discrepancies between the actual utilization of health care by beneficiaries and that observed in the population as a whole. According to the law of large numbers, the smaller the number of beneficiaries, the greater is the risk that these discrepancies will be significant. The real cost of the risk* may then be greater than or less than that of the total population. The purpose of the safety loading is to make allowances for the loss* that would be incurred by a scheme if the real cost of the risk was greater than the initially calculated pure premium. The safety loading is calculated as follows:

Safety loading (for a health service) =

Pure premium × Coefficient (N, p)

Where N = number of beneficiaries and p = the probability of utilizing the health service
As N and p increase, the coefficient and the safety loading decrease

For a chart listing various values for the coefficient (N,p) as a function of the values of N (size of the population) and p (probability), please refer to:

▶ **4.5.4 – Calculating the safety loading,** Volume 2, Chapter 4, page 147.

Fourth step: Calculate unit operating costs

This element of the premium corresponds to the operating costs of the health micro-insurance scheme that are assigned to each individual.

A preliminary approximation of this figure may be determined as +/-10 per cent of the sum of the adjusted pure premium and the safety loading. When establishing the budget estimate of the health micro-insurance scheme (see step 9 below), this figure can then be adjusted, often upwards. Next, the unit operating cost is calculated by estimating the total operating costs and dividing this figure by the estimated number of beneficiaries.

Estimates of unit operating costs are more precise in subsequent years because they are based on the actual operating costs incurred during previous accounting periods.

Fifth step: Calculate the unit surplus

The unit surplus is expressed as a percentage of the total of the three preceding elements; it establishes the unit amount of surplus to be set aside.

Sixth step: Calculate the total premium

The formula for calculating the premium may be used to determine the premium per individual, per covered health service and per year. Consequently:

- if several health services are covered, the total individual premium is equal to the sum of the premiums determined for each health service;
- the annual premium may be divided into daily, monthly, quarterly, etc. payments, depending upon the periodicity selected. This arrangement must be adapted to the characteristics of the target population's income;
- the premium corresponding to a family or group of persons may be calculated as follows: (1) by multiplying the total individual premium by the exact number of members of the family or group; (2) by multiplying the total individual premium by an identical average figure to be used for all families or groups, which would give large families an advantage. Other intermediate methods of calculation may also be used.

Example: A scheme provides three levels of premium: one for families of from one to three persons; a second for families of from four to eight persons; a third for families of nine persons or more.

The various steps in the premium calculation process are illustrated in the practical example contained in:

▶ **4.5.6 – Performing premium calculations (practical example),** Volume 2, Chapter 4, page 149.

Action 3: Take into account the level of the target population's willingness to pay

The evaluation of the target population's willingness to pay may be used to identify a premium level that is affordable for a large majority of the population and/or to identify several categories of potential members with differing levels of willingness to pay.

A data-presentation tool on the level of willingness to pay is provided in Volume 2:

▶ **4.5.7 – Calculating willingness to pay,** Volume 2, Chapter 4, page 157.

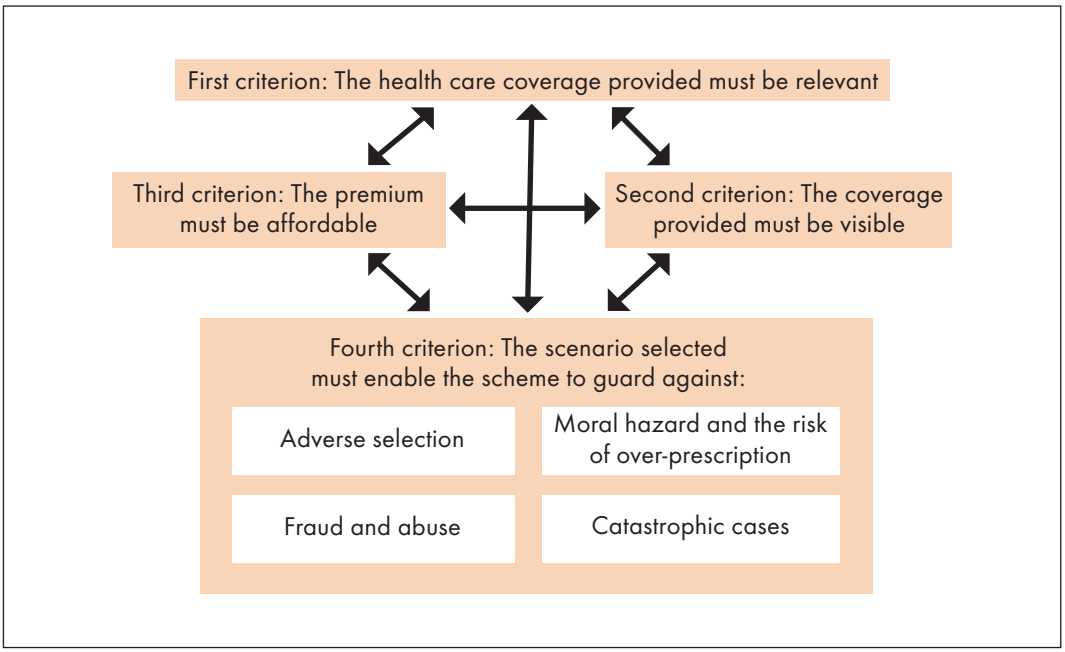
Note: When the ability to pay* of the target population or of certain categories of the target population, such as indigents, is very low, efforts must be made to seek additional sources of financing. In particular, if legislation guarantees access to a minimum package of health services and if the population's ability to pay is insufficient to cover the average cost of such a package, the State could make up the difference (by subsidizing premiums).

Action 4: Choose the benefit/premium combination(s)

Premium levels vary significantly, depending upon the health services covered and the levels of coverage provided. To assume responsibility for all health expenses incurred by beneficiaries would be unrealistic because it would require too high a premium, thus making it unaffordable for potential members with the lowest incomes. For this reason, a compromise must be worked out, together with the target population, between the benefits to be provided and the premiums to be paid.

In order to achieve this compromise, the actors associated with the scheme must ensure that each of the potential scenarios fulfils the following four criteria or requirements:

Criteria for selecting the benefit/premium combination(s)



- the health care coverage provided must be relevant;
- the coverage provided must be visible;
- the premium must be affordable.
- the scenario(s) selected must enable the scheme to guard against insurance-related risks: adverse selection, moral hazard, over-prescription, catastrophic risks*, fraud and abuse.

The scenarios selected will be those that best meet the above criteria.

First criterion: The health care coverage provided must be relevant

The health services to be covered must effectively correspond to situations that members perceive to be a risk. These are health services whose utilization poses financial constraints to members, owing to the fact that their consumption is either frequent or costly. Frequently utilized health services fall into the category of primary health care; these are referred to as minor risks. Less frequently utilized and costly health services fall into the category of secondary and tertiary health care services; these are referred to as major risks. The promoters of health micro-insurance schemes are often divided on which of these two risk categories to cover.

Minor risks: Utilization of primary health care

Primary health care constitutes the first level of entry into the health system and its costs are relatively low. The coverage of minor risks by a health micro-insurance scheme is principally aimed at promoting quick access to health care in order to prevent a decline in the health status of sick persons. However, this type of coverage must contend with two major constraints:

- owing to the frequent occurrence of minor risks, premium levels will be high. As a result, access to the health micro-insurance scheme will be difficult for the poorest families;
- the coverage of minor risks is particularly exposed to the phenomena of adverse selection, moral hazard and over-prescription. These can undermine the viability of the health micro-insurance scheme.

Major risks: Utilization of secondary and tertiary health care

The coverage of major risks, on the other hand, is aimed at organizing protection against the most costly health services, that is, those that present the greatest financial difficulty for families, particularly when serious or urgent cases arise. The coverage of major risks allows for setting a lower premium level, despite the high unit cost of the related health services, given the low frequency with which these risks occur. However, the coverage of major risks is subject to the following constraints:

- the frequency of hospitalizations and surgical operations is low. Depending on the context, it may be estimated that out of 100 persons, as few as between four and eight persons will need to seek secondary treatment in the course of a year. The protection provided will consequently offer a low level of visibility, thereby running a strong risk of discouraging members;
- if families have difficulty paying for primary health care, the health micro-insurance scheme will fail to resolve problems related to the postponement of treatment and the decline in the health status of sick persons;
- a health micro-insurance scheme starting up operations or a small-sized scheme may quickly find itself in financial crisis following a very costly hospitalization case if no precautions have been taken, such as setting a maximum benefit or introducing a reinsurance* or co-insurance mechanism.

Second criterion: The coverage provided must be visible

Even if the members of a health micro-insurance scheme have understood the principles of solidarity and risk management, they must be able to see for themselves that the scheme is functioning. This is because:

- the payment of a premium imposes a certain constraint, requiring that people pay "out of their own pockets" either frequent instalments (every week, every month) or a relatively large amount once per year;
- premiums are pooled in a common fund, and it often happens that local organizations experience problems related to poor management, whether of an intentional or unintentional nature. There is a risk that distrust will arise rapidly if benefits are provided only rarely;
- health micro-insurance schemes that take the form of mutual health organizations assume as one of their basic principles a democratic style of management, which calls for regularly assembling members. However, if the mutual organization is not very active, that is, if benefits are provided only rarely, members will have little motivation to take part in decision-making.

Consequently, a health micro-insurance scheme that chooses to cover only health services that are used rarely, such as emergency hospitalizations or surgery, runs the risk of not being very lively and attractive. A scheme that covers minor risks, on the other hand, will be very active, and therefore very visible, but will require members to pay a high premium, no doubt rendering the scheme less accessible.

Third criterion: The premium must be affordable

The protection that a health micro-insurance scheme is able to offer its members depends upon what the members are prepared to pay (willingness to pay) and what they are able to pay (ability to pay). Willingness to pay depends at once on individuals' level of income and their perception of the risks: the greater a person's aversion* to risk, the more he or she will be willing to pay. An individual's ability to pay is the maximum amount he or she is capable of paying; it is therefore linked to income. Ability to pay is always greater than or equal to willingness to pay, even for persons with a strong aversion to risk. In a context of poverty, however, the levels of ability to pay and willingness to pay are both very low and tend to be indistinguishable from one another.

A premium that is too high will be prohibitive for the vast majority of the scheme's members. A health micro-insurance scheme that delivered all health services, primary and secondary, for "free" would consequently be very attractive – but economically and financially unfeasible. Conversely, several experiences have shown that health micro-insurance schemes with low premiums have the highest population coverage rates.

When selecting health services and their levels of coverage, the actors must gauge the consequences of a given decision on premium levels and verify that the latter remain affordable for a large proportion of the scheme's potential members. If the premium level required for covering a particular package of services at 100 per cent of expenses incurred is too high, certain elements of the package may be withdrawn and/or the levels of coverage reduced through the introduction of co-payments. Co-payments help to reduce premium levels and effectively counter moral hazard and the risk of over-prescription. On the other hand, co-payment levels that are too high may result in a failure to resolve the problem of health care accessibility. They may also slow down the trend of enrolment owing to the relative unattractiveness of the benefit plan.

Note: Seeking additional sources of financing, such as State-subsidized premiums, enables the scheme to improve the coverage of the poorest members of the population who cannot afford to pay the required premium.

Fourth criterion: The scenario selected must enable the scheme to guard against insurance-related risks

The coverage of basic* health services utilized frequently by households, such as consultations, medicines, laboratory tests and injections, presents a high level of moral hazard and risk of over-prescription, which can lead to a considerable increase in the scheme's expenses. Co-payments (percentage co-payments, deductibles, etc.) are an effective means of countering these risks.

The coverage of costly and partially foreseeable treatments, such as planned hospitalizations, optical items and treatment for certain chronic illnesses, is accompanied by a high risk of adverse selection.

Example: Persons who know they must undergo a costly surgical operation within the next six months join a health micro-insurance scheme with the assurance that the operation will be covered when the required waiting period is over.

The scheme must therefore carefully select the services for which coverage is to be provided and, if necessary, introduce other, more suitable mechanisms, such as health savings, for covering foreseeable health expenses, or solidarity funds, for covering chronic health expenses.

The coverage of costly and unforeseeable health care services, such as unplanned hospitalizations, leaves the scheme highly exposed to the risk of "catastrophic cases", which can jeopardize the financial vitality of the scheme. The scheme can protect itself by reducing the level of coverage it offers for these services.

Example of a catastrophic case and a precautionary measure: The scheme may protect itself, beginning in the first year, against the financial consequences of a greater-than-expected number of very costly hospitalizations for surgery, by limiting the number of hospital days covered.

The following table provides a summary of various measures that may be taken in order to limit these risks and their impact on the scheme.

Risks	Measures[1]
Adverse selection Opportunistic behaviour	● Carefully choose the health services to be covered: avoid planned hospitalizations ● Offer increasing levels of coverage as a function of the number of years of membership ● Introduce restrictions on coverage (co-payments): limit the number of hospital days covered, make the reimbursement of surgical operations or specialist consultations subject to a maximum benefit
Moral hazard Risk of over-prescription	● Carefully choose the health services to be covered: avoid covering only minor risks; limit coverage of medicines to generic drugs* or to a list of essential drugs* ● Introduce limits on coverage (co-payments): deductibles; percentage co-payments; maximum number of days; flat-rate or maximum benefits
Catastrophic cases: epidemics, exceptionally high expenditures	● Precisely define the sphere of intervention of the health micro-insurance scheme by excluding the coverage of health services that are specific to certain serious pathologies ● Introduce limits on coverage (co-payments) and annual maximum limits for each covered person ● Include members and their dependents in prevention programmes ● Offer other methods of financing for planned health expenses (health savings) or chronic health expenses (solidarity funds) ● If possible, set up a reinsurance or co-insurance mechanism

[1] The measures listed here are not exhaustive. In particular, the influence of the various membership arrangements has not been taken into consideration. On this subject, please refer to Step 8, page 81.

Summary table: Criteria to be used in selecting the benefit/premium combination

	Hospital care*		Basic health care
	Unplanned	Planned	
1. Is coverage relevant?	*depends on real needs/needs expressed by the population*		
2. Is coverage visible?	No	No	Yes
3. Is premium affordable?	Yes	Yes	Partially
4. Is coverage subject to insurance-related risks?			
● moral hazard and over-prescription	Yes	No	No
● adverse selection and opportunistic behaviour	Yes	No	Partially
● catastrophic cases	No	No	Yes

Step 6: Prepare negotiations or agreements with partner organizations, particularly with health care providers

Step 6 consists, in particular, of preparing negotiations with the health care providers pre-selected in step 3. This involves reaching an agreement on the quality and price of the health care to be provided, patient reception procedures for insured persons, treatment protocols, methods to be used to pay for health services (fee-for-service or global payment) and/or a third-party payment agreement. In the case of a third-party payment agreement, the steering committee must also reach an agreement on the verification procedures to be followed and on the rules pertaining to invoicing and payment.

This step also consists of preparing partnership agreements, where applicable, with other organizations identified during the data-collection and analysis phase:

- the local health authorities, in order to secure a commitment from them to improve the health care supply through the provision of additional staff or equipment at the district or regional level;
- a trade union or cooperative in a position to promote the scheme among its members and assume responsibility for enrolments and the collection of premiums;
- a prevention/information/health education programme with which the scheme might organize sessions to raise awareness among members regarding hygiene, the prevention of certain illnesses, etc.;
- a financial establishment located in the vicinity, where the health micro-insurance scheme might open an account;
- a private insurance company or a reinsurance company that could reinsure a share of the scheme's risks;
- a technical union of health micro-insurance schemes offering technical support or financial services;
- an association or trade union of transport operators with which the health micro-insurance scheme might conclude an agreement for patient evacuations.

This step also consists of preparing an agreement with the State, where applicable, concerning the grant of financial assistance. This would make it possible, for instance, to subsidize the premiums of the poorest families.

It is advisable for the steering committee to closely associate the representatives of the future partner organizations in efforts to prepare the agreements concerning them. The steering committee should:

1. Summarize the data collected for the purposes of objective 9 – "To establish a basis for negotiating with health care providers, negotiating with transport operators, collaborating with prevention programmes, and obtaining information on public aid".
2. Prepare a file or a chart for each partner containing the elements needed to draft the agreements. For an example of a "health care provider" chart, please refer to:

▶ **4.6 – Preparing negotiations or agreements with partner organizations** (health care providers and others), Volume 2, Chapter 4, page 158.

3. Begin negotiations with partners. In the case of a health care provider, this involves:
   - Action 1: Define standards of quality and treatment protocols (standardize health services) and reach an agreement on fees (regulate the price of services);
   - Action 2: Choose the methods to be used to pay providers for health services – whether according to the fee-for-service, episode of illness or capitation method – and the mechanisms to be used for payment: services provided through third-party payment mechanisms, procedures to follow, frequency of payments to providers.
4. Regularly inform the target population of the progress of negotiations through working group sessions.
5. Put together a list of the decisions that will be confirmed when the scheme is officially established.

Action 1: Define standards of quality and treatment protocols, and reach an agreement on fees

This involves "standardizing" the health services delivered to insured persons by the health care provider in order to ensure a particular level of quality and "regulating" the price of these services in order to avoid an uncontrolled rise in the expenses of the health micro-insurance scheme.

In order to standardize health services, a deadline can be set in advance for the quality standards and objectives to be achieved.

Example: The rate of availability of essential drugs should increase from 50 to 80 per cent before 1 January 2006.

Treatment protocols may also be defined. These are standardized procedures of treatment for each type of pathology that define the diagnostic interventions (laboratory tests, X-rays, etc.), medical treatment or medicines to be prescribed. If followed, they allow for treating the patient at the lowest cost and at a guaranteed level of quality.

In order to regulate the price of health services, fees may be established on the basis of each health service or cluster of health services. These are used by health care providers as a basis for billing the services provided to the scheme's beneficiaries.

This rationalization of health services (standardizing health services and regulating the fees charged) offers both advantages and disadvantages. It limits the scheme's costs and allows it to ensure the quality of the health care provided. On the other hand, it implies concluding an agreement with health care providers (general agreement, or on a case-by-case basis) and requires the services of a medical adviser* for overseeing the agreements.

Action 2: Choose the methods to be used to pay providers for health services

Payment methods, in this case, refer to the different means employed by the health micro-insurance scheme and/or by patients who are members of the scheme to "purchase" medical services from providers. Four methods of payment may be distinguished:

Payment on a fee-for-service basis consists of paying the provider for each delivered health service that is covered by the health micro-insurance scheme.

Example: If a patient covered by the scheme undergoes a consultation, the consultation fee is paid to the provider either directly by the patient (who then claims reimbursement) or by the health micro-insurance scheme (in the case of a third-party payment arrangement). Likewise, if a covered patient utilizes several health services, the cost of each service is paid to the provider.

Payment by cluster of health services consists of paying the health care provider a global fee for a group of related health services.

Example: A global "Consultation and treatment" fee includes consultation at a health centre, and, depending on the patient's needs, medicines, examinations, etc. Additional example: a fixed daily rate per hospital day includes accommodation fees, consultations, examinations performed during the hospital stay, etc.

Payment per episode of illness consists of paying the health care provider a global fee for all services provided in connection with an episode of illness or a maternity case.

Example: A global "maternity" fee includes all health services utilized before delivery, as well as the delivery itself – regardless of whether it is complicated or uncomplicated – and the follow-up after delivery.

A capitation payment consists of paying the health care provider a global fee per person covered – or per "head"– and for a defined period, usually one year.

Each method of payment has its advantages and disadvantages in terms of countering moral hazard and the risk of over-prescription, on the one hand, and in terms of the quality of health services, on the other.

Global payment mechanisms – based on clustered health services, episodes of illness or capitation – are techniques that permit shifting to health care providers part of the financial burden of the risks related to sickness. When a patient consumes little, the provider "wins". When a patient consumes more than average, the provider "loses". This is referred to as the transfer of risk from the health micro-insurance scheme to the health care provider.

These mechanisms limit over-prescription to the extent that any increase in prescriptions (medicines, diagnostic interventions, etc.) is borne by the provider when these services are included in the global fee. Conversely, in the case of a fee-for-service arrangement, health providers may have a tendency to prescribe more medicines than necessary, require patients to return for consultation several times, or perform a greater number of diagnostic tests than necessary in order to amortize their medical equipment, etc.

Moreover, such tasks as claims management, checking invoices and paying providers, are relatively simple under the global payment method. Conversely, under the fee-for-service method, these tasks may require the services of one or more specialists.

Nonetheless, the global payment method may entail a decline in the quality of care if providers cut back on the services provided in an attempt to contain costs. The health micro-insurance scheme will have to rely upon medical advisers to implement quality control mechanisms for these services, which implies additional costs.

Lastly, the capitation method of payment may give rise to a form of risk selection* on the part of providers. In offering services, providers may tend to favour patients who present a low risk of illness and who will therefore not consume too many health services, and to discourage those who present a high risk. The health micro-insurance scheme must see to it that such practices do not arise.

Methods of payment	Advantages	Disadvantages	Accompanying measures
Fee-for-service	● Contributes to quality health care	● Exposes scheme to risk of over-consumption and over-prescription ● Complicates management ● Requires that health micro-insurance schemes bear entire burden of risk	● Checking of invoices ● Prior agreement* ● Co-payments
Global payment (clustered health services, episode of illness, capitation)	● Reduces risk of over-consumption and over-prescription ● Simplifies management ● Allows transfer of risks to health care provider	● May lead to reduction in quality of health care ● May encourage risk selection	● Quality control of health care through regular inspections ● Monitor attitudes of health care staff (risk selection)

When health care is billed on a fee-for-service basis, by clustered health services, or by episode of illness, the health micro-insurance scheme can use two coverage mechanisms:

- direct payment by the patient in exchange for treatment, referred to as a third-party guarantor mechanism: patients advance the cost of their health expenses and then claim reimbursement from the health micro-insurance scheme;
- third-party payment: patients pay health care providers only the amount of the co-payment at the time services are delivered. The provider obtains payment for the remaining expenses from the health micro-insurance scheme.

The capitation method of payment, on the other hand, generally uses a third-party payment mechanism: the scheme pays the health care provider directly the annual comprehensive fees corresponding to the individuals covered, which entitles the latter to free access to the partner's health care structure.

Step 7: Define the scheme's organization

This step consists primarily of defining the relationship between the health micro-insurance scheme and the responsible organization, including how the scheme relates to the organization's other activities. It also involves determining the scheme's legal status and internal organization in conformity with the current legislative framework.

In following this step, the steering committee may adopt a participatory approach that allows for the involvement of the representatives of the target population in the committee's activities. This approach involves:

1. Summarizing the data collected:
   - for the purposes of objective 10 – "To establish a basis for defining the organization and operation of the scheme". These data include in particular examples of the organization of other health micro-insurance schemes;

- for the purposes of objective 1 – "To understand the context". The legislative framework of the country concerned (laws governing insurance companies, mutual benefit organizations, associations or cooperatives, etc.) may partially determine the organization of the scheme and how it relates to the other activities of the responsible organization.

2. Preparing a table that will be used during working group sessions to identify the internal bodies and actors of the scheme. For a sample of a table to be used for this purpose, please refer to:

▶ **4.7 – Defining the scheme's organization,** Volume 2, Chapter 4, page 159.

3. Convening a working group to:

- Action 1: Define the relationship of the scheme to the other activities of the responsible organization;
- Action 2: Determine the legal status of the scheme;
- Action 3: Define the scheme's organization: internal bodies and actors.

4. Putting together a list of the decisions that will be confirmed when the scheme is officially established.

Action 1: Define the relationship of the scheme to the other activities of the responsible organization

In many cases, the health micro-insurance scheme is set up by an organization that engages in other activities, such as:

- economic activities (agricultural cooperative, micro-credit institution, tontine, etc.);
- social activities (mutual aid for family events, organization of celebrations, etc.);
- other insurance-related activities (life insurance, theft insurance, fire insurance, etc.);
- health-related activities (provision of health care, sale of medicines, health education, prevention, etc.);
- trade union activities (defence of the right to work and the right to housing, legal defence, member representation, etc.);
- activities related to financing access to health care other than health insurance (health credit, health savings, prepayment, solidarity funds, etc.).

In some cases, the activities have no direct connection to the health micro-insurance scheme. In other cases, they are complementary.

Examples: Health savings is a form of risk management that can complement health insurance coverage. Health credit allows for pre-financing health expenses in the absence of a third-party payment.

It is important to define the relationship between the health micro-insurance scheme and the other activities from the following standpoints:

- Legal. When the responsible organization is a health care provider, it is generally desirable for the health micro-insurance scheme to have an independent legal status, separate from that of the health facility.

- Accounting and financial. Even if the scheme has an independent status, transfers of funds may be envisaged with the other activities of the responsible organization. Hence, the scheme's operations may be financed in part from the earnings generated by economic activities. Transfers from one activity to another must remain transparent, which implies separate accounting.
- Functional. It is important to decide if the future scheme will be assisted by decision-making and supervisory bodies that are separate from those of the original responsible organization, or if certain bodies will be common to both. It must also be decided what resources (human, material, physical facilities) may be made available to the new scheme in an effort to limit its operating costs in the first few years.

Action 2: Determine the legal status of the scheme

Health micro-insurance schemes may take the form of a variety of legal entities, depending upon their objectives – whether more social or more commercial in nature – and the legislative environment in which they operate. The most common are: mutual organizations, associations, cooperatives or commercial enterprises.

Action 3: Define the scheme's organization: internal bodies and actors

All health micro-insurance schemes must include:

- Decision-making bodies. The general assembly (of shareholders or members) and the board of directors* usually have the power to make decisions. The general assembly approves the statutes, internal rules, budget and financial statements, and establishes the general policy of the scheme in accordance with the statutes. The board implements the general policy established by the general assembly.
- An executive body responsible for the day-to-day administration of the health micro-insurance scheme. They may be broken down into operational divisions, such as the claims management, membership management, personnel and accounting departments, etc.
- A supervisory body. This may include a supervisory committee* or an internal or external audit service, responsible for ensuring the scheme's compliance with the statutes and internal rules*, as well as its observance of contracts and management procedures. It also verifies the accuracy of the financial statements and, more generally, attempts to prevent the abusive or fraudulent use of the scheme's resources.

A wide variety of organizational formats exist for each of these functions.

Example: In the case of a medium-sized scheme, direct suffrage may be used. A larger or geographically extensive scheme may set up a pyramid-type structure, comprising local sections that elect representatives to the general assembly. Additional example: the day-to-day administration of a large scheme may be distributed among central departments (general management, accounting, membership management, claims management) and a regional authority in each of the scheme's areas of operation. In the case of a small scheme, an executive committee, consisting of a president, secretary and treasurer, may suffice for the day-to-day management of the scheme.

Moreover, each of the decision-making, executive and supervisory functions may be performed by:

- scheme members. In mutual organizations, the power to make decisions is entrusted to members with a seat in the general assembly;
- volunteer, compensated or salaried staff by the health micro-insurance scheme or by other branches of activity of the responsible organization (pooling of human resources). The scheme's ordinary activities, such as the collection of premiums, enrolment of new members, etc., are often carried out by volunteers during the start-up of the scheme. Once it has been in operation for several years, a scheme is usually able to compensate these persons or to hire salaried employees. When the operating costs of a scheme are subsidized, the scheme may envisage hiring salaried employees from the start. However, its viability could be undermined should this type of assistance no longer become available;
- partner health care providers who may perform certain managerial tasks, such as collecting premiums, enrolling new members, checking the membership cards* of insured persons;
- technical assistance provided by projects, NGOs, decentralized departments of the State, trade unions or associations, technical unions, etc.;
- specialized consultants, such as accounting experts, statisticians, etc.

Tasks that call for specific expertise, such as accounting, monitoring or evaluation, may be outsourced to external actors.

Step 8: Define the scheme's methods of operation

This step consists of defining the mechanisms and the material and human resources to be implemented in order to ensure the effective operation and management of the health micro-insurance scheme. In particular, this involves:

- defining the operating rules, i.e. membership arrangements, payment of membership fees* and premiums, coverage of health expenses;
- defining management* procedures, i.e. the steps required to put these rules into practice;
- defining monitoring procedures to ensure the proper functioning of the health micro-insurance scheme;
- verifying that the operating rules and the management and monitoring procedures enable the scheme to guard against insurance-related risks: adverse selection, moral hazard, over-prescription, fraud, abuse and catastrophic risks.

In any case, the establishment of management and monitoring procedures requires adequate familiarity with the principles governing the operation of this type of scheme. The discussion of these falls outside the scope of this Guide and is dealt with in another guide, which the reader is invited to consult:

▶ *Guide de gestion des mutuelles de santé en Afrique* (Management guide for mutual health insurance organizations in Africa), ILO/STEP, 2003.

Whether or not a participatory approach is used, the procedure to be followed in this case consists of:

1. Summarizing the data collected for the purposes of objective 10 – "To establish a basis for defining the organization and operation of the scheme."
2. Preparing the decision-making materials that will be used by the working groups, including:
   - comparative tables, which may be used to assess the advantages and disadvantages of each proposed operating rule;
   - role tables, which help to break down each process and identify the human and material resources needed. For an explanation of this method, please refer to:

     ▶ **4.8 – Defining the scheme's methods of operation,** § *Devising a role table*, Volume 2, Chapter 4, page 161.
3. Convening a working group that includes representatives of the target population, or convening a select committee (steering committee + experts) in order to:
   - Action 1: Define the main operating rules: rules pertaining to membership, payment of premiums, coverage of health expenses, reimbursement of members or payment of providers:
     - membership rules: Who may join? Are there restrictions with respect to geographic location, occupation, age, etc.? How can double indemnity be avoided?;
     - dependents: Who are the beneficiaries? What does the term "family" include: extended family, ascendants, descendants, children who have attained the majority, working children, polygamous relationships, elderly persons, etc.?;
     - categories of persons whose membership or coverage poses problems in terms of financing;
     - persons protected by another health insurance plan;
     - membership arrangements: Individual, family or collective membership? Automatic or voluntary membership?;
     - enrolment period: Open or closed?;
     - conditions of withdrawal and termination;
     - existence of membership fees and their amount;
     - method of calculating premiums for families: individual rate, global family rate, etc.;
     - frequency of premium payments;
     - procedures for reviewing premiums;
     - existence and duration of waiting period;
     - procedures to follow in order to be eligible for coverage;
   - Action 2: Define the principal management procedures, i.e. the various activities related to enrolment, the collection of premiums and the provision of coverage;
   - Action 3: Define the monitoring procedures that help to ensure the proper functioning of the health micro-insurance scheme, including:
     - monitoring the application of operating rules and management procedures;
     - monitoring the risk portfolio*;
     - budgetary monitoring;
   - Cross-cutting action: Ensure that the operating rules enable the scheme to guard against insurance-related risks: adverse selection, moral hazard, over-prescription, fraud, abuse and catastrophic risks.
4. Putting together a list of the decisions that will be confirmed when the scheme is officially established.

Action 1: Define the main operating rules

Definition of a member

In principle, any person who has attained the prescribed minimum age (determined in accordance with the customs and conditions of the country or region), without discrimination of any kind on the basis of health, sex, race, ethnic origin, religion, philosophical or political ideology may enrol in a health micro-insurance scheme, provided that he or she agrees to observe the statutes and operating rules of the scheme and to pay his or her premiums regularly.

Nevertheless, when a health micro-insurance scheme is set up by a civil society organization, it is natural, at least during the initial stages, for membership criteria to be defined in terms of common bonds between members: the inhabitants of a village or neighbourhood, workers within an enterprise, members of a social movement or professional organization, such as a trade union, women's association, etc.

When the scheme is managed by a health care provider, membership criteria are, a priori, broader – to the extent that the user population of the health facility is generally not restricted to a single community.

When the scheme is managed by a commercial enterprise (such as an insurance company wishing to provide coverage to the most destitute segments of the population, for example), very strict criteria pertaining to the age or state of health of users are sometimes employed.

Example of a restrictive criterion: Members must be under the age of 65 at the time of enrolment in the scheme.

The various restrictions placed on the definition of what constitutes a member each have their share of advantages and disadvantages. The following table lists for certain restrictions on age, state of health or place of residence, the advantages and disadvantages of some criteria applied in schemes.

Membership criteria	Advantages	Disadvantages	Accompanying measures
Minimum age (for example: 18)	• Excludes persons who do not possess civil liability		
Maximum age (for example: 65)	• Reduces amount of claims	• Introduces exclusion, contrary to operating principles and objectives of most schemes	• Provide for additional forms of solidarity: for example, a separate fund for persons living with HIV/AIDS
Absence of chronic disease	• Reduces amount of claims		
Residence in a given village or neighbourhood Employment in a given enterprise	• Encourages cohesion, social control* and mutual aid	• Reduces scheme's viability (schemes are less exposed to risks if beneficiaries are spread out over several geographic areas)	

Definition of a dependent

In most cases, a number of individuals in a member's family may enjoy the benefits provided by the scheme. These individuals usually include spouses and legitimate, natural or adopted children up to a certain age.

The precise definition of a dependent and/or the limit to be placed on the number of dependents is important if the scheme plans to apply a global premium per family, or a premium that is not exactly proportional to the number of persons in the family. The definition of a dependent is a trade-off between:

- taking local customs into account: the existence of polygamous families, ascendants (elderly persons) who are cared for by their children, young single persons who live in their parents' home while waiting to become financially independent;
- the need to offer affordable premium levels.

When premiums are not proportional to the size of the family, an overly broad definition of a dependent has the effect of increasing premium levels and requiring too high a premium of small families.

In general, family members are considered to be dependents only if they are, in actual fact, financially dependent on the member. Spouses and children who work and earn an income are no longer "dependent" and must register as members in their own right.

Categories of persons whose membership or coverage poses problems in terms of financing

The health care consumption of certain categories of persons is much higher than the average for the target population. These include elderly persons and persons with chronic diseases, such as diabetes, hypertension and cardiac deficiency, persons living with HIV, etc.

Their inclusion as members or dependents in a greater proportion than their ratio to the target population can jeopardize the financial equilibrium of the scheme inasmuch as premiums are calculated on the basis of the target population's average health expenses. On the other hand, social or ethical considerations often make it unthinkable to exclude them from the scheme. Such exclusion also runs contrary to the objective of universal coverage.

The following solutions may be envisaged:

- promote family enrolments that include young persons and elderly persons, sick persons and persons in good health;
- require a higher premium of first-time members who have reached a certain age. Such a decision poses problems of exclusion and should be implemented only in those cases in which the members in question did not join the health micro-insurance scheme when they had the chance to do so;
- carefully choose the health services to be covered by the health micro-insurance scheme and the levels of coverage to be provided;

  Examples: Limiting hospitalization coverage to 12 days per person and per year; disallowing coverage of specific treatments for certain serious pathologies.

- disallow coverage of certain patent medicines or brand-name drugs*;
- seek other methods of financing for treatments needed by chronically ill persons. In some countries, treatment for diseases such as tuberculosis, leprosy or HIV infection is provided by special programmes run by the State or by external financing institutions. In the absence of such external assistance, consideration may be given to the creation of a solidarity fund that is independent of the insurance scheme.

Persons protected by another health insurance plan

Some persons may benefit from another generally pre-existing health insurance coverage: social security, a health insurance plan organized by their employer, etc. If the health micro-insurance scheme agrees to cover such persons, whether as members or dependents, it is important that mechanisms be set up so as to avoid over-compensating them when benefits accrued in connection with the two plans are higher than the health expenses actually incurred.

The following measures may be taken in such cases:

- stipulate in contracts* and/or the internal rules that coverage is to be provided up to the amount of expenses incurred, and as a complement to any benefits to which the person may be entitled from other sources;
- introduce specific management procedures for persons protected by another health insurance plan: reimbursement upon presentation of receipts, verification procedures, etc.;
- do not set up a third-party payment mechanism for these persons.

Example: A health micro-insurance scheme assumes responsibility for 100 per cent of expenses incurred for consultations, up to a maximum limit of 500 MUs per consultation. Through the enterprise where he or she works, a scheme member is already a member of a mutual health organization that covers 50 per cent of consultation fees.

The member undergoes a consultation and pays 1,400 MUs. The mutual organization of the enterprise reimburses 50 per cent of that expense, or 700 MUs. With the invoice from the health care provider and the reimbursement voucher from the mutual organization, the member then files a claim for reimbursement from the health micro-insurance scheme for the remaining portion of his or her expenses, or 700 MUs. The health micro-insurance scheme reimburses 100 per cent of these remaining expenses, up to a maximum of 500 MUs, or a total of 500 MUs. This leaves 200 MUs to be financed by the member.

Membership arrangements

Membership in a health micro-insurance scheme may be of the following types:

- individual: each person may join on an individual basis;
- family-oriented: all members of a family must be registered;
- collective: the employees of an enterprise or the members of a cooperative join collectively and not as individuals.

An individual may have a greater or lesser degree of freedom to join a health micro-insurance scheme. Membership may be:

- Voluntary. The decision to join a health micro-insurance scheme is taken by each individual or each family.
- Automatic. Belonging to a group (cooperative, village, trade union, enterprise) or concluding a contract, such as a request for credit from a microfinance institution, automatically entails membership in a health micro-insurance scheme. The decision to join the scheme is not taken by the individual, but by the group to which he or she belongs or the institution of which he or she is a client.
- Compulsory. This refers to the situation of individuals, families or groups who are compelled to join a scheme without this decision having been made by them or the group to which they belong. This is the case with many wage-earners who are required to join a social security scheme, for example.

Each type of membership presents advantages and disadvantages, the main aspects of which are contained in the table below. A health micro-insurance scheme may apply one or more membership arrangements jointly.

Example: A scheme provides collective and automatic membership for the employees of an enterprise with which it has concluded an agreement, and voluntary family-oriented membership for the members of village-based groups.

Membership arrangements	Advantages	Disadvantages	Accompanying measures
Collective and family-oriented membership	• Reduces adverse selection • Increases population coverage rate	• May reduce attractiveness of the scheme	• Establish agreements with enterprises, or trade unions in the case of collective membership
Individual membership	• Simplifies and increases flexibility of membership • May increase attractiveness of the scheme	• Increases risk of adverse selection and fraud	• Waiting period • Verification of benefit entitlement
Voluntary membership	• Is often the only arrangement possible in the informal economy	• Increases risk of adverse selection	• Waiting period
Automatic membership	• Reduces adverse selection • Simplifies management (collection of premiums at group level)	• May lower members' sense of responsibility (possibility of fraud and abuse) • Compulsory membership is often not applicable in the informal economy	• Verification of compliance with obligation to join scheme • Verification in order to limit moral hazard, fraud and abuse
Compulsory membership	• Eliminates adverse selection		

Enrolment period: open or closed

When enrolment in the scheme is permitted at any time of the year, this is referred to as an open enrolment period.

When enrolment is permitted for only a limited period of the year, this is referred to as a closed enrolment period. In a closed enrolment period, the risk of adverse selection is reduced. Since potential members cannot choose when to enrol, there is less risk that they will do so at a time when they are planning to incur major health expenses. A closed enrolment period also simplifies management since the effort required to collect premiums may be concentrated in a short period of time, while that required to monitor enrolment and verify entitlement to benefits presents less of a burden. This solution has been well-received in rural areas when it is combined with the payment of premiums during harvest season. A closed enrolment period makes it less necessary to establish a waiting period. However, it does constitute a constraint for potential members and may decrease enrolment trends.

Conditions of withdrawal and termination

Members must have the ability to withdraw from the health micro-insurance scheme.

Arrangements concerning withdrawal are related to those of membership. If membership is collective, withdrawal is also collective; a group member cannot withdraw from the scheme on an individual basis.

In order to protect itself from opportunistic behaviour on the part of members, the scheme can establish strict rules regarding withdrawal from the scheme. For example, it may establish a closed withdrawal period, according to which members or groups may submit requests for withdrawal only during certain periods of the year, or only on the anniversary of their enrolment. It may also establish somewhat restrictive procedures concerning requests for withdrawal, such as requiring members to file requests one month before the desired date of withdrawal. Likewise, the scheme may establish restrictive provisions concerning the termination of dependents by the member. However, such measures are difficult to apply because they are contingent upon being able to constraint members that did not abide by the rules, which often is not possible.

For its part, the scheme must reserve the right to terminate members and dependents in certain circumstances, such as the repeated failure to pay premiums, cases of obvious fraud or abuse, etc.

All these rules must be defined clearly in the internal rules or the contract.

The existence of membership fees and their amount

Membership fees are used to cover the cost of enrolment. They may be replaced by the sale of the membership card, which is more acceptable to members. Membership fees are usually paid upon enrolment on a one-time-only basis. However, some schemes require members to pay these fees each time they renew their membership card.

The membership fee must not be so high as to discourage potential members from enroling to the scheme.

Method of determining the premium for a family: individual rate, global family rate, etc.

There are a variety of ways to determine premiums:

- individual premiums: each person, whether member or dependent, pays the same premium amount. Alternatively, each person pays a premium, but dependent's premiums are lower than those of members. Premiums may also be determined on the basis of individual characteristics, such as age, sex, state of health, place of residence or occupation;
- global family premium: a single premium is paid, irrespective of the number of dependents in the family;
- intermediate types of premium: the "single/family" premium, with one premium level for single persons without dependents and another for families, irrespective of the number of dependents; or several premium levels depending upon the size of the family;

  Example: An initial premium level for families of from one to three persons; a second premium level for families with from four to nine persons; a third premium level for families with more than nine persons.

- income-based premiums: the premium level is proportional to income, with the possibility of establishing a ceiling.

The following table indicates the main advantages and disadvantages of the various methods of determining premiums.

Methods of determining premium	Advantages	Disadvantages	Accompanying measures
Individual premium (each covered person pays a premium)	● Based on equality among members (no «transfers» between large and small families)	● Encourages adverse selection (members give priority for registration to family members who present a high risk of sickness or maternity) ● Encourages fraud concerning the identity of beneficiaries	● Waiting period ● Closed enrolment ● Identity checks: membership cards with photos of dependents
Global premium per family, not proportional to the number of beneficiaries	● Creates solidarity among families	● Encourages abuse (since members have a tendency to register a maximum number of dependents)	● Limit the number of dependents ● Verify compliance with rules concerning dependents
Income-based premium	● Creates solidarity between rich and poor ● Philosophy of equity and inclusion	● Very difficult to apply in the informal economy	

Frequency of premium payments

Premiums may be paid in a variety of ways: daily, weekly, bi-monthly, monthly, quarterly or by trimester, bi-annually, annually, etc. The collection of premiums is complicated by a high payment frequency (daily, weekly, or bi-monthly).

The health micro-insurance scheme can:

- choose a single payment frequency that applies to all members;
- allow members to choose the payment frequency that suits them best.

The first option is easier to manage. In order to choose the most suitable payment frequency, the data collected for the purposes of objective 8 – "To evaluate the target population's willingness to pay" must be taken into account. These data indicate the payment frequency preferred by the target population, and, in the case of an annual or bi-annual arrangement, the most favourable months for payment of the premium.

For an example of how to present data on seasonal variations in willingness to pay, please refer to:

▶ **4.8 – Defining the scheme's methods of operation,** § *Seasonal nature of income and willingness to pay*, Volume 2, Chapter 4, page 160.

Procedures for reviewing premiums

It is important to establish the frequency with which premium levels will be reviewed and to define the indicators to be used to review these levels.

Examples of review frequency: Every year on the anniversary of enrolment; every 1st of January. Examples of indicators used to review premiums: claims ratio, inflation rate.

The existence and duration of the waiting period, sometimes referred to as the observation or qualifying period

The waiting period is the time following enrolment during which members pay their premiums but cannot yet benefit, or enable their dependents to benefit, from the services provided by the health micro-insurance scheme.

This period is necessary in order to prevent opportunistic behaviour in persons who might enrol in the scheme at a particular moment of need – in anticipation of childbirth or a planned surgical operation, for example – and withdraw from the scheme once the need had been met. The waiting period also has the effect of reducing the cost of the risk during the first year, which can be taken into account by lowering premium levels over the entire length of the membership. The waiting period is less useful when membership is collective, automatic or compulsory.

There is no standard length of time for the waiting period. If it is too short, it may fail to prevent opportunistic behaviour and adverse selection; if it is too long, it may risk discouraging enrolment. Besides the waiting period can vary from one covered health service to another. In the case of maternity, the usual waiting period is from nine to 10 months. For other risks, this period is usually shorter – generally lasting from one to three months. The use of different waiting periods, depending upon the risk involved, complicates management.

Procedures to follow in order to be eligible for coverage

Verification of scheme membership and entitlement to benefit

In order to be eligible for third-party payment, preferential agreements with health care providers or simply to obtain reimbursement, patients must be protected by the scheme, as a member or dependent, and be up to date with their premium payments. Verification of scheme membership and entitlement to benefits may, depending upon the case, be carried out before, during or after the utilization of health services.

Verification prior to or at the time health care is delivered may be carried out primarily:

- in the case of a third-party payment mechanism, in which members and/or dependents are not required to advance payment for health care expenses covered by the health micro-insurance scheme;
- in the case of schemes that have concluded agreements with certain providers concerning fees, quality and/or treatment protocols.

Verification prior to or at the time care is delivered may be carried out by the health care provider. Presentation of the membership card may be used as proof of membership in the scheme.

The guarantee letter* is a mechanism that may be used to prove that members are up to date with premium payments. This is a certificate of entitlement that the patient must obtain from the health micro-insurance scheme before obtaining care. This procedure – which is quite burdensome, particularly in the case of emergencies – may be replaced by stamping the membership card on each premium due date as proof that the premium was paid.

Verification following the delivery of health care is carried out by scheme managers. After receiving care, and in the absence of a third-party payment, the patient (member or dependent) submits an invoice to the health micro-insurance scheme specifying the services that were delivered and the expenses incurred. Some schemes require the use of model invoices, which are easier to read and contain all the information needed by the scheme to carry out verification and issue reimbursement.

Other mechanisms conditioning coverage

For certain costly health services, the health micro-insurance scheme may set up a prior agreement mechanism, according to which members or dependents must submit an estimate to the scheme before receiving care. If approved, the scheme issues an authorization of coverage. This mechanism may be used to limit the scheme's exposure to moral hazard and the risk of over-prescription. The health micro-insurance scheme must call upon the services of a medical adviser to examine requests for prior agreement.

The health micro-insurance scheme may set up a system of compulsory referral for health care provided at the second or third level of the health pyramid (hospitalizations, specialist treatments). The member or dependent is required to consult a provider at one level before being able to obtain care from a provider at a higher level. This mechanism may be used to reduce the consumption of costly, specialist treatments that are not absolutely necessary.

The following table summarizes the advantages and disadvantages of the mechanisms of prior agreement and compulsory referral.

Mechanisms	Advantages	Disadvantages	Accompanying measures
Prior agreement	● Reduces over-consumption and over-prescription	● Requires burdensome administrative procedures for beneficiaries ● Entails costs in that it requires the services of a medical adviser	● Resort to the services of a medical adviser
Compulsory referral	● Reduces consumption of costly services	● Reduces freedom of choice ● Difficult to set up in schemes that are already in operation ● Presupposes a well-organized health pyramid	

Action 2: Define the principal management procedures

Once the main operating rules have been established (rules pertaining to membership, payment of premiums, coverage and/or reimbursement) the steering committee may draw up a detailed description of the scheme's management procedures through the use of the role table method. For an illustration of this method, please refer to:

▶ **4.8 – Defining the scheme's methods of operation**, § *Devising a role table*, Volume 2, Chapter 4, page 161.

The role table method may be used to list all the activities necessary for the scheme's management and operation and to verify that its human resources are sufficient and have been allocated optimally.

Each operation carried out by the health micro-insurance scheme may be seen as a process that includes a number of steps, requires a variety of skills and utilizes tools such as forms, registers, computerized tools, etc.

The role table is drawn up, in this case, on the basis of the following: an analysis of the principal management procedures, understanding of the various steps, identification of the actors involved in each step, details concerning the duties and responsibilities of the actors, a list of all tools and documents utilized (sheets, registers, computerized tools) and instructions on how to use them.

The use of the role table provides actors with a better overall view of the scheme's operation and a better understanding of each person's role and the nature of his or her involvement. It allows the actors, as a whole, to reach an agreement on the steps and rules that everyone will be required to follow. It may be used in preparation for drafting the procedures manual and designing record-keeping tools. Role tables may also be used for training officials. In addition, they may serve as a basis for future agreements between the health micro-insurance scheme and health care providers.

For more information on management procedures and accounting operations, please refer to:

▶ *Guide de gestion des mutuelles de santé en Afrique*, (Management guide for mutual health insurance organizations in Africa), Parts 3 and 4, ILO/STEP, 2003.

Action 3: Define the monitoring procedures

Various monitoring procedures may be identified in order to ensure the proper functioning of the health micro-insurance scheme:

- monitoring the application by the various actors of the operating rules and management procedures helps to ensure that all upstream verifications have been carried out (before accepting new members, before issuing reimbursements, etc.) and that record-keeping devices have been properly utilized;
- monitoring the risk portfolio allows for the timely detection of such phenomena as over-consumption and over-prescription, which can risk jeopardizing the financial equilibrium of the scheme. It may also serve as a basis for adjusting premium levels;
- budgetary monitoring is used to ensure that the budget estimate has been met. It consists of comparing the estimate made at the start of the accounting period with the actual transactions registered during the accounting period. Discrepancies between the estimate and the actual transactions necessarily entail making adjustments to activity programmes or establishing a new budget;
- cash flow monitoring is used to ensure that the health micro-insurance scheme will be able to meet its obligations, in particular with respect to beneficiaries and providers, without having to maintain too high a level of liquidity. It consists of comparing estimated cash receipts and expenditures against actual transactions. Discrepancies between estimates and actual transactions necessarily entail making adjustments to cash flow management and activity programmes.

For more information on monitoring activities, please refer to:

▶ *Guide de suivi et d'évaluation des systèmes de micro-assurance santé* (Health Micro-Insurance Schemes: Monitoring and Evaluation Guide), Volume 1: Methodology, Part II – Monitoring tools and procedures, ILO/STEP and CIDR, 2001.

Cross-cutting action: Ensure that the operating rules make it possible to limit the scheme's exposure to insurance-related risks

The scheme's operating rules must, to the extent possible, provide a means of limiting the phenomena of adverse selection, moral hazard, over-prescription, fraud, abuse and catastrophic risks, and their impact on the scheme.

Some of these rules are presented in the summary table below:

Countering adverse selection and opportunism	
Membership rules	Compensate for the enrolment of persons with a high risk of illness with the enrolment of persons in good health by: ● promoting family membership: as soon as one family member enrols, all other family members must be registered; and/or ● encouraging group membership **Example:** All the members of an enterprise, trade union, association, religious community, etc.
	Promote automatic membership by concluding agreements with structured groups, such as trade unions, enterprises, associations
	● Set a maximum age for first-time members **or** ● Have first-time members who have reached a certain age pay a higher premium
Enrolment period	Establish a closed enrolment period
Rules pertaining to eligibility for coverage	Introduce a waiting period whose length may depend on the services covered **Example:** Nine months in the case of maternity
Rules pertaining to withdrawal or termination	Introduce restrictive provisions concerning withdrawal from the scheme or termination of membership
Premiums	Introduce a global premium per family in order to avoid the disproportionate registration of persons with a high risk of illness
Membership fee	Require the payment of an additional membership fee for members failing to renew their membership by the established deadline (annual membership renewal, for example)
Countering moral hazard and the risk of over-prescription	
Rules and procedures pertaining to eligibility for coverage	Introduce a prior agreement mechanism for costly and non-urgent health services
	Introduce a system of compulsory referral to regulate access to care at a higher and more costly level
Monitoring procedures	Introduce procedures to monitor and control the health care consumption of beneficiaries as from the first year
Other verification procedures	Encourage social control and the development of a sense of responsibility in each member and dependent

Countering fraud and abuse	
Dependents	Establish a narrow definition of the family in order to limit abuse (such as the enrolment of a large number of persons per family) in cases in which the premium does not depend upon the number of beneficiaries
Premiums	Introduce particularly rigorous identity checks in cases in which each member of the family pays a premium
	Limit the number of dependents when premiums remain the same regardless of family size
Rules and procedures pertaining to eligibility for coverage	Utilize a guarantee letter in order to verify that members are up to date with their premiums
	Clearly indicate the beneficiaries' identity on the membership card: last name, first name, date of birth, photo id
	Verify patient identification and entitlement when service is delivered, especially when scheme members benefit from third-party payment or preferential fees
	Verify patient identification and entitlement when reimbursing patients in the case of direct payment for services
Limit the scheme's exposure to financial risks associated with catastrophic events, such as epidemics or exceptionally high health expenses	
Membership rules	Spread the risks over several geographic areas by accepting members from various villages or districts
Rules pertaining to eligibility for coverage	Introduce a waiting period in order to build up financial reserves as from the first year
Rules for insuring coverage	Subscribe to a reinsurance or co-insurance plan

Step 9: Prepare the scheme's budget estimate

The purpose of this step is to verify the overall financial coherence of the future health micro-insurance scheme.

The budget is based on estimates of the income and expenditure needed to carry out the activities of the health micro-insurance scheme over the course of a defined period, generally referred to as an accounting period. The budget must be balanced in terms of income and expenditure.

Each quarter, a comparison of estimates against actual income and expenditures should serve as a basis for determining what measures, if any, are needed to properly execute the budget, and consequently, to maintain the financial equilibrium of the scheme.

The establishment of a budget estimate, which is carried out once the scheme has been set up, involves:

1. Listing and evaluating the total estimated revenues of the scheme. These consist primarily of premiums, membership fees, receipts from fee-based activities, donations, grants and subsidies, if any.
2. Listing and evaluating the total estimated expenses of the scheme. These consist primarily of the expenses associated with covered health services, the provision of ancillary health services (health education classes, etc.), operating costs (payroll costs, office supplies, etc.) and training and facilitation costs.
3. Establish the budget estimate and verify that financial equilibrium has been attained. The establishment of the budget estimate is explained and illustrated in Volume 2.

▶ **4.9 – Preparing the scheme's budget estimate**, Volume 2, Chapter 4, page 163.

Readers may also consult:

▶ *Guide de gestion des mutuelles de santé en Afrique* (Management guide for mutual health insurance organizations in Africa), Part 5, ILO/STEP, 2003.

4. If the budget is not balanced or if the contingency reserve item is too low, make adjustments: increase premiums, seek new sources of financing, reduce certain operating costs.

It is not always necessary to use a participatory approach for establishing the budget. However, it is preferable to include representatives of the target population if adjustments must be made, particularly if premium levels must be increased.

5. Phase to prepare for setting up the scheme

Introduction

Objectives of the phase to prepare for setting up the scheme

The last phase of the feasibility study consists of drafting a report based on the set of assumptions and outcomes of the various phases already completed. This report formalizes all the various aspects of the feasibility study: the course of action taken, the steps followed and results obtained in the data collection, and the decisions reached. The feasibility study report provides an opportunity to verify the overall coherence of the scheme before the start-up of operations.

This last phase also consists of setting down in the reference documents and tools all the decisions made during the preceding phase. These documents and tools are necessary for starting up operations. They include: the action plan, statutes, organizational chart, internal rules (in the case of a mutual organization) or contracts, management tools and documents, procedures manual and agreements with health care providers.

Note: This is not an exhaustive list of the documents and tools the scheme will need to implement, manage and monitor its operations – all documents relating to accounting and to budget and cash-flow monitoring, for example, have been omitted – but rather those directly related to the decisions made during the feasibility study, and which it is thus logical to produce at the end of the study.

For a detailed description of all the documents and tools needed by the scheme, please refer to:

▶ *Guide de gestion des mutuelles de santé en Afrique* (Management guide for mutual health insurance organizations in Africa), ILO/STEP, 2003 and *Guide de suivi et d'évaluation des systèmes de micro-assurance santé* (Heath micro-insurance schemes: monitoring and evaluation guide), ILO/STEP and CIDR, 2001.

The phase of preparation culminates in the official establishment of the scheme. At that point, the steering committee is dissolved and responsibility is handed over to the decision-making, executive and supervisory bodies charged with representing and managing the health micro-insurance scheme.

Chapter contents

This chapter provides a brief description of the feasibility study report, as well as of the various reference documents and tools mentioned above.

The feasibility study report

The feasibility study report provides a summary of the process involved in carrying out the study and its outcomes. It is drafted by the steering committee on the basis of the set of assumptions and outcomes of the various phases of the feasibility study.

Note: The report is usually prepared at the conclusion of the feasibility study, and thus, after the scheme's reference documents and tools have been prepared. However, in order to stress its importance, the feasibility study report will be discussed before these documents.

There are several reasons why it is important to prepare such a report.

First reason: It describes the course of action taken during the feasibility study, including the data-collection procedure, the decision-making process and the design of the scheme. In particular, the report specifies why certain data were collected rather than others, why certain options were chosen over others, etc. Keeping a record of the procedure followed and the rationale behind the decisions reached helps to prevent calling the scheme's strategy into question from one day to the next, or selecting, on the basis of insufficient analysis, options which had previously been rejected.

Second reason: The report also assembles the collected data. These data may be used to prepare studies concerning, inter alia, the health, economic or social situation that existed prior to setting up the scheme. They may also be used to carry out studies concerning the scheme's impact, in particular, on the frequentation of the health facilities, the means of treatment sought in response to illness, financial difficulties experienced by households in dealing with sickness or maternity, and, lastly, to make new decisions when expanding a scheme, without having to organize another full-scale data collection.

Example: If the scheme's managers choose to extend coverage to include new services, they can give preference to the services that were considered to be a priority by the target population during the feasibility study. Nevertheless, it is important regularly to conduct new polls or surveys of the target population in order to ensure that the health micro-insurance scheme is still in line with the needs and expectations of the target population.

Third reason: Preparing a report compels the steering committee to formalize all the components of the feasibility study and to verify the overall coherence of the scheme before starting up its operations.

The report should not be too long. However, it is imperative that certain key data be included: the process of carrying out the study, including its steps and milestones; the methods of collection and facilitation utilized; the various data-collection, calculation and data-presentation tools utilized (data-entry forms, interview forms, survey questionnaires, premium calculation charts, role tables, etc.); figures for a number of reference indicators, such as the frequentation rate; the initial assumptions relating to the scheme, such as its budget estimate; and the statistics used as an input for calculating premiums (probabilities and/or frequencies, quantities consumed and unit costs).

For examples of both a chronological and a thematic outline for preparing the feasibility study report, please refer to:

▶ **5.1 – Sample outlines of the feasibility study report,** Volume 2, Chapter 5, page 169.

The action plan

The action plan is a summary report used to plan and to describe all the necessary actions for starting up or expanding a health micro-insurance scheme. The steering committee may adopt a participatory approach that associates representatives of the target population in efforts to define, in particular, the strategy for setting up or expanding the scheme.

Drawing up an action plan consists of:

1. Defining (in some cases, using a participatory approach) the strategy for setting up or expanding the scheme. This consists mainly of replying to the following questions:
   - What areas (or groups) will the scheme cover?
   - When will the start-up/expansion take place?
   - How many promotional campaigns are planned?
   - What are the objectives of the promotional campaigns in terms of the number of enrolments?
   - How will the start-up/expansion be carried out?
2. Drafting a document that formalizes the replies to each of these questions and drawing up the corresponding programme. For a sample action plan, please refer to:

▶ **5.2 – Sample plan of actions,** Volume 2, Chapter 5, page 174.

The statutes and the organizational chart

The statutes constitute a reference document that describes, in particular, the scheme's purpose and organization, and the relationship between the various internal bodies and their respective functions.

The statutes fulfil several roles:

1. They establish the objective of the scheme, as well as the rules pertaining to its organization (relationship between the internal bodies, tasks of the various actors) and its financing (in particular, rules for reviewing premiums at the end of the accounting period).
2. Once they are approved by the competent authorities, the statutes confer juridical personality* upon the scheme. The scheme can then open a bank account, or conclude agreements with health care providers or contracts with insured persons (for schemes other than mutual health organizations).
3. They determine the rhythm of the scheme's activity, e.g. the frequency with which general assemblies are held, annual reports and financial statements are submitted and approved, officers stand for re-election, etc.
4. Depending upon the legal status of the scheme, the statutes may determine the rights and obligations of members (in the case of a mutual organization) or of investors (in the case of a commercial enterprise).

The broad features of the statutes are conditioned by the institutional and legal framework within which the health micro-insurance scheme operates. There are two possible situations.

First situation: In some countries, there are laws governing mutual health organizations and/or insurance companies. These laws establish, inter alia, model statutes to which all health insurance schemes must conform. In Mali, for example, the mutual benefit insurance code establishes model statutes pertaining to mutual organizations.

Second situation: No specific legislation exists. Health micro-insurance schemes adopt statutes that conform to existing laws and regulations governing associations, cooperatives, commercial enterprises, etc.

Drafting the statutes generally involves several steps. At the conclusion of the feasibility study, the steering committee assembles and consolidates the rules of organization and operation that have been decided upon and prepares draft statutes in conformity with current legislation. The draft statutes are then presented to the scheme's decision-makers, who adopt the statutes after making any necessary changes. The adoption of the statutes allows for the establishment of the internal bodies, the election of officers, the legal recognition of the scheme through its registration with the competent authorities and the start-up of its activities. Any subsequent amendment to the statutes must be approved by the scheme's decision-making body before being registered with the competent authorities. In the case of a participatory scheme, it is sometimes necessary to convene an extraordinary general assembly.

The amendment process may be quite complicated. For this reason, it is prudent to include only the most essential aspects of organization and operation in the statutes. Other documents which are easier to amend, such as the internal rules or insurance contracts, may complement the statutes.

The statutes may also be complemented by the organizational chart. This is a diagram representing the various internal bodies involved in administering the health micro-insurance scheme and their hierarchical relationships. The organizational chart provides a graphic overview of the distribution of responsibilities within the scheme.

For an example of how to draft statutes, please refer to:

▶ *Guide de gestion des mutuelles de santé en Afrique* (Management guide for mutual health insurance organizations in Africa), ILO/STEP, 2003, Part 2, Chapter 3, which describes the statutes of the mutual organization of cycle taxi owners of Kenlodar.

The internal rules or the insurance contract

The internal rules (in the case of a mutual organization)

Only health micro-insurance schemes that are set up and managed by and for their members (mutual organizations) have internal rules.

Note: In mutual organizations, members participate in management through the election of officers and the general assembly. Mutual organizations are the collective property of their members; the latter are at once the insurers and the insured. For this reason, there is no formal contract governing the relationship between the mutual organization and its members (since one cannot conclude a contract with oneself). Rather, this relationship is governed by the rights and obligations set forth in the statutes and internal rules of the organization.

The internal rules complement the statutes. They clarify a certain number of the mutual organization's methods of operation.

The internal rules do not constitute a necessary document for obtaining the official recognition of the mutual organization. As its name indicates, it is an internal document that provides a detailed description of the rules of organization and operation. The internal rules therefore constitute a reference document that serves to establish the responsibilities of the members and the internal bodies, and to ensure the proper management and supervision of operations. Unlike the statutes, amendments to the internal rules do not require undertaking formalities before the authority registering the scheme.

The internal rules have the same binding nature as the statutes, provided, however, that their establishment is stipulated in the statutes and that members are aware of their content at the time of enrolment. It is for this reason that enrolment in a mutual organization consists of accepting the provisions of the statutes and the internal rules.

Several steps are involved in drafting the internal rules. At the conclusion of the feasibility study, the steering committee prepares draft internal rules based on the consolidated list of decisions concerning the scheme: rules of organization and operation, provisions concerning insurance coverage and services, provisions concerning payment of premiums, etc. This draft is then approved by the constituent general assembly of the mutual organization. Any subsequent amendment to the internal rules must be approved by a general assembly.

For an example of how to draft internal rules, please refer to:

▶ *Guide de gestion des mutuelles de santé en Afrique* (Management guide for mutual health insurance organizations in Africa), ILO/STEP, 2003, Part 2, Chapter 3, which describes the internal rules of the mutual organization of cycle taxi owners of Kenlodar.

The insurance contract

Some health micro-insurance schemes conclude contracts with their members. This includes most schemes managed by health care providers, as well as commercial insurance* schemes. In most cases, the members are not co-owners of the scheme but are merely its clients.

The insurance contract is the document that establishes the mutual obligations of the members and the health micro-insurance scheme, including the terms and conditions of membership, withdrawal, termination, insurance coverage and services, and the payment of premiums. Insurance contracts are clearly defined, limited in time, renewable and revocable. It is by virtue of the contract that entitlement to benefit is established.

An insurance contract is binding to the extent that membership in the scheme is contingent upon acceptance of its provisions. It is signed by each member (in the case of an individual contract) or by a group of members (in the case of a group contract*). Individual contracts are generally "standardized", that is, they are identical for all members; whereas group contracts are often "customized", meaning that they may vary from one organization to another. Regardless of whether a contract is individual or collective in nature, individuals subscribing to them are bound not by the scheme but rather by the contract.

Note: Mutual organizations may conclude group agreements with organizations (such as cooperatives, trade unions or enterprises) in which scheme membership is automatic, or even compulsory, for the members of these organizations. Even in such cases, membership in the mutual organization or association remains an individual undertaking in which each member subscribes to the statutes and the internal rules. The group agreement simply allows for streamlining certain administrative tasks, such as group collection of premiums, group submission of claims, etc.

The process of drawing up insurance contracts is simpler than that of drafting internal rules, since the contracts do not have to be approved by the general assembly (if one exists), but merely by the legal representative of the scheme, such as the president or general manager.

For a contract framework, as well as a sample individual contract, please refer to:

▶ **5.3 – Contract framework and sample health insurance contract***, Volume 2, Chapter 5, page 177.

Management tools and documents

The steering committee may consider setting up a management system that is entirely manual. It may also rely upon a computerized management system, or a mixed system using, for example, "paper-based" record-keeping devices at the scheme's branches and a computerized tool at the main office. In such cases, the data entered at the branch level are submitted regularly to the central management department, which then records them electronically.

Management tools and documents are prepared on the basis of the operating rules established during the scheme design phase. For obvious reasons, it is important for the main documents and tools to be ready before launching the scheme. Moreover, it is indispensable for all actors concerned to be trained in how to use these various devices.

For paper-based devices, preparation consists of drafting the documents and duplicating them: printing blank membership cards, model invoices, registration forms, etc. For computerized tools, preparation consists of installing a ready for use management software or designing and developing a tailored application.

Tools and documents pertaining to membership management

Tools and documents pertaining to membership management should enable managers to register members and their dependents, monitor the covered population and verify members' and dependents' entitlement to benefits.

In a manual or "paper-based" management system, these tools and documents consist of sheets, registers and cards.

Examples: The membership sheet, membership register, membership monitoring chart and membership card.

In a computerized management system, certain sheets and registers are replaced by computer files known as "tables".

Functions	Examples of tools and documents	
	Manual system of management	**Computerized system of management**
Register members and their dependents	● Membership sheet	● Membership sheet ● Enrolment transactions table
Monitor the number of members and dependents	● Membership register ● Membership monitoring chart ● Manual calculation of indicators: number of members, size of families, etc.	● Beneficiary table ● Automatic calculation of indicators
Verify patients' benefit entitlement in the case of third-party payment	● Membership card	● Membership card or ● Printout of members and dependents

For a detailed description of the tools and documents utilized in a manual system of management, please refer to:

▶ *Guide de gestion des mutuelles de santé en Afrique*, (Management guide for mutual health insurance organizations in Africa), ILO/STEP, 2003, Part 3, Chapter 1.

Tools and documents pertaining to premiums management

Tools and documents pertaining to premiums management should enable managers to register premium payments, detect payments in arrears and monitor premium transactions.

Functions	Examples of tools and documents	
	Manual system of management	**Computerized system of management**
Record premium payments or payments in arrears for each member	● Premiums sheet	● Premiums sheet ● Membership fee and premium payment table
Monitor premium payments	● Premiums register ● Membership fee and premium monitoring chart ● Manual calculation of indicators: level of arrears, premiums collection rate	● Reminder monitoring table ● Automatic calculation of indicators

For a detailed discussion of the tools and documents used in a manual system of management, please refer to:

▶ *Guide de gestion des mutuelles de santé en Afrique*, (Management guide for mutual health insurance organizations in Africa), ILO/STEP, 2003, Part 3, Chapter 2.

Tools and documents pertaining to claims management

Tools and documents pertaining to claims management should make it possible to avoid the occurrence of certain insurance-related risks, such as fraud, over-consumption of health care, etc. However, they must not be so numerous or so complicated as to cause members to experience undue delays in obtaining care.

The tools and documents utilized may differ depending upon whether the scheme sets up a third-party payment mechanism or a mechanism to reimburse members following the delivery of health services (see table below).

<table>
<tr><th rowspan="2">Functions</th><th colspan="2">Examples of tools and documents</th></tr>
<tr><th>Manual system of management</th><th>Computerized system of management</th></tr>
<tr><td colspan="3">Third-party payment mechanism</td></tr>
<tr><td>Check entitlement
before care is provided</td><td colspan="2">Guarantee letter or authorization of coverage</td></tr>
<tr><td>Order and issue payment to providers</td><td colspan="2">Treatment certificate * and consolidated invoice* of provider</td></tr>
<tr><td colspan="3">Reimbursement mechanism</td></tr>
<tr><td>Order and issue reimbursement
to members</td><td colspan="2">Receipt or individual invoice</td></tr>
<tr><td colspan="3">All cases (third-party payment, reimbursement)</td></tr>
<tr><td>Check kind and cost of most
expensive services</td><td colspan="2">Request for prior agreement</td></tr>
<tr><td>Register information concerning claims</td><td>Claims register</td><td rowspan="2">● Claims table
● Automatic calculation of indicators</td></tr>
<tr><td>Monitor utilization of health services</td><td>● Claims monitoring chart
● Manual calculation of indicators: average unit cost, quantity consumed, etc.</td></tr>
</table>

For a detailed description of the tools and documents used in a manual system of management, please refer to:

▶ *Guide de gestion des mutuelles de santé en Afrique*, (Management guide for mutual health insurance organizations in Africa), ILO/STEP, 2003, Part 3, Chapter 3.

The procedures manual

The procedures manual is a document that describes, for each management operation, the activities to be performed, the tasks of the actors involved and the management tools and documents to be used.

Management procedures must be defined for the following operations: enrolment, changes in membership, withdrawal, collection of membership fees, billing of premium, requests for prior agreement, reimbursement of insured persons in the absence of a third-party payer and payment of providers under a third-party payment mechanism.

Each operation has its rules for recording data, checks to be performed (e.g. before settling claims, the insured person's entitlement to benefit must be checked) and rules for issuing documents or payment orders.

The procedures manual may also describe the rules to be followed for monitoring membership, premiums and claims. In this case, it explains the checks that are to be performed, the indicators to calculate, the measures to be taken to deal with discrepancies and the frequency of checks and calculations.

The procedures manual fulfils several functions: (1) it serves as a reference, helping to prevent omissions; (2) it encourages actors to become familiar with each others' tasks; and (3) it constitutes a basic document for training the new managers and staff of health micro-insurance schemes.

The procedures manual, which is drafted at the conclusion of the feasibility study, is not a static document. Rather, it should evolve; in particular, by keeping pace with changes to the scheme and its development.

The procedures manual may include:

- a reminder of the objectives of the health micro-insurance scheme and, if necessary, the main articles of the statutes and internal rules dealing with management procedures;
- for each operation, a description of the activities involved, the tasks of the actors concerned and the management tools and documents to be used;
- rules for monitoring operations in each management division (membership/premiums/claims): checks to be performed, indicators to calculate, measures to be taken to deal with discrepancies, and the frequency of checks and calculations.

For a detailed description of management and monitoring procedures, please refer to:

▶ *Guide de gestion des mutuelles de santé en Afrique*, (Management guide for mutual health insurance organizations in Africa), ILO/STEP, 2003, Part 3, Chapters 1- 4.

Agreements with health care providers

These are contracts concluded between the health micro-insurance scheme and a health care provider describing the mutual obligations of the two parties and, more precisely, formalizing the mechanisms of coverage (with or without a third-party payer), payment (global payment, fee-for-service, contractual fees), verification and standards of quality (treatment protocols, quality objectives to be met).

The contents of the agreements are defined little by little during the scheme design phase by the steering committee, which works in close collaboration with the managers of the health facilities concerned.

Note: Some schemes that reach agreements with health care providers do so without drawing up written contracts. It is therefore not necessary to draft a contract in order to establish an agreement with a provider. Nevertheless, written agreements do have the advantage of making the terms of understandings more specific and of serving as a reference in the event of a dispute, if any of the parties fails to honour its obligations.

Depending upon circumstances, schemes may draft either a standard agreement that is common to all health facilities or several agreements (one for each health facility). The use of standard agreements reduces drafting time and simplifies efforts to monitor compliance with agreements and to deal with amendments.

Agreements must be ratified by the decision-making bodies of the health micro-insurance scheme. As far as health care providers are concerned, the ratification of the text of an agreement may involve the managers, management committees or regulatory bodies of the health facilities. Finally, the text of the agreement may be approved by other actors (support organizations, unions of mutual organizations, etc.), which may act as guarantors or assist in the contractualization process.

Generally speaking, the signatories of the agreement are, in the case of the health micro-insurance scheme, the president or general manager, and in the case of the health facility, the manager in charge or – if he or she does not have the authority – his or her superior (official of the regulatory body).

For an outline of an agreement with a health care provider, as well as a sample agreement, please refer to:

▶ **5.4 – Agreement framework and sample agreement with a health care provider,** Volume 2, Chapter 5, page 182.

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