# L'Union des Mutuelles de Santé de Guinée Forestière
## Guinea

CGAP Working Group on Microinsurance
Good and Bad Practices
*Case Study No. 17*

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## Good and Bad Practices in Microinsurance

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1. A **series of case studies** to identify good and bad practices in microinsurance
2. A **synthesis document** of good and bad practices in microinsurance for practitioners based on an analysis of the case studies. The major lessons from the case studies will also be published in a series of **two-page briefing notes** for easy access by practitioners.
3. **Donor guidelines** for funding microinsurance.

## The CGAP Working Group on Microinsurance

The CGAP Microinsurance Working Group includes donors, insurers, and other interested parties. The Working Group coordinates donor activities as they pertain to the development and proliferation of insurance services to low-income households in developing countries. The main activities of the working group include:

1. Developing donor guidelines for supporting microinsurance
2. Document case studies of insurance products and delivery models
3. Commission research on key issues such as the regulatory environment for microinsurance
4. Supporting innovations that will expand the availability of appropriate microinsurance products
5. Publishing a quarterly newsletter on microinsurance
6. Managing the content of the Microinsurance Focus website: www.microfinancegateway.org/section/resourcecenters/microinsurance

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Although the study was written by persons who have taken part directly or indirectly to the implementation of the program, it was not in their intention to demonstrate its success but to point out its strengths and weaknesses. In this respect, the role of the consultant has been very helpful.

# Acronyms

| | |
|---|---|
| ACF | Action against Hunger |
| AFVP | Association française des Volontaires du Progrès |
| BHS | Basic health services |
| CIDR | International Centre for Development and Research |
| CIMA | Inter-African Conference on Insurance Markets |
| FANAF | French-speaking African national Insurers’ Federation |
| GDP | Gross Domestic Product |
| GNF | Guinean Franc |
| GTZ | Deutsche Gesellschaft für Technische Zusammenarbeit |
| HIPC | Highly Indebted Poor Countries |
| IMF | International Monetary Fund |
| IS | Institut de la Statistique (Quebec) |
| MFI | Microfinance institution |
| MHO | Mutual Health Organization |
| MIS | Management information system |
| MoH | Ministry of Health |
| MPA | Minimum package of activities |
| MURIGA | Mutuelle pour la prise en charge des risques liés à la grossesse et à l’accouchement (Mutual organizations for pregnancy and delivery risks) |
| n.a. | Not available |
| NGO | Non-governmental Organization |
| NSSO | National Social Security Office |
| PNLS | Programme National de Lutte contre le Sida (National programme for the fight against HIV/AIDS) |
| PPP | Purchasing Power Parity |
| RC2 | Projet de relance café-cacao (Cocoa and coffee revival project) |
| ROSCA | Rotating Savings and Credit Associations |
| TU | Technical Unit |
| UGAR | Union Guinéenne d’Assurances et de Réassurances |
| UMSGF | Union des Mutuelles de Santé de Guinée forestière (Forestry Guinean Mutual Health Organizations’ Union) |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Program |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNICEF | United Nations Children’s Fund |
| WHO | World Health Organization |

# Executive Summary

The Union des Mutuelles de Santé de Guinée Forestière (UMSGF) is an association of mutual health organizations (MHOs). It was established as part of a health insurance program initiated in 1999 by the International Centre for Development and Research (CIDR). Overall, the insurance sector in Guinea is underdeveloped and neither the target populations nor health care providers are particularly familiar with health insurance.

Forestry Guinea is a region with strong agricultural potential, inhabited by a variety of ethnic groups in villages that are relatively isolated from the main urban areas. The role health microinsurance could play was recognized once preliminary studies determined that the target population was facing serious financial difficulties in accessing health care services despite the fact that public facilities charged relatively low fees. The inability to access health care was connected to the target population's irregular cash flow, including lengthy lean periods with more expenses than income.

CIDR is a non-governmental organization (NGO) involved in various development fields since 1961. The NGO aims at organizing persons in the informal economy to help them assume responsibility for their economic, technical and financial needs. In particular, CIDR works in the following sectors: microfinance, microenterprise development, support to decentralization processes, microinsurance, and the management of health services. In the field of microinsurance, CIDR has used different approaches in different areas:

- MHOs organized in regional networks in Benin (20 000 beneficiaries), Guinea (14 000 beneficiaries), Tanzania and Kenya
- Comoros Islands: Village-based social security with automatic membership
- Mali: Collaboration between a mutual health organization and a microfinance institution
- Uganda: Health insurance scheme co-managed with a not-for-profit health care provider

CIDR also promotes recognized social movements in the health policy development process that can minimize the chronic malfunctions in health service systems, such as drug shortages, poor quality care and illegal payments.

In Guinea, CIDR chose to organize the management and governance functions of microinsurance according to the principles of mutualism because of the local social dynamics, such as cohesive communities with multiple self-help organizations. Additionally, there was an absence of formal social or professional organizations that could have undertaken the tasks of management and product distribution.

The current program was divided into three phases: a pilot phase to test microinsurance products and the mutual model (1999-2002); a consolidation phase in which a regional network of mutual health organizations was created (2002-2005); and an institutionalisation phase that will facilitate the gradual withdrawal of CIDR's support (2005-2007).

Health credit managed by self-help groups and health insurance with cash reimbursements to members were tested during the pilot phase. However, these were quickly replaced with a more attractive insurance arrangement with direct third-party payments to contracted public health facilities.

From its inception, the MHOs' network has experienced steady internal and external growth.[1] By 2005, the UMSGF has brought together 21 rural and 7 urban MHOs comprising of a total membership of 2,656 families and 14,071 individuals, or roughly 100 families per scheme. This is equivalent to about 10 percent of the target group in those areas.

To meet the needs and financial capabilities of their target populations, the MHOs designed low-cost products (€1.3 premium per person per year in 2005) that offered benefits for hospitalization and surgical procedures at public health facilities. This situation was gradually modified to take into account the diversification of available health care delivery services, as not-for-profit providers increased. The benefits were also modified to meet the demands of the members, such as the addition of outpatient care.

Within 5 years, the adopted insurance management strategy has enabled mutual health organizations to build sufficient equity (€19,500 over 5 years from an annual volume of collected premiums of €12,000 for 2004/05), so they could embark on product diversification. The MHOs benefit from a guarantee system that provides them with access to an intervention fund should their reserves fall below a safety threshold.

The project has a specialized Technical Unit to organize risk monitoring and management functions that go beyond MHOs' primary capacities. In the near future, the technical staff (risk manager and medical doctor) will be employed by the UMSGF. The Union's major challenge is for all of the network's organizations to cover their expenses in the years to come. MHOs will have to allocate 17.5 percent of their collected premiums to pay for the Technical Unit's services and to cover the Union's running costs.

Increasing the membership of the MHOs and the size of the network is a challenge that must be overcome to ensure financial independence. The breakeven point to establish financial independence is predicted to be around 60,000 members. This membership level could be reached if the health care quality and the target group's purchasing power does not erode.

In the absence of specific legislation regulating mutual organizations, a not-for-profit organization status was adopted as a temporary measure. The UMSGF is involved in discussions taking place at the national level to draft a bill adapted to its particular status within Guinea.

*Lessons: Technical Aspects*

**Product design.** Although according to mutual principles, members choose their benefits, the operator's initial power of induction is strong. It must have a sound knowledge of the target

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[1] External growth is the establishment of new MHOs; internal growth is an increase of members within an existing MHO.

groups' purchasing power and preferences to design products that are both appealing to, and affordable for, a significant part of the target population.

Positioning the product's selling price above its actual cost price turned out to be a strategy suitable to the context in which the MHOs' were established. It enabled them to build equity without imposing lengthy waiting periods on their members. In the end, MHOs will probably need to design multiple products to maximize their membership.

**Marketing and communication strategy**. Specific sensitisation, information and communication activities must be carried out over a long period of time by specialized staff. Elected officials' capacity and availability in handling these activities by themselves should not be over-estimated. MHOs are not in a position to fund this initial investment out of their own resources.

Member subscription through mutual groups has proved useful since it eases premium collection, improves information flows and, when necessary, is a means of organizing members' representation within the governance bodies.

**Health risk management and control.** Health providers' behaviour has a major effect on the viability of health insurance products. Specific monitoring and control measures have to be set up. Calling in a medical consultant and hiring liaison officers to assist the insured within health facilities are important means of preventing potential conflicts or disputes between scheme members and health staff, and between MHOs and health providers.

**Customer lessons.** For its target market, the program chose low-income unorganized populations with little schooling, living primarily in rural areas. The observed level of contributions makes it impossible for the network to reach full financial independence if it only serves this group. It would be preferable for the Technical Unit to generate additional income by providing services to other mutual health systems rather than diversifying target group within the UMSGF, which would risk diverting it from its initial mission.

*Lessons: Institutional Aspects*

Reaching MHOs' maximum capacity for autonomous management should be an important preoccupation for the technical support operator. The latter must not assign MHOs' elected officials with day-to-day managerial functions that they cannot perform in the long run. Offering MHO managers a cash incentive of up to 5 percent of collected premiums appears to be an efficient measure to maintain them in their function. The MHOs' limited capacities to manage health microinsurance in a professional way must be taken into account.

Therefore, it is advisable to place MHOs in a regional network to ensure their sustainability. During the structuring phase, the sharing of responsibilities, functions and tasks between primary MHOs and the central level must be clearly defined in consultation with the elected officials. Elected officials and scheme managers must be given as much autonomy as possible to administer and run their organizations.

# 1. The Context

Guinea, the world's largest bauxite producer, is responsible for 40 percent of the world's bauxite trade and is potentially a rich country. The mining sector and the exploitation of resources contribute to over 30 percent of the GDP (2004). Farming and fishing, from which the majority of the population gets its livelihood, account for less than 25 percent of GDP.

Yet, with a GDP per capita of $390, Guinea is one of the world's poorest countries. More than 50 percent of Guineans live on less than $1 a day. Poor economic performance, acute economic and social problems, as well as a budget deficit, have led some donors to pull out. In 2004, the IMF froze subsidies originally granted through the highly-indebted poor country (HIPC) initiative. The European Union (and its member countries) provides more than three quarters of the financial aid Guinea receives, which in total amounts to $18 per capita (2002). Despite an active policy of promoting education and health, Guineans' living conditions remain dire, as shown in the Table 1.1.

**Table 1.1 Macro Data**

| Guinea | | Source |
|---|---|---|
| GDP (US$ Billions) | 3.08 | IMF |
| Population (millions) | 8,600,000 | UNDP* |
| Population density per km2 | 31 | |
| Percentage urban / rural population | 34.5 | UNDP |
| GDP/Capita (US$) | 390 | 2003 IMF |
| GDP Growth Rate | 4.8% | 2003 IMF |
| Inflation[2] | 6.0% | 2003 |
| Exchange Rate (Currency per €1)[3] | 2,438 | 2004 |
| PPP GDP per Capita | 16 | WHO – 2002 |
| Infant Mortality (per 1000 live births) | 98-136 | UNICEF 2000 |
| Under Five Mortality (per thousand) | 229-177[4] | UNICEF 2000 |
| Maternal Mortality (per 100,000 live births) | 1,600 | 2001 UNICEF |
| Access to safe water (% of population) | 52% | 2001 UNDP |
| Health Expenditure as% of GDP | 5.8% | 2002 IS Quebec |
| Health Expenditure per capita (US$) | 13 | |
| Doctors per thousand people | 488 hospital physicians | MOH/GTZ |
| Hospital beds per thousand people | 2,833 beds | MOH/GTZ |

## 1.1 Role of the State in Insurance

Guinea's under developed insurance sector primarily targets businesses and employed individuals. Whereas car insurance is mandatory, public social insurance systems (National Social Security Office) suffer from serious dysfunctions and have not been able to reach their

[2] In 2003, observed actual inflation rate was close to 15 percent
[3] €1 = GNF1,463 (2000); €1= GNF1,715 (2001); €1= GNF 1,740 (2002); €1= GNF 2,000 (2003); €1= GNF2,438 (2004); €1= GNF3,800 (2005). These exchange rates are used in all calculations of figures in GNF.
[4] According to the Region of the country.

objectives. The growth of mutual health organizations (health microinsurance) for the informal sector is recent.

Guinean laws surrounding the insurance sector, detailed in ordinances No. 103/PRG/86 on liberalizing the insurance market (1986) and No. 080/PRG/87 on regulating insurance organizations' activities (1987), were repealed in 1998. Legislation was reshaped and drew inspiration from the CIMA's treaty (Inter-African Conference on Insurance Markets).[5] Previous laws did not fit well with Guinea's economic and financial situation as well as its evolving insurance sector. They had notably left out clauses dealing with life insurance and the functioning of mutual health organizations. There were also shortcomings in terms of the technical reserves and acceptable investments in prudential funds guidelines. There was an absence of clauses on scaling physical injuries and on regulating insurance brokers and intermediaries. In addition, a decree of 11 October 1994, regulating the Guinean social mutual insurance system was not frequently enforced.

The Ministry of Finance, through the Central Bank is the authorized regulatory body. It aims to protect public savings, encourage insurance companies to increase their involvement in the country's development through an investment orientation, and ensure that registered insurance companies maintain a minimum solvency margin. The Central Bank may request an insurer to be audited at its own costs by an external auditor. Four insurance companies are under supervision. However, the controlling body is not always capable of performing its role, which undermines the growth of the market.

## 1.2 Insurance Industry Basics

Guinean insurance companies focus their activities on the property and casualty market (fire, civil liability, transport, automobile, etc.). Following the example of the CIMA countries, civil liability insurance for motor vehicle owners and transport insurance on imports are mandatory. The requirement for businesses to purchase insurance policies (damage and civil liability) from local companies is not always respected and is difficult to enforce.

Insurance companies do not target customers in the informal sector. This population segment does not interest them, as it would require sufficient staff and organizational capacities to serve this market. These preconditions are difficult to achieve since there is a widespread shortage qualified staff in the insurance sector. Consequently, the informal working population lack the benefits of health or other types of insurance.

**Table 1.2 Insurance Industry Premiums**

| Premiums | 1999 | 2000 | 2001 | 2002 | 2003 | Variation 2003-2002 |
|---|---|---|---|---|---|---|
| FCFA ('000) | 4 862 004 | 4 659 974 | 5 672 787 | 7 358 496 | 5 341 940 | -27.4% |
| Thousand of € | 7 412.72 | 7 104.70 | 8 648.86 | 11 218.93 | 8 144.44 | -27.4% |

1 €= 655.9 FCFA

[5] Guinea has not ratified the CIMA treaty that is enforced in all other French-speaking African countries, but drew inspiration from it when it adapted its own insurance laws.

**Figure 1.1 Life Insurance Premiums (millions of CFAF) and % Change, unadjusted for inflation**

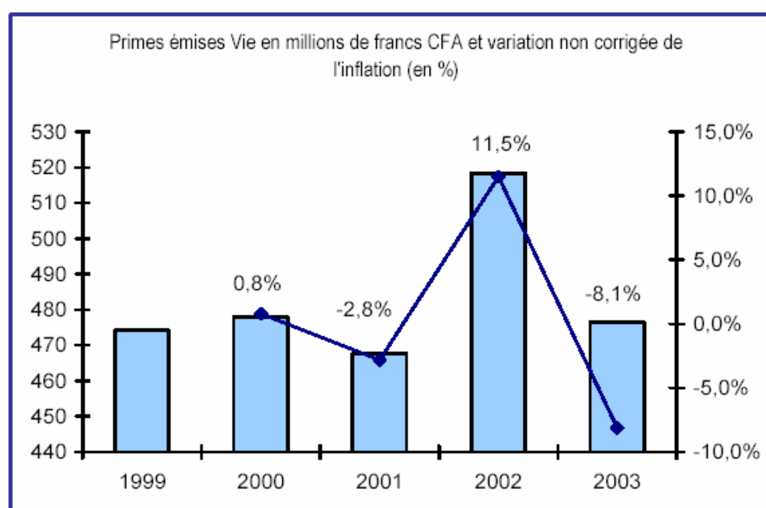
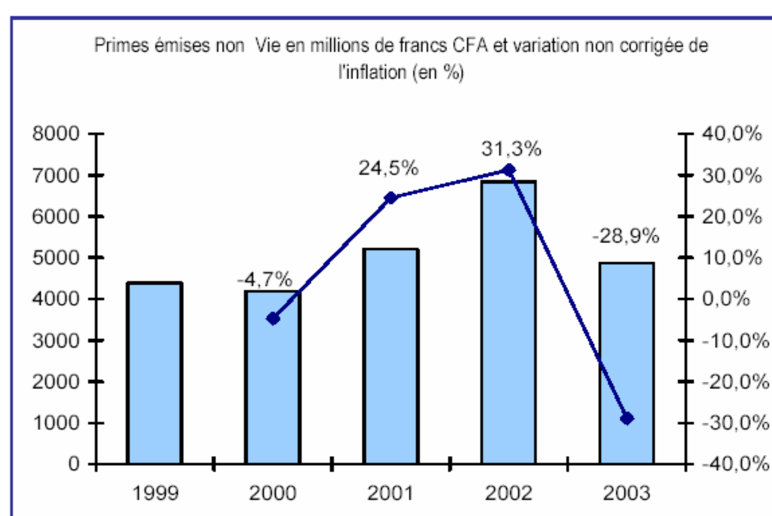



**Figure 1.2 Non-life insurance Premiums (millions of CFAF) and % Change, unadjusted for inflation**




*Source : FANAF (French-speaking African national Insurers' Federation) Market figures 2003, Reviewed in February 2005*

The Guinean insurance market has yet to develop. It is ten times smaller than the Senegalese market and twice as small as the Malian market. In the FANAF zone, only two countries (Burundi and the Central African Republican) have less developed insurance markets than Guinea. As shown in Table 1.2, premiums decreased by 27.4% in 2003, primarily due to the relocation of mining risks to non-Guinean insurance markets. In addition, it should be noted that life insurance accounts for less than ten percent of premiums, whichs indicates that insurance is not primarily used as a savings or personal protection mechanism.

The insurance sector is faced with difficulties that prevent it from expanding, not the least of which is the fact that the Guinean economy is not growing; the 2003 GDP is lower than that of 1999 (see Table 1.3). Other challenges include:

**Table 1.3 Inflation, GDP and Population (1999-2003)**

| | 1999 | 2000 | 2001 | 2002 | 2003 |
|---|---|---|---|---|---|
| Inflation rate (%) | 4.6 | 6,8 | 5.4 | 3.0 | 6.2 |
| GDP | 1,096.6 | 1,108.4 | 1,140.6 | 984.8 | 1,003.1 |
| Population | 9.8 | 10,0 | 10.2 | 8.7 | 8.8 |

*GDP in billions of CFAF; Population in millions.

- The largest industrial investments are in the mining sector, which is likely to not use the Guinean insurance market. The Guinean insurance industry lacks the capacity to cover industrial risks.
- There are only a few companies involved in the insurance market and possibilities for competition are limited.
- Only one life insurer, the UGAR, which accounts for 70 % of the market, officially reports its results to the French-speaking African National Insurers' Federation.
- Although there are many insurance intermediaries, their contribution is limited to bringing in new business to the companies.
- Regulatory authorities have difficulty enforcing rules since they lack resources and coercive power.
- The lack of capacity to control the insurance industry and the lack of effectiveness of enforcement by the police is demonstrated through the fact that rules regarding mandatory insurance are not fully observed. However, this situation is not specific to Guinea, but applies to Africa as a whole.

**Table 1.4 Insurance Industry Basics**

| Issues | Observations |
|---|---|
| Name of insurance regulatory body | Ministry of Finance (Central Bank) |
| Key responsibilities of the regulatory authority | Regulatory authorities are responsible for supervision and control of insurance dealings, prudential guidelines, assessment of physical injuries, regulation of insurance intermediaries, procedures of out-of-court-settlements and arbitration to prevent overburdening the court system |
| Minimum capital requirements for an insurance license | • Minimum capital requirement is GNF 1 billion for limited insurance companies<br>• Minimum capital of GNF300 million for mutual organizations (Article 151 of the insurance code)<br>• Microinsurance is not mentioned |
| Other key requirements for regulatory compliance | Measures of regulated commitments, regulated assets as well as back-up procedures have been established. The calculation method for liability insurance and personal insurance is specified. |
| Minimum capital for reinsurers | N/A |
| Number of regulated private insurers | Four regulated private insurers |
| Value of annual premiums of regulated private insurers | GNF20.6 billion (2003) |
| Value of annual premiums of other regulated insurance organizations | Less than GNF100 million in 2003 |
| Number of re-insurers | 0 |
| Unregulated insurance organizations | 109 mutual health organizations in 2003 |

## 1.3 The Role of the State in Social Protection

In theory, the government covers civil servants' health expenses through the National Social Security Office (NSSO). In fact, such protection is not always guaranteed. Likewise, workers affiliated with the NSSO do not receive any benefits during the first eight days of illness. The allocation of public resources, partially funded by foreign aid, is the main way of improving the population's access to care. Health care prices are among the lowest in West Africa.

In 2003 and 2004, hospitals received grants from the Ministry of Health (MoH) so they could provide the poor with free care. In practice, because there is not an efficient mechanism to identify who is and is not eligible, the hospitals rarely provide the poor with free care.

The Guinean health system is organized around health facilities at two levels: the Community Health Centre (under which there are often one or several integrated facilities) and the District Hospital. The Health Centres only provide outpatient care and prevention services (vaccination, ante-natal care). They also carry out simple deliveries. Cases of illness that do not fall under the MPA (minimum package of activities), are referred to the District Hospital, which has the capacity to handle the most common hospitalisations and to carry out basic surgical procedures (e.g., simple and strangulated hernias, laparatomy, caesarean section). Cases beyond the District Hospital's competence are referred to the N'zerekore Regional Hospital for specialized services, such as paediatric, obstetrics and gynaecologic care.

The pricing method officially applied in health facilities is based on a flat rate covering the costs of treatment, complementary exams and drugs. In the event of an admission, the flat rate also includes hospital room and board charges. The fee schedule is supposed to guarantee the partial recovery of the facilities' running costs (excluding staff charges) and drugs re-stocking costs. The very clear increase in stocking expenses observed since 2001 was not matched by a rise in fees or grants allocated by the central level. Consequently, Guinean health facilities' financial position has significantly deteriorated since then.

**Table 1.5 State-subsidised Health Care Services – 2003 Fee Schedule (in €)**

| Flat rates (including drugs) | District Hospital | Regional Referral Hospital |
|---|---|---|
| Medical Hospitalisation (for an adult) | 6 | 7.5 |
| Major surgery | 15 | 20 |
| Simple delivery | 1.5 | 2.6 |
| Outpatient care | 1.5 | 2.4 |

The MoH has recently set up a "focal point" in charge of coordinating the development of mutual health organizations in the country. This centre's scope of action is limited to promoting and tracking mutual initiatives. Moreover, contracting with MHOs is being promoted at the hospital level. The first contracts negotiated between MHOs and hospitals were supported and validated by the Ministry of Health.

## 1.4 Profile of Microinsurance

Microinsurance is beginning to develop in the field of health, particularly in rural settings because of many operators. Various approaches are being tested:

- MURIGA (with UNICEF and World Bank funding): Essentially aimed at covering complicated deliveries (referral and caesarean section), "mutual organizations to cover pregnancy and delivery risks" were established by the decentralized health authorities and the communities. They do not really qualify as self-managed mutual health organizations and they appear to be functioning poorly.
- MHOs at the sub-prefectorial level (supported and funded by GTZ): Established in three prefectures of Guinea, these self-managed organizations cover essential primary care in health centres and posts.
- Producers' mutual health organizations (promoted by the Nantes-Guinée NGO with financing from the French Ministry of Foreign Affairs): Established with two existing producers'cooperatives, these MHOs cover primary care services and some referrals to hospitals (transport and part of inpatient care). One schems works with a community dispensary connected to a producers' organization.
- Mutual health organizations of Forestry Guinea: These MHOs, the focus of this paper, are financed by the French Ministry of Foreign Affairs and the European Union, and supported by CIDR.

Apart from the MURIGAs, which do not have a legal status, the MHOs established under the above-mentioned programs are registered as not-for-profit organizations with the Ministry of Territorial Administration and Decentralization. A 2003 inventory of organizations offering microinsurance products identified 109 mutual societies, of which 55 mutual health organizations were in operation (36 in rural areas), with an estimated 35,000 insured people who were current with their premium payments.[6] The schemes averaged 600 members and their total estimated net income of the 55 schemes did not go beyond GNF 100 million (i.e., less than US$100,000). Close to half of these organizations were MURIGAs (51) that had unclear membership data and are often non-operational.

Despite low levels of membership, mutual insurance is growing significantly and is supported by the MoH and donors. The MoH's department of hospital services is particularly in favour of the development of microinsurance initiatives. It considers microinsurance important in increasing people's access to health care while improving hospitals' cost recovery.

Similarly, the Ministry of Territorial Administration and Decentralization has eased the delivery of permits for new mutual health organizations. Implementation of a regulatory framework specific to MHOs is being reviewed in these two ministries as well as in the Ministry of Social Affairs. Besides the MURIGAs (where staff from the health administration and health centre in-charge handle promotion and part of the management), no support is directly provided from the State to mutual organizations.

[6] Concertation entre les acteurs du développement des mutuelles de santé en Afrique. Inventory of Health Insurance System in 11 countries 2004.

# 2. The Institution

## 2.1 History

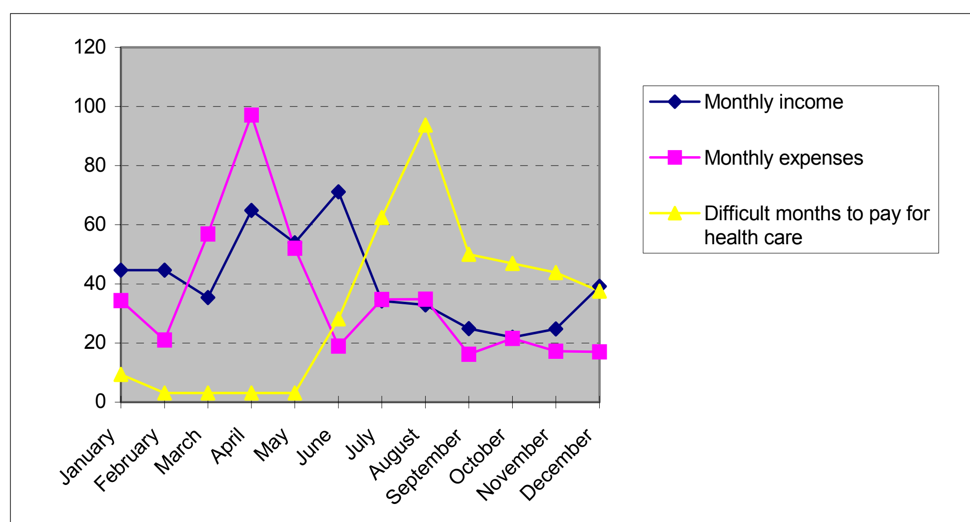
The Forestry Guinean Mutual Health Organizations' Union (UMSGF) was established as part of an International Centre for Development and Research (CIDR) program in 1999. In the absence of an appropriate regulatory framework, CIDR opted to register the union as a not-for-profit organization to promote a democratic culture within mutual organizations.

The UMSGF provides representation for the MHOs in dealings with their main partners (local authorities and health providers) and promotes the mutual movement at the local and national level. It also manages a guarantee system open to all mutual schemes promoted by CIDR. The UMSGF is present in the N'zerekore, Yomou and Lola prefectures in the southeast of the country, bordering Liberia in the south and the Ivory Coast in the east, where approximately 800,000 people live.

The UMSGF brings together all mutual health organizations created and supported by CIDR's technical support program since 1999. CIDR chose Forestry Guinea as its area of operations based on a preliminary study that identified the opportunity and feasibility of creating a self-managed health insurance system. At an economic level, Forestry Guinea is considered relatively wealthy. Usually, farmers grow both food- and cash-crops.

It could therefore be argued that there is a capacity to pay health insurance premiums. However, farmers' income is generated during the first months of the year, which results in a lack of disposable income from July onwards (see Figure 2.1), which is correspondingly a period of high morbidity from malaria. A mismatch between the periods when rural households had a positive cash flow and months of high morbidity was the main cause for not being able to afford health care. This offers a significant opportunity for the development of health insurance.

**Figure 2.1 Origin of Financial Difficulties for Households to Pay for Health Care**



Other factors also contributed to the expectation that mutual health insurance could succeed. For example, **at a social level,** there is strong cohesion in most rural villages. The existence of a tradition of self-help was confirmed by the existence of many groups, usually organized on an ethnic basis, that help on occasions such as births, weddings, deaths, and illnesses. The number of groups that included self-help in the event of health problems was an indicator of the existing financial difficulties related to illness. Over 80 per cent of those surveyed said that they always faced difficulties to meet health expenditures, indicating the limits of traditional self-help mechanisms in the event of illness. The size of villages (averaging 2,500 inhabitants) was sufficient to enable health risk pooling at the village level.[7]

**At the health provider level,** monopolistic public healthcare facilities, which deliver highly subsidized services and are strongly supported by donors, were identified as yet another asset. The quality of care was considered acceptable from a technical perspective. The availability of drugs, at above 95 percent[8], was good at the time of the study. Nevertheless, the proportion of standard prescriptions was less satisfactory (an average of 51 percent in the Forestry area).

The decision to purchase insurance is affected by the perception of health care provision. Therefore, the target population's perception of health providers was surveyed. Close to two thirds of the surveyed population thought that the care received was efficient.[9] Between 3/4 and 2/3 of respondents said they were satisfied with the availability of drugs. The gap between drug availability in the wards and the patients' perceptions of drug availability indirectly suggests the existence of illegal prescriptions and practices. The existence of widespread illegal practices and shortages of drugs is a key element that could potentially jeopardize the success of the project as health workers do not hesitate in charging unauthorized "fees" as a prerequisite for providing care.

The financial impact of parallel payments is evident through the preliminary surveys conducted in the region: the average declared cost of hospitalisation (medical or surgical) was GNF80,000 per episode which was much higher than the official prices charged by health providers (which on average are GNF20,000).[10] These surveys determined that the scale of these practices at health facilities is quite uneven. This factor, which could undermine the insurance initiative, was taken into account when MHOs' promotion strategy was designed.

*The MHOs' Promotion Strategy*

Since it was launched in 1999, the network has followed a three-stage strategy:

Phase 1: Communities jointly designed health insurance products and management procedures (1999-2002)
Phase 2: Network expansion and structuring of the MHOs' Union (2002-2005)
Phase 3: Institutionalisation (2005-2007)

[7] The MHOS managed low and controlled prices risks (as seen below, flat fees are applied in public health facilities). Epidemic risk has to be re insured.
[8] Availability rate = Number of days 10 most commonly used drugs are available in a year/360*10
[9] Survey carried out by Montreal University in 1997
[10] Only 20 percent of those surveyed said they received a receipt against payment.

**The first phase** began with research to select the first areas of operations (Yomou and N'zerekore prefectures) and the villages to establish the first mutual health organizations. Through a participatory process involving local administration, traditional authorities and village representatives, twelve MHOs were created between 1999 and 2002 (6 in 2000, 4 in 2001 and 2 in 2002).

The organizations' constitution and rules were discussed to define terms of membership and members' representation in the Board of Trustees and Executive Committee, how to manage collected funds, and the responsibilities of the people in-charge. The services included in MHOs' benefits packages were also established through a collective decision-making process. The system in place today is the result of several adjustments made to the methodology during the first year when group-run health loans and ceilings on benefit reimbursements were established.

*Microcredit for Health Care*

To offer a service that meets the needs of the surveyed groups, third-party payment was favoured over MHOs reimbursing benefits. Potential members expressed that they did not have sufficient funds to get treatment during the lean period. The third-party payment mechanism, which removes all or part of the financial exchanges between health staff and patients, also reduces illegal practices such as over-charging. Unfortunately, however, the establishment of third-party payment requires an agreement from the provider, which had not been obtained during the preliminary studies. This payment mechanism had not been an objective during the conception of the network.

Fears that members may not be treated correctly without a formal commitment of the health providers led to the gradual establishment of health insurance. Such worries were based on the fact that even though an agreement was "wrung" out of a health provider (regional or prefectorial hospital), it did not guarantee that staff would comply with it. CIDR's experience from other programs in West Africa called for caution. That is why the launching of an insurance third-party payment product was delayed until the end of the negotiation process with the public health care providers.

To satisfy scheme members that were impatiently waiting for the start of coverage, access to credit in the event of health problems was proposed to them. Easing payment terms did not affect financial dealings with the health staff, but increased the patient's solvency. Since the communities considered that groups inside the village should form the basis of the future MHOs, the program supported the formation of groupings organized around a credit activity. Loans were granted for serious health situations that would result in transport and/or hospitalisation expenses. Some groups would also provide loans for traditional healing. Maximum credit amounts varied from one group to the next.

Forty-two groups of various sizes, made up of 421 members and representing 2948 potential dependants, were created in the first six schemes. While it was expected that pre-existing groups would sign up to manage health insurance, most groups were constituted around the health "credit" activity. All groups opted for the same financial tool: an interest free loan with a three-month repayment period. Contribution to the revolving loan fund was set at $0.8 per dependant and the credit limit was between $3.5 and $7 depending on the groups. Experience

showed that the optimal group size was between 50 and 100 beneficiaries for the system to function on self-help basis and not as a form of contingency savings.

*Benefit to the Beneficiaries*

During the first year, groups granted 116 loans for a total amount of $595 corresponding to an annual credit recourse rate of 8.8 percent per insured person. Yet groups quickly identified the limitations of health loans which, in the most critical cases, only covered part of their expenses. On the program's initiative, groups within the same village were invited to merge to form an organization with the following objectives: self-help in the field of health and prevention, and negotiating with health services to obtain third-party payment.

Before negotiations with health providers succeeded, the organizations started an insurance product with a reimbursement of the claims issued by the group members. Because they have not yet obtained lump sum fees with health care providers, a ceiling was applied with a deductible payment. The maximum amount that could be granted to the insured was calculated according to each type of pathology (medical hospitalisation of a child, and adult surgical procedures) and based on the patients' estimated expenses. Despite the project's recommendation, organizations' members decided that programmed surgical procedures and chronic diseases should be covered. The organizations undertook negotiation with the carriers' union to get preferential transport prices for their members.

Depending on the organization, reimbursement ceilings ranged from €3 to €15 and deductibles were set between €6 to €15. A patient that belonged to an organization that had set its reimbursement ceiling at €15 and the deductible at €6, had to first pay out-of-pocket up to €6 of his/her health provider's bills. The organization would step in for amounts over €6 and within a €15 limit.

Premiums ranged between €1.5 and €2.2 per dependant per year. Premiums were collected by the group, which would then pass them on to the organization. Members of a given group stood together for the payment of premiums. All members of a same group would see their eligibility suspended if the group failed to pay its instalments on time. A three-month waiting period was enforced.

In practice, for a member to receive benefits, the group would address in writing a request for a treatment authorization to the organization; receive from the organization's manager the set amount as a lump-sum payment; accompany the patient and pay for expenses incurred above the deductible. It would then fill in a "patient follow-up form" and pass it on to the organization. If the amount paid to the member patient was below the lump-sum amount paid by the organization, the group would keep the balance.

The capped payment of members' health expenses represented a preliminary stage to the establishment of a third-party payment mechanism. It provided the insured with limited security because of the enforcement of deductibles and payment ceilings. Members were informed that these terms of coverage were temporary and would be replaced by direct payments to health providers by the organizations upon the providers' agreement.

Despite the product's limitation, satisfactory penetration rates were recorded during the first year: 2,050 people were ensured for a target population of 17,300, that is to say an 11.8 percent penetration rate (ranging from 7 percent to 36 percent).

The MHOs also intended to cover the destitute when the organizations' financial situation made it possible, however this was not achieved for two reasons. First, the distinction between those who can and cannot pay for premium is not easy to make. The idea that anybody can become destitute prevails among the members and the population in general. Second, the project has not pushed the MHOs to include this activity until the MHOs and the network have reached financial sustainability.

*Third-party Payment*

Once the MHOs were created, the project implemented a contracting process in two hospitals. Negotiations tackled:

- Third-party payment and repayment period
- The choice of benefits subject to third-party payment
- Flat-rate billing provided by health providers to the organizations including the delivery of all necessary drugs. Guinean public hospitals already charged flat rates inclusive of drugs. But for a variety of reasons, many public hospitals were not able to prevent shortages. Patients would then have to purchase the prescribed drugs in private pharmacies through out-of-pocket payments. Permanent availability of drugs was strongly demanded by organizations' members.
- Third-party payment control procedures to end over-billing practices

The organizations' managers were trained to negotiate. The project acted as a facilitator, advising them in defining their negotiation strategies, organizing role-plays, and informing health providers of the organizations' expectations. Negotiations took place in the presence of all staff members of the hospitals.

The outcome differed from one hospital to the next. In the prefectorial hospitals, which are smaller, the above-mentioned demands were accepted without difficulties. The hospital director was committed to improving staff behaviour towards patients and fighting against over-billing. He played a key role in the negotiations. A skilled manager, he was able to avoid drug shortages in the hospital.

The N'zerekore hospital, however, could not commit to providing drugs to the insured on a continuous basis. Agreements had to be signed with private pharmacies and a flat rate amounting to $8.42 per hospitalised patient was established for drug purchase. To compensate, the hospital agreed to reduce its rates, although not sufficiently.

Table 2.1 compares the rates negotiatied by the MHOs at the two hospitals. The surcharge due to unavailable medication in N'zerekore hospital ranges from 15 to 173 percent according to the treatments. For equivalent services, the differential between the cost of care at N'zerekore Regional Hospital and the official negotiated rates at Yomou Prefectorial Hospital ranges from +24 to +65%.

**Table 2.1 Pricing Differences between Hospitals**

| | Official flat rates N'zerekore Hospital | Negotiated flat rates | MHOs flat rates for drugs | Total cost for MHOs | Surcharge for MHOs | Official and negotiated flat rates Yomou Hospital | Differential Yomou % N'zerekore |
|---|---|---|---|---|---|---|---|
| Surgical procedure | $21.05 | $15.79 | $8.42 | $24.21 | 115% | $15.79 | 65% |
| Medical hospitalisation – adult | $7.89 | $5.79 | $8.42 | $14.21 | 180% | $6.32 | 44% |
| Medical hospitalisation – children below 15 | $3.95 | $2.37 | $8.42 | $10.79 | 273% | $2.63 | 24% |
| Complicated deliveries | $6.84 | $4.74 | $8.42 | $13.16 | 192% | $5.26 | 40% |

Agreements were signed between Yomou Hospital and the village organizations in November 2000 and in March 2001 with N'zerekore hospital and private pharmacies. Agreement signing did not pose any particular problem with new schemes as the first contracts were used as a reference framework.

The secondment of a liaison agent[11] was not planned in the initial contracts. This measure introduced later proved necessary to limit the risks of conflicts between scheme members and health care staff.

**Phase 2** focused on three key objectives: 1) increasing the number of MHOs; 2) expanding the range of benefits; 3) and setting the basis for structuring the network. Between 2003 and 2005, 17 new MHOs were established, bringing the number of organizations in the network to 28 (a scheme created in 2001 ceased operating in 2004).

The membership has developed according to each organization's own dynamics and potential. While searching for new members, MHOs also wanted to broaden their range of services and health providers. Thus, from 2002, agreements were created with health centres and posts to cover outpatient care and minor surgical procedures. Conversely, the organizations progressively dropped their "health credit" products since members' demand for such products was minimal. In November 2001, the UMSGF was established by ten MHOs in operation. From then on, new schemes joined the Union every year.

**Phase 3**, from 2005 through 2007, will aim at institutionalising the network and gradually withdrawing CIDR's support. This will be on the basis of the existing and new organizations as well as through mobilizing human resources currently involved in the support project.

In each of these stages, the process of structuring the mutual movement is adapted to the context of MHOs' implementation. In rural settings, some villages decided to create their own mutual organizations, which is appropriate where the membership potential is above

[11] A liaison agent is a staff hospital member recruited and compensated by the UMSGF who is trained to give to the member the appropriate information on his rights and obligations.

1000 beneficiaries. In other cases, villages without sufficient demographic potential combined to create inter-village or sub-prefectorial MHOs. Two mutual schemes were established through pre-existing farmers' organizations that produced palm oil and hevea (a gum used in making latex).

In urban settings, various approaches were adopted: a territorial approach geared to create neighbourhood MHOs; a socio-professional approach based on existing organizations (artisans' MHO); and a community-based approach in collaboration with self-help associations willing to structure and develop their operations to improve their members' access to health care. The various approaches, combined with the evolution of the services offered, enabled the establishment of a large number of new MHOs every year, and resulted in a rather significant increase in membership, as shown in Figure 2.2.

**Figure 2.2 Growth in Membership (2000 - 2006)**

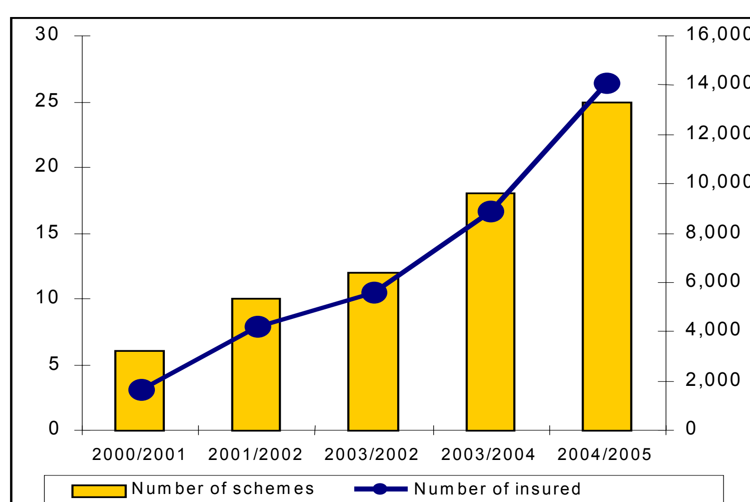



**Table 2.2 Key Operational Data**

| Year | 2000/01 | 2001/02 | 2003/02 | 2003/04 | 2004/05 |
|---|---|---|---|---|---|
| Premiums received (GNF) | 5,049,400 | 13,130,250 | 15,919,850 | 28,153,800 | 45,880,800 |
| Premiums received (€) | 3,451.4 | 7,656.1 | 9,149.3 | 14,076.9 | 18,819 |
| Number of claims | 87 | 171 | 429 | 670 | 2,467 |
| Cost of claims (GNF) | 1,716,500 | 3,243,650 | 5,181,000 | 7,440,250 | 16,874,250 |
| Cost of claims (€) | 1,173.2 | 1,891.3 | 2,977.5 | 3,720.1 | 6,921.3 |

**Box 1. Milestones in the History of UMSGF**

Start of the program: April 1999
Preliminary Surveys: June-July 1999
Start of the communication campaign: August 1999
Start of health credit services by groupings: August 2000
Signature of agreements with health providers: November 2000 through March 2001
Start of MHOs' benefits coverage with third-party payment: November 2000 (Yomou hospital) and March 2001 (N'zerekore hospital).
UMSGF's Constitutive General Assembly: November 2001

**Table 2.3 Insurance Organization Basics – Trends**

| | 2004/05 | 2003/04 | 2002/03 | 2001/02 | 2000/01 |
|---|---|---|---|---|---|
| Total assets* (in €) | 19 597,4 | 19 256,6 | 12 814.4 | 10 103.8 | 2 619.3 |
| Total capital | 12 136 | 10 426 | 9 173 | | |
| Number of branches | 25 | 18 | 12 | 10 | 6 |
| Total number of all clients | 14 071 | 8 859 | 5 589 | 4 197 | 1 622 |
| Number of microinsurance staff | 11.5 | 10 | 8 | 4.5 | 3 |
| Staff turnover (%) | 0 | 12.5 | 0 | 20 | 0 |
| Number of policyholders / microinsurance staff | 1 223 | 885 | 698 | 932 | 540 |
| Microinsurance marketing costs | None | None | None | None | None |

* Mutual Health Organizations' network outside of the UMSGF

## 2.2 Organizational Development

The Forestry Guinean mutual movement is in the process of being structured. Today, a number of functions are still managed by the project. The current institutionalisation phase plans for a gradual transfer of all specialized functions performed by the project to the existing or future structures. The network will consist of four types of organizations: mutual groups, primary mutual health organizations, the MHOs' Union and the Technical Unit.

*Mutual Groups*

The mutual group is the MHO's basic structure. Each group brings together between 10 and 15 families who already know each other (e.g., they may live in the same neighbourhood, belong to the same association, belong to the same tontine, etc.) and who trust each other.

Each group names two leaders (a secretary and a "president") who act on a voluntary basis and share various tasks: setting up the group, registering heads of households and their dependants, disseminating information about benefits, following up on patients that received benefits, and collecting funds (initial entry fee and annual health premiums). To perform these tasks, the group leaders have access to simplified management tools such as: a register of membership and a register to monitor premium payments, and receipt books. Groups willing to do so may put together a "health credit" fund that will be informally managed by them. The appointed officers also act as member families' representatives during MHO's board meetings.

*Primary MHO*

The MHO is the first level of health risk management and pooling. Its geographic base may be one or several villages in a given district. Social relations between neighbouring villages and the size of the number of insured are the two deciding elements of an MHO's target area. Each primary mutual health organization consists of mutual groups (an average of 6.6 groups per MHO in 2005). Any family that belongs to a group and has paid its premium is a member of the organization.

To date, the General Assembly is made up of one representative per member family. The assembly elects a Board of Trustees (2 members per group) and an Executive Committee of six members. The General Assembly also names a manager among its members who will take on day-to-day management functions. The Board of Trustees meets on a quarterly basis. It reviews the overall strategy and forecasted financial statements. It also manages the Executive Committee and the scheme manager.

The Executive Committee is involved in controlling fund flow and overseeing the work of the manager, who is on a part-time contract. The manager earns an average of €7 monthly and handles the day-to-day operations. This position also takes on external representation functions and is involved in promotion and development.

*The Forestry Guinean Mutual Health Organizations' Union*

The Union is a civil society organization representing the mutual movement in Forestry Guinea. The UMSGF has been given two key missions that it will to assume completely once the CIDR support is withdrawn:

1) A political and governance role toward the network:
    a. Representing MHOs in dealings with health authorities
    b. Supporting negotiations with health providers and contracting in the name of the network
    c. Supervising MHOs' community life
    d. Defining the rules for the guarantee system and validating its commitments

2) A governance function toward the Technical Unit, whose main functions are:
    a. Training managers and the elected representatives
    b. Carrying out medical audits of health providers
    c. Carrying out annual financial audits of the MHOs
    d. Providing support to the mutual organizations on technical insurance aspects (premium calculation, frequency monitoring, etc.)

The Union's General Assembly is made up of three representatives per MHO. Each MHO sends one person to the Board of Trustees that elects a committee of six from its members.

*The Technical Unit*

Specialized functions are currently performed by the project team (manager or field agents). From the perspective of CIDR's withdrawal, several scenarios can be considered.

Specialized functions could be handled in-house by a Technical Unit, which would be directly integrated into the Union, providing the network with the technical and financial expertise they need. The Unit would be made up of a secretary general, a manager in charge of risk and financial aspects, a manager in charge of MHOs' development aspects (training of and following up on scheme managers and elected representatives), a medical consultant, and an administrative assistant who would also be in charge of data entry.

Other scenarios are also considered in which some functions would be carried out in-house, while others would be outsourced to external service providers. All of the scenarios will be

reviewed and discussed with the mutual organizations' and the Union's leaders during the program's third phase (2005 to 2007).

*Insurance Knowledge and Expertise*

The network is based on mutual principles and the elected representatives are active in day-to-day management. As shown in Table 2.4, roles are clearly shared between various actors in each of the network's organizations.

**Table 2.4 Current Roles and Responsibilities of Various Actors**[12]

| | Group | MHO | UMSFG | Project Support |
|---|---|---|---|---|
| **Contract production & membership management** | | | | |
| Who collects premiums? | Manager | | | |
| Who calculates premiums' amount? | | | | Technical Unit (TU) |
| Who updates the registers of membership? | | Manager | | |
| Who recovers premiums? | | Committee + Manager | | |
| Who monitors cash collection? | | Manager | | |
| Who recovers debts? | | Committee + Manager | | |
| **Risk management** | | | | |
| Who negotiates agreements with service providers? | | Committee + Manager | | TU |
| Who controls service providers' invoices? | | Manager | | |
| Who monitors risk frequency? | | | | TU |
| Who monitors claims average cost? | | | | TU |
| Who performs medical control of claims? | | | | TU |
| Financial Management | | | | |
| Who prepares the projected budget? | | Manager | | |
| Who prepares the cash flow plan? | | Manager | | |
| Who prepares the income and expenditure? statement? | | | | TU |
| Who prepares the balance sheet? | | | | TU |
| Who proposes the allocation of results? | | | | TU |
| Who maintains accounting records? | | Manager | | |
| Who decides on the exclusion of a member? | | Board of Trustees | | |
| Who controls membership cards' validity? | | Manager | | |
| Who controls the cash box? | | Committee | | |
| **Statutory obligations** | | | | |
| Who organizes the General Assembly? | | Committee + Manager | | |
| **External control** | | | | |
| Who carries out audits? | | | | TU |
| **External relations** | | | | |
| Who manages contractual relations with service providers? | | Committee | Committee | |

[12] When institutionalisation process will be achieved, UMSGF will ha taken over the responsibilities handled by the Project support.

At present, CIDR provides the necessary skills for health insurance management. The project manager is responsible for transferring skills to local managers who will staff the future Technical Unit, as well as to the mutuals' managers and elected officials. The level of knowledge and skills expected from each actor is defined as follows:

- The MHO manager handles the scheme's day-to-day management, which includes maintaining the membership register, paying health providers and handling bookkeeping. In rural MHOs, managers are farmers with limited education. In urban MHOs, managers usually are more educated and work as artisans or in the trading sector. They are also sometimes civil servants.
- Eventually, managers' functions will include monitoring claims frequency and average costs, preparing simplified income statements and balance sheets, and monitoring health care provided at primary level facilities (health centres and posts).
- The elected representatives (to the Mutual Board and Union) will need to have a greater command of the implications of contracting with health providers to become completely autonomous when monitoring contracts and negotiating new partnerships.

*General Qualifications of Staff*

A team of field agents was put together at the start of the project's operations and gradually grew in size as the network developed. Field agents took part in the research process for the establishment of MHOs. They are in charge of carrying out preliminary surveys, selecting sites, conducting community information meetings to establish new mutuals, and providing support to the MHO's elected representatives and managers.

As for management positions, since skills in the field of insurance were not available in the market, the program hired executives with sufficient educational background—a physician, an accountant, a sociologist and an agricultural engineer—to be trained in the specific areas of insurance and the development of mutual organizations.

*Training: Staff, Managers, Board*

All field agents received initial training by the project team in the field of health insurance management. Activities are also carried out so they assume ownership of the methodology used to create and monitor mutual organizations. Later, an ongoing training program will be designed based on the specific skills that field agents will have to transfer to those they will be working with (scheme managers, Board of Trustees and Executive Committee members).

Management receives specific training and support according to their profiles and positional requirements. Several of them participated in internships and/or training programs abroad (France and sub-region). The risk analyst was given individualized training in risk management and did an internship with a private company in Senegal that manages health insurance policies of private insurers.

*Governance*

As indicated in Table 2.5, there are two levels of governance in the network: the mutual health organization level and the Union level. At the primary MHO level, governance is

organized according to mutual principles: the members' General Assembly is the sovereign body. It has the power to decide on premium amounts and benefits coverage, taking into consideration the recommendations of the Board of Trustees. It decides on the mandates and the choice of the mutual manager. Other bodies (Board of Trustees and Executive Committee) share steering, monitoring, control and day-to-day operational functions.

At the Union level, governance functions are still rather limited. They will develop as it becomes more necessary to take on the functions of the guarantee system and the technical unit (tasks currently performed by the project). Governance of the Union will then rely on two operating principles: 1) the Union will train MHOs' managers and elected representatives – this transfer of expertise will be a recurring activity; 2) the Union will carry out medical and financial audits of the mutual organizations – this transfer of responsibilities is important in network structuring.

**Table 2.5 Governance Responsibilities**

| | MHO | UMSFG |
|---|---|---|
| **Production of the contract & membership management** | | |
| Who decides on the admission or exclusion of a member? | Committee | |
| Who decides the amount of premiums? | General Assembly | |
| **Marketing & communication** | | |
| Who decides the communication strategy? | | Committee |
| **Risk management** | | |
| Who decides temporary exclusion from entitlement to benefits? | Manager | |
| Who decides on the benefits to be covered? | General Assembly | |
| **Financial management** | | |
| Who decides on the reimbursement of service providers? | Committee + Manager | |
| Who approves the projected budget? | Committee | |
| Who decides on the allocation of results? | Board of Trustees | |
| Who approves the allocation of results? | General Assembly | |
| Who decides on financial investments? | Board of Trustees | |
| Who decides on cancelling a membership? | Board of Trustees | |
| Who punishes fraud? | Board of Trustees | |
| Who acts in cases of embezzlement? | Board of Trustees | |
| **Statutory obligations** | | |
| Who calls the General Assembly? | Board of Trustees | Board of Trustees |
| **External Relations** | | |
| Who may bring a legal action? | Committee | Committee |
| Who takes on liaising with the supervisory authority? | | Committee |

## 2.3 Resources

MHOs' financial resources essentially consist of members' premiums and, to a minor extent, donations from individuals living in the villages. There are hardly any financial returns because of the limited investment opportunities. Premiums collected by the MHOs cover the entire benefits and contribute towards building reserves. The program provides initial support to the schemes in the form of cash allocations and in-kind grants to establish reserves.

CIDR's support program is funded by two main donors: the European Union and the French Ministry of Foreign Affairs. The first phase also received financial support from the

Michelham Foundation (a private foundation) and from UNICEF. The project provides considerable support to the Union. Although it its partly financed through members' premiums, the bulk of its operating costs are covered by project subsidies. Similarly, the project provided most of the contributions made to the guarantee system.

## 2.4 External Relationships

*Technical Assistance*

At the moment, MHOs and the network benefit from a permanent expatriate technical assistant.

Support agreements are signed with the MHOs at the time of their establishment. These agreements define the various forms that project support will take throughout the first year (manager's training, supply of management tools and techniques, advantage of contracting with service providers, etc.).

After one year, technical assistance is offered through a field agent's regular visits to the scheme leaders (from one to three times a month). The project's management team also offers support to: the Board when project budgets are approved; the committees when contractual relations with health providers are monitored; and the General Assembly when the development strategy, premium amounts and benefits coverage are defined.

From the 2005/06 budget year, each MHO in operation for over a year will define an "agreement of objectives". This will plan training, advisory and support activities for the scheme leaders and their corresponding means. The agreement will also list expected results in terms of capacity building, structuring, organizing and membership.

*Financial Assistance*

Financial assistance provided by the project is targeted, occasional and always on a sliding scale. It contributes to establishing reserves, which are up to 100 percent of entry fees collected during the first year, to strengthen the MHOs' financial positions. MHOs also receive grants for their constitutive General Assembly and first ordinary General Assembly.

In addition, all mutual health organizations receive a subsidy to finance their first assets: fitting out premises and purchasing furniture for meetings. The program funds inputs geared towards carrying out activities necessary to establishing the network: including the project team's means of transport and salaries, office and computers.

## 2.5 Risk Management Products

Risk management procedures established by the program cover several aspects of the MHOs' network. During the set-up phase, it is necessary to conduct a feasibility study that highlights potential risks that the project may face, and then adapt the system based on the conclusions of the study. During regular operations, risk management falls into two categories:

1) **Social control**
    a. Performed by mutual scheme members and manager with the objectives of strengthening social ownership of the MHOs' project, preventing moral hazard and fraud, and assessing upcoming health expenditures.
    b. This control capacity is reinforced by the UMSGF whose mission is to perform technical, medical and financial audits.
    c. Mechanisms also control the insured's identity and by keeping health providers informed of people whose claims have been accepted by MHOs.

2) **Technical control**
    a. Relies on a set of measures that help monitor risks considered to be potentially harmful to the network, such as overusage, fraud, and failure to apply the agreements signed with health providers. Control is shared between the mutual, the Technical Unit and the Union.
    b. Control through medical and technical audits is performed by a medical consultant called in by the program. This medical consultant's role in risk control is essential. Computerized tracking carried out for the network and for the schemes also contributes to controlling risks.

*Accounting and Financial Audits*

Audits performed by the risk auditor are primarily about bookkeeping. Controls are carried out according to six main lines of investigation:

- Cash receipts
- Accounting irregularities at the MHO's level and at the bank's level
- Analysis of the benefits account (claims)
- Analysis of the operating account
- Irregularities in bookkeeping
- Investment analysis

The actual audit is followed by recommendations to the MHO's board Specific verifications, planned or random, are implemented to avoid a recurrence of irregular situations, particularly in terms of accuracy in recording accounting entries, and to limit the risk of fraud. These controls entrusted to the schemes' manager focus on reconciling accounting entries in the bank and cash books. The conformity of the elements that constitute the "claims files" must also be checked. Additionally, field agents must analyse running costs and verify that they were properly recorded. To implement these recommendations, the support program has training modules in the proper use of management tools and basic accounting techniques.

*Statistical Information*

Technical data is automatically compiled and computerized for each MHO to produce statistical indicators.[13] This management information should make it possible to anticipate increases in expenditures so they do not threaten the balance of the underwriting. The project has developed specific tools, such as the one in Figure 2.3, that assist in monitoring trends in loss ratios among other things.

[13] This process is also used to set premiums.

**Figure 2.3 Loss Ratio Trend Tool**

| Services | Frequencies | | | Average costs | | |
|---|---|---|---|---|---|---|
| | previous year | current year | observed in …months | previous year | current year | observed in … months |
| Surgery / chronic disease | - | - | - | - | - | - |
| Surgery | - | - | - | - | - | - |
| Intensive care | - | - | - | - | - | - |
| Emergency hospitalisation - paediatrics | - | - | - | - | - | - |
| Emergency hospitalisation - paediat./chronic disease | - | - | - | - | - | - |
| Emergency hospitalisation - adults | - | - | - | - | - | - |
| Emergency hospitalisation - adults/chronic disease | - | - | - | - | - | - |
| Hospitalisation | - | - | - | - | - | - |
| Complicated delivery | - | - | - | - | - | - |
| Delivery | - | - | - | - | - | - |
| Observation | - | - | - | - | - | - |
| Minor Surgery | - | - | - | - | - | - |
| Lab exam, outpatient | - | - | - | - | - | - |
| Consultations & prescriptions | - | - | - | - | - | - |
| Social services | - | - | - | - | - | - |
| Transport | - | - | - | - | - | - |
| **Total Services Mutual schemes** | - | - | - | - | - | - |
| | **Projected loss ratio** | | | - | | |

The project's selected strategy consists of providing mutual scheme members with statistical results obtained through data processing. By improving members' understanding of the insurance mechanisms, such information contributes to controlling overusage.

*Computerized Analysis and Monitoring*

The program has set up a simplified management information system (MIS) to monitor monthly consumption (frequency and cost) by MHO and by service providers. An automated risk management tool, monitoring data by subscriber and by the insured (consumption monitoring), will be implemented in the next phase. The workload resulting from the increased data processing makes computerizing the network a relevant management issue. Computerization eases data processing. Manual processing for audit and monitoring purposes is becoming very tedious; it causes delays in processing the data and is vulnerable to errors.

Currently, one of the major limitations of risk control and monitoring is that the data are not of sufficient quality to explain causes and consequences of unfavourable events. Monitoring trend lines is the only way to raise alarm and initiate appropriate interventions. The future MIS will monitor the mutual schemes' operations and produce information related to:

- New members, cancellations, resignations
- Premiums
- Benefits
- Statistical indicators
- Accounting information (bank and cash books, projected budgets)

The establishment of an information system that could produce automatic statements on the position of the network and each MHO (claims, comparison between projected and actual

data, financial statements) will be given careful consideration. This will help mutual schemes maintain a basic level of autonomy in risk management and reduce dependency on the Technical Unit. Trade-offs between efficiency of MIS and price will be considered.

## 2.6 Profit Allocation and Distribution

Because of the mutual and not-for-profit nature of the organizations, annual surplus is not redistributed among members or elected representatives. Rules on surplus appropriation are proposed by the project and approved by the mutual organizations. Surplus is primarily allocated to reserves. Only newer schemes that need to allocate part of the surplus to secure funding for the next year may do so (which needs to be less than 30 percent of the current year's surplus). Annual surplus is transferred to reserves until MHOs have reached full membership capacity. The objective is that once the number of insured has stabilized, the reserve ratio will represent 75 percent of the total benefits paid in the previous budget year (reserves year n/benefits payment year n-1).

Once reserves have been endowed up to a set level, primary MHOs' General Assembly may decide on further allocation, such as contributions to health education or sensitisation activities, or investments in improving health care services.

## 2.7 Investment of Reserves

Mutual schemes hold reserves to cope with growth (as they are likely to double in size), to protect themselves against uncertainties in health provision (tendency to increase cost of services), and to absorb the expected increase in claims once members have learned how to use the MHO's services. Reserves are deposited in a blocked account at the Village Savings and Credit Network of Rural Credit of Guinea, a microfinance institution (MFI). Although these blocked accounts bear interest, they do not compensate for the depreciation of the Guinean Franc.

## 2.8 Reinsurance

Currently, mutual health organizations do not have reinsurance. Reinsurance needs were analysed in 2001 and subscription to a "stop-loss" reinsurance fund was considered. Various indicators were taken into account when assessing reinsurance:

- From the beginning, the project contributed to a reserve fund managed by the schemes and to a guarantee fund, which was initially managed by the project and now by the UMSGF. This first level of protection is deemed satisfactory considering the nature of the risks borne by mutual organizations.
- Indeed, the adoption of flat-rate billing for services provided by health or transport providers limit the risk of escalating costs. The only time when costs cannot be controlled is when hospitals with no remaining stocks give prescriptions to private pharmacies. This risk is minimal considering health providers' compliance with therapeutic protocols and the control of the medical audits.

Mutual health organizations remain exposed to sudden increases expenses, which may have two origins: 1) internal factors, such as a lack of control over adverse selection, moral hazard and fraud; and 2) external factors, such as epidemics (meningitis, typhoid, cholera, etc.) and natural disasters. In the event of serious epidemics, corresponding treatments are usually exempted from payment in public facilities, thus limiting the risk borne by the MHOs. The risk that an MHO would default because of excessive medical consumption and not because of management failure was considered to be minimal.

Several obstacles have been identified in the feasibility of reinsurance:

- Reinsurance would have to be established at the national or international (sub-regional) level to have efficient risk pooling since MHOs are all located in one geographic area.
- Establishment of a reinsurance system assumes that information and background data is available. Such information does not exist at the moment even though the gap will be filled once the network is computerized. However, behavioural trends data over a long period is available and could be used for modelling purposes even it is not very detailed.
- A mechanism for the provision of reinsurance did not exist and a specific project would have had to be set up. This did not rank among the support organization's priorities.

In addition, there is a risk that MHOs will resort to reinsurance to offset the consequences of poor management. The responsibility of the mutual schemes' managers to control risks is considered a key element in the viability of health microinsurance. It is thus necessary to ensure that reinsurance does not challenge this principle.

These factors have led the program to postpone considerations of setting up a reinsurance system. The topic will be brought up again once the efficiency of the monitoring procedures adopted by the schemes has been verified. In the meantime, the program established a guarantee fund managed by the UMSGF. Schemes facing financial difficulties can access loans from the fund subject to a financial audit to determine the cause of the deficit. Loans are conditional upon schemes adopting a set of recovery measures, such as increasing premium amounts and strengthening control procedures.

The principle of lending funds is in itself another factor of frailty. The guarantee fund's intervention is dependent on the MHO's commitment to reimburse the loan while it is going through difficult times. The MHO will need to generate specific resources for this purpose, through either imposing moderation in medical consumption or through increasing the level of premiums. The guarantee fund is therefore a measure that is not entirely satisfactory. Yet in the current situation, it is the soundest way to assist mutual health organizations facing financial difficulties.

# 3. The Members

The MHOs' target population are people working in the informal economy and those that do not have access to health insurance through their employers. Social links between members (based on belonging to a same group or living in the same village) appear more important for the cohesion of the MHOs than their individual social status.

In rural areas, the place of residence defines target populations. Here one finds a relatively stable population, as two-thirds of the residents were born in the village. Farmers represent the majority of the village's working population. In addition, there are also retail traders, artisans and some civil servants (essentially teachers).

In urban settings (towns of N'zerekore, and Lola), the majority of the targeted people are artisans and traders. Retired persons, civil servants (with the exception of servicemen that benefit from unlimited access to health care) and other employees can become members since MHOs do not discriminate based on socio-economic or health criteria. Employed persons account for 10 to 20 percent of membership in some of N'zerekore's MHOs.

The heads of households join the MHO schemes and register their spouse(s) and children. MHOs' target population is very diverse:

- On an **ethnic** level: the population is made up of a majority of Guerze natives, as well as the Malinke, Kono, Peul and Toma. There are tensions between ethnic groups that originate from the forest and the others. Violent confrontations happen on a regular basis, but so far, they have not hindered the MHOs and the UMSGF. According to a 2003 survey, the MHO members' ethnicity was identical to the rest of the population.
- On a **religious** level: MHOs include Catholics, Protestants, Muslims and Animists
- On a **professional** level. The six oldest mutuals consist of farmers (30.3 percent), artisans (8.1 percent), small traders (10.1 percent), business managers (11.1 percent), pensioners/retired (4 percent) and homemakers (17.2 percent).

The illiterate accounted for 57.6 percent of membership. The illiteracy rate is higher among non-members and among heads of household that did not renew their premiums. It would thus appear that the level of schooling does influence membership. The median income was estimated at €120 per person per year, or € 0.33 per day according to the preliminary study carried out in 2000.

**Table 3.1 Comparative Socio-economic Data: Members vs. Non-members**

| Comparative characteristics of the target population | Contributing member | Non-member | Non renewing member |
|---|---|---|---|
| Age | 46.7 | 46.42 | 48.54 |
| Household size | 9.32 | 9.39 | 9.42 |
| Number of spouses | 2.22 | 2.12 | 2.25 |
| Income level (*) | 6.21 | 6.68 | 5.33 |

*Source: Survey carried out in 2003 in 195 households*, (*) Estimated on a scale from 1 to 10

**Table 3.2 Client Information Table**

| Issues | Observations |
|---|---|
| Intended target groups | Low income households: informal sector, rural and urban |
| Actual clients | Idem |
| Exclusions of specific groups | None |
| General economic situation of clients | Households (9 members) living on less than €90 per month |
| Key economic activities of clients | Farmers (rural); artisans and employees (urban) |
| % of clients working in the informal economy | 89 percent |
| Social characteristics of clients | Open to everyone, diversified ethnic background |
| Geographic characteristics | Rural and urban areas in the region of Forestry Guinea |
| Nature of membership | Family-based |
| Methods of recruitment of clients | Through the creation of mutual groups |

## 3.1 Conditions

Forestry Guinea is split into two zones: the Northern savannah belt with woodland and moderate rainfall that is populated by the Kissi, Malinke and Toma. The Southern belt is populated by the Guerze, Mano, Kono, Konianke and Malinke. Characterized by a dense tropical forest and heavy rainfalls (2300 mm/yr), the belt's forestry resources were heavily exploited in the past. They now generate little income. Climatic conditions make it possible to cultivate various types of crops (e.g., rice, tuber, coffee, cocoa, palm trees, bananas).

The processing of palm oil is one of the region's most dynamic agribusiness activities. It is a source of income for farmers that own palm tree plantations and supply industrial or traditional processing units. It also generates income among rural families when one of their members dedicates his/herself to oil extraction using traditional methods. Because of its dynamic agricultural sector, the region is also characterized by heavy trading with other border regions and neighbouring countries.

The villages in rural forestry regions usually have over 2,000 inhabitants living in houses grouped together. Villages are separated one from another by the forest and are connected by dirt roads that are sometimes in very bad condition. Villages' relative remoteness and weak external communication links explain the large number of local markets and may have contributed to strengthening social ties between village's residents. Diversity and ethnic tensions are more prevalent between the region's two belts than within villages.

Urban areas are heavily influenced by the region's agricultural activities. Nevertheless, the city of N'zerekore has its own specificities, given its size (between 150,000 and 200,000 inhabitants) and a heavy concentration of artisans in various sectors, including clothing (accounting for 30 percent of all craftsmen), food (bakers, butchers, small restaurant owners), wood work (joiners, carpenters) and metal work (sheet metal workers, mechanics, electronic workers). The city's economic activity is significantly impacted by the presence of international organizations involved in the management of the Liberian and Ivorian conflicts. Nevertheless, in N'zerekore, just as in the other towns of the region (Lola, Yomou, Diecke, Gouecke), a large part of the population lives on the outskirts with farming as their main activity in addition to the secondary activity that they have in town.

## 3.2 Major Risks and Vulnerabilities

Health, country and financial risks have been identified as the key vulnerabilities to which the program and the mutual insurance organizations' network may be exposed.

*Health Risks*

The morbidity characteristics, shown in Table 3.3, are similar to the epidemiologic profile of low-developed African regions. The first four diseases progress endemically are foreseeable. Affecting practically all of the MHOs' target population, they are linked to living conditions and account for nearly 70 percent of observed diseases. Hernias, a chronic pathology for which treatment may be anticipated, are linked with the physical strain of farming. The same applies to bilharzias, which affects farmers in paddy fields. Typhoid fever develops in an endemo-epidemic mode. Epidemic outbreaks should not be excluded. Pathologies 9 and 10 are related to pregnancy, which is a major risk for women of childbearing age since the maternal mortality rate is estimated to be 528 per 100,000 (SOGO 1999).

**Table 3.3 Breakdown of Episodes of Care at the Lola Hospital**[14]

| N° | Pathologies treated at Lola Hospital in 2003 | % of outpatient cases | % of hospitalisations |
|---|---|---|---|
| 1 | Malaria | 32.17 | 21.99 |
| 2 | Genital infections | 13.75 | 0.43 |
| 3 | Anaemia | 12.55 | 10.5 |
| 4 | Acute respiratory infections | 11.28 | 12.72 |
| 5 | Traumas | 9.39 | 7.50 |
| 6 | Hernias | 6.30 | 13.9 |
| 7 | Intestinal bilharziasis | 7.01 | 5.15 |
| 8 | Typhoid fever | 2.09 | 5.87 |
| 9 | Pelvic Dystocia | n.a. | 12.46 |
| 10 | Abortion | 2.38 | 6.00 |
| 11 | Other | 3.10 | 3.50 |

The risk associated with HIV/AIDS exists, but does not appear on the list. The hospitals do not specifically monitor it and little information is available on HIV seropositivity among the target population. Confidentiality that surrounds the illness makes assessing the prevalence and providing coverage to HIV patients difficult. The latest study by the PNLS (2002) in Forestry Guinea's urban areas puts forward an HIV seropositivity rate of 6 percent among teenagers and 8 percent among pregnant women.[15] These data reflect a significant level of "seroprevalence" that may be explained by important population's shifts and by the economic and social instability resulting from the conflicts at the border. The seropositivity ratio is estimated to be between 3.2% and 4.27% among the mutual schemes' target population.

[14] General pathology observed in the whole province has a comparable profile. It presents however a greater share of diarrhoeal diseases.

[15] A Ministry of Health estimate based on surveys in 2002, which showed that 2.8 percent of the country's 8.5 million inhabitants were HIV positive and that the prevalence rate rose to 7 percent in the main towns of the Forestry region, "Guinea: Little Action as Refugees Fuel AIDS," IRIN, 27 July 2004.

*Risks Connected to Health Providers*

Emergency transport to the hospital is sometimes problematic because of the cost—drivers do not hesitate to charge high prices to transport a sick person in a difficult situation. Once they get to the hospital, patients may not receive the necessary care for at least two reasons: 1) shortages of drugs or medical consumable material, and 2) unauthorised fees. For primary care, there is also a problem with low-skilled and sometimes unqualified health agents.

These risks have led the UMSGF to lobby for the reinforcement of health providers' capacities. This important concept of co-development appears to be the key in preserving product appeal. If health providers were no longer capable of bringing satisfaction to most scheme members, the insurance product would no longer meet policyholders' expectations.

*Country Risk*

The country's potential instability is an internal risk factor (the political and economic situation) to which the program may become exposed. External factors also play a part in the country's difficulties, ranging from the constraints imposed by mining companies that limit the state budget to attempts at destabilization. Guinea's geographic proximity to Liberia and Sierra Leone imply numerous difficulties. Conflicts in these countries have led hundreds of thousands of refugees to enter Guinea since 1990. The Ivorian conflict only made matters worse. The main areas of active conflict in the Ivory Coast border Forestry Guinea.

*Financial Risk: Currency Depreciation*

Guinea entered an inflationary spiral that may result in a disaster, especially because of the current salary freeze. Estimations of Guinea's monetary growth are in the region of 40 percent per year. The resulting consequences are obvious: in June 2004, the dollar was trading at GNF2,600 on Conakry's black market. In April 2005, it was GNF3,580. This represents a 38 percent fall against the dollar and led to a reduction in the population's capacity to consume imported goods.

The continuous deterioration of the Guinean franc presents a high risk with multiple repercussions that may commence a domino effect: as the currency devaluates, access to imported goods becomes more difficult (particularly in terms of food purchases), salaries are frozen, precariousness rises, and consequently morbidity may also increase.

An increase in the cost of health provision particularly in the cost of drugs is feared. This situation may contribute to deteriorating the mutual schemes' underwriting result or in imposing an increase in the premium amount. This would make the insurance product less appealing in a context of increasingly scarce resources.

## 3.3 Relationship between Client Risks and Institution's Services

Risk analysis has led the MHOs to prioritize the improvement of health conditions over financial improvements in the insured's access to care. Various activities that have been carried out by the program should be passed on to the UMSGF in the future:

- Participation of the MHOs' officials in village mobilization during the National Immunization Days.

- Creation of a position of a field agent in charge of health education and sensitisation whose focus will be on women of the mutual schemes.
- Organization of information and sensitisation meetings on the risks linked to sexually transmittable diseases, including HIV/AIDS.

In addition, measures have been implemented on three levels to reduce risks connected to health care provision: the providers, the supervisory bodies and the health department.
At the providers' level, negotiations have taken place to lower the risk of not receiving care and drugs fast enough in the case of an emergency. A liaison officer at N'zerekore hospital, financed by the program, receives the insured members and resolves any misunderstandings between members and the health staff. In the two prefectorial hospitals, sensitisation campaigns have been organized by the program. The hospitals' directors were invited to attend a training workshop on mutual insurance systems at CIDR's headquarters in France.

At the level of the supervision bodies, the regional and prefectorial health authorities have been directly involved in the negotiation process. They have representatives in the joint monitoring committees.

Finally, the Ministry of Health's Department for Hospital Services, as well as the "Mutual Health Organizations' Focal Point," have been informed of the developments in contracting and other outcomes. The MoH stepped in directly to address some concerns raised when signing the initial agreement with the N'zerekore hospital. Moreover, to improve the quality of primary health provision, the UMSGF has set up a partnership with a French NGO, "Santé Sud" to establish medical practices in rural areas.

## 3.4 Familiarity with Insurance

Limited insurance with third-party payment and co-payment is a new concept for most of the target population. However, the existence of self-help groups organized according to the principle of 'obligation of means,' where a set amount is contributed by each member when one falls sick, clearly reflects a social tendency for solidarity in the face of illness. Two initiatives remarked during the preliminary study showed a predisposition to accept the insurance mechanisms developed by mutual insurance systems:

- A traditional group of rural women had already spontaneously adopted the third-party payment principle. For a monthly fee, the group paid the hospital bills' for one of its sick members.
- A self-help society called "ASARO" was created by a resident of N'zerekore in response to the death of his brother who was a victim of embezzlement practices at the hospital. The society provides its members with financial support and visits them during episodes of hospitalisation.
- The vast number of ROSCAs and other informal savings and credit groups reflect that the milieu is familiar with collective organizations in which management is delegated to a few leaders and in which there is a capacity to build financial systems based on the collection and mobilization of funds.

# 4. The Products

Benefits offered by the MHOs have evolved to respond better to the members' needs and expectations. The MHOs that began operating in 2000 focused primarily on covering major inpatient risks. Later on, they chose to gradually expand their services based on their location and their referral hospital. New benefits consisted either of broadening the range of services available at a designated health facility, or contracting with a new health provider for new services. When designing their benefit packages, newly created MHOs have benefited from the lessons learnt from the agreements already established with service providers.

Moreover, because of the deterioration of health facilities' capacity to provide quality care while complying with the total care system for hospitalisation (accommodation, treatment, exams and prescriptions), MHOs have extended their coverage to ensure that members are treated properly. Complementary services include intensive care, examinations required prior to surgical procedures and during hospitalisation, as well as external prescriptions of generic medicine when they are justified with a shortage in the hospital's pharmacy.

**Table 4.1 Product Details**

| | Product Features and Policies |
|---|---|
| Microinsurance type | Health insurance |
| Group or individual product | Individual product (for family coverage) |
| Term | One year |
| Eligibility requirements | Being resident of a village, member of a group (pre-existing or new) |
| Renewal requirements | None |
| Rejection rate | None |
| Voluntary or compulsory | Voluntary; all members of the family have to register. |
| Product coverage (benefits) | • Lump sum to cover transport to the hospital in rural MHOs<br>• For all MHOs, coverage of medical inpatient care, eligible and emergency surgery, complicated delivery<br>• In the oldest MHOs, coverage of outpatient services including drugs and simple delivery for a flat fee co-payment |
| Key exclusions | People not living in villages where MHO is located |
| Pricing – premiums (2005/06) | Ranging from €1 to €2 per person per year |
| Pricing – co-payments and deductibles (2005/06) | 30 cents flat fee co-payment for outpatient services; no co-payment for inpatient care and surgical procedures |
| Pricing – other fees (2005/06) | Membership fees range from €1.2 to €2 per family; 10 percent discount for families of more than seven |

After five years of operations, the MHOs can be split into two groups according to the products they offer: rural schemes and urban schemes. Services offered by rural schemes are detailed in Table 4.2. At the beginning of budget year 2005/06, 21 MHOs out of the 28 that make up the network offered these services.

**Table 4.2 Rural MHOs' Benefit Package**

| Covered services | Health facilities | Conditions for coverage | Comments |
|---|---|---|---|
| **I) Inpatient care** | Prefectorial hospital and regional referral hospital | Preliminary treatment; Authorization consultations to be paid by the insured | |
| Hospitalisation | | Third-party payment | Programmed & emergency |
| Surgical procedure | | Third-party payment | |
| Intensive care | | Third-party payment | |
| C-section | | Third-party payment | |
| Simple and complicated deliveries | | Third-party payment | |
| Blood transfusion | | Third-party payment | |
| Examination during hospitalisation | | Third-party payment | |
| External prescriptions of generic medicine during hospitalisation | | Reimbursement, prescriptions made by the medical staff and approved by the liaison officer to be bought in private drug stores | |
| **II) Primary Care** | Sub-prefectorial health centres and health posts | 30 percent co-payment to be paid by the insured, except for deliveries | |
| Curative Consultation | | Third-party payment | |
| Simple delivery | | Third-party payment | 100 percent coverage |
| Minor surgery | | Third-party payment | |
| **III) Transport** | | | |
| Normal transport | | Reimbursement | |
| Emergency transport | | Reimbursement of pre-determined amount | |

Besides this benefit package, some MHOs have complementary services in response either to specific demands from their target population, such as:

- Flat rate benefit for body transportation in the event of death at the hospital
- Flat rate coverage for circumcision
- A "newborn babies package" as an incentive for ante-natal care and for reporting births in member households
- Outpatient treatment at the hospital on a referral by the health centre

The recent emergence of church-owned private providers of health services has made it possible for some rural MHOs to broaden their selection of providers. These facilities are either inpatient clinics or dispensaries that provide primary care. The same benefits package and conditions to access care elsewhere have been adopted in these facilities.

In urban areas, since the hospital is close by and there are a variety of alternatives to receive outpatient care when needed, MHOs had to primarily focus on covering hospitalisations. Therefore, a major difference for the benefit package provided by the 7 urban MHOs in the network is that it does not include transportation. In addition, recently the N'zerekore MHOs

have decided to provide full cover for pregnant women (antenatal care, delivery, vaccination and outpatient care during pregnancy).

Some of the insured have repeatedly requested that their MHOs expand benefits coverage to include all outpatient services. Considering the significant increase in premiums that such an enlargement would entail, General Assemblies have preferred not to go that way for now. It is very likely, however, that in a near future urban MHOs will have to offer a wider range of services with different levels of benefits corresponding to different premiums to respond to the expectations of a rather segmented client base.

## 4.1 Partners

As described above, the providers of health services are the network's main partners. In rural areas, transportation providers are also key partners.

All of the MHOs also work with the Rural Credit of Guinea. They deposit most of the collected funds there and manage their cash flow from fixed-term and current accounts. At a first glace, the relationship is simply one of a client/service provider type. However, the two networks are connected in many ways, including some elected officials who are involved in both structures. The directors of the sub-prefectorial MFIs are always invited to take part in the MHOs' general assemblies. They are often members of a scheme and participate in promoting health insurance in their circles. Options for more institutional cooperation are being developed. To begin with, coverage will be offered to the families of all of the MFI elected officials and staff through either existing MHOs or a specific structure established to that effect. Later on, thought should be given to cater to all of the Rural Credit clients in the MHOs' area of operations.

## 4.2 Distribution Channels

The schemes distribution channel operates as follows:

- Promotion of MHOs and their benefits is carried out by the group leaders, who are in charge of enrolling new members. They pre-register new members and their dependants in group registers, which are also used to monitor the payment of membership fees (for new families) and premiums—staggered payments are usually made in advance to pay the upcoming year's premium.
- Group leaders also collect expired membership cards when the budget year ends.
- Once premiums have been collected, registered data and membership cards are passed on to the manager (together with the collected funds). The manager updates his/her membership book and makes new cards.
- When making membership cards, managers are often helped by the president or treasurer (as well by a field agent for the new schemes). One card is issued per family with a unique personal code. A card includes each dependant's name, gender and birth date.
- Cards are numbered, validated and stamped with the corresponding year in the presence of one or several committee members.
- At the general assembly, which marks the beginning of the budget year, cards are handed out in public to the head of household or the group leader. Information is then given on benefits and conditions for coverage.

There are no exclusions based on one's health condition or age. However, if a head of household tries to circumvent the rule of family membership[16], s/he is then excluded along with all of his/her dependants.

The member registration system appears to be quite efficient. There are few cases of premiums paid for dependants that do not appear on the membership card. Providers' use of group names and card numbers make the monitoring of invoices easier. Member registration, premium collection and monitoring, making membership cards and distribution are activities strongly supported by the project's team during the first two to three years of a scheme's operation. Over time, the scheme managers gradually assume these functions.

However, collecting old membership cards remains problematic once the involvement of field agents has been reduced. People in-charge have difficulties in recovering membership cards that are still with families (e.g., for families that do not wish to renew their membership). Some cases of fraud have been observed through using expired cards that had not been taken out of circulation.

## 4.3 Benefits

Mutual health organizations' primary role is to offer services tailored to their members' needs, given their propensity to pay. MHOs have developed contractual relations with health service providers to improve the quality of care provided to their members. Consumer satisfaction[17] and image surveys conducted among the insured and in the MHOs' surroundings clearly show that contracts signed between MHOs and health providers have had a positive impact on the quality of treatment received by scheme members (as opposed to non-members). Although they have not completely disappeared, forced gifts, under-reporting and over-billing have been greatly reduced.

Providing information to patients and their families has been greatly eased by the involvement of the liaison officer, medical consultant and scheme's manager. The latter have acquired a real capacity to hold talks with hospital's management and staff through their participation in monitoring committees and regular visits to hospitals.

Membership with an MHO is family-based. All dependants must be registered. Group leaders are responsible for ensuring that no household members are excluded from coverage (particularly children). To ease their task, MHOs offer free coverage for children born during the budget year.

In polygamous households, which are numerous in some target groups, family registration is carried out separately for each spouse and her dependants. One membership card is for each mother and her children.

To limit financial difficulties that women face in basic health facilities during pregnancy (to pay for ante natal cares and delivery), MHOs in N'zerekore have entered into a contractual

[16] He may be willing to reduce the number of registered members to save money or try to register a non-member of his family for whom he has to support health expenditures.
[17] Mutuelles de santé en Guinée Forestière : Etude de satisfaction Aurélie Divet septembre 2003

relation with the city's health centres to obtain third-party payment for all health care services given to female members.

## 4.4 Premium Calculation

The premium calculation has been greatly eased by the use of flat rates in health facilities and the contracting process with health providers through which the rates for all covered services are detailed beforehand.

Projected frequencies are calculated for each scheme. In the first year, frequencies are estimated according to the target population's attendance rate at health facilities, the distance to get to these facilities, and data from similar programs supported by CIDR in West Africa. These semi-empirical estimations are fine-tuned once scheme members' actual use of health facilities is better known. The frequencies appeared to be over-estimated, but the project recommended not to reduce the premium so as to give to MHOs the possibility to build up reserves, and/or to enhance the benefits without increasing the premium.

A percentage is added to the pure premium to take into account the running costs of the MHOs and the network, as well as the need for the guarantee system and the accumulation of reserves. Until the 2004/05 budget year, a 30 percent loading was added to the pure premium according to the following breakdown:

- 21 percent to cover the mutual health organization's own running costs
- 2 percent to cover the Union's running costs
- 2 percent to contribute to the guarantee system
- 5 percent to build up the scheme's reserves

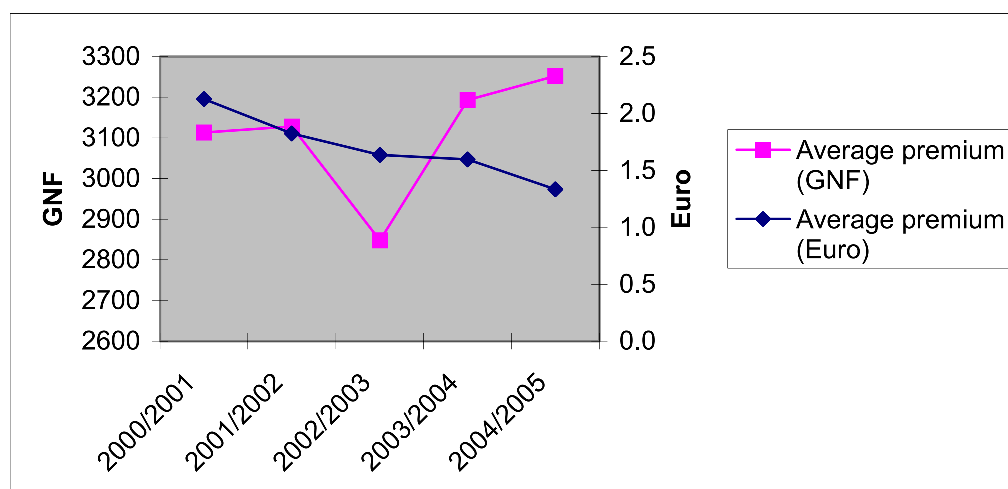
As of 2005/06, because of the devaluation of the Guinean franc, part of the premium will be indexed to inflation. Moreover, it was decided that contributions to the guarantee system would be integrated in the pure premium. Finally, the loading to the pure premium was decreased to 27 percent and divided up into the following:

- 25% to cover the MHO's own running costs
- 2% to cover the Union's running costs

To account for inflation, a 20% loading was applied to the part of premium intended to cover running costs.

On the whole, premiums in Guinean francs have remained relatively stable over the first six years of operations (see Figure 4.1). Because of the stability of the cost of care and the adjustments brought to theoretical frequencies based on experience, premiums have only risen by an average of 5 percent even when the benefits have broadened considerably. When expressed in Euros, however, the average premium value has not stopped decreasing.

**Figure 4.1 Changes in Average Premium (in Euros and GNF)**




*Operations Costs*

As shown in Table 4.3, MHOs' running costs have evolved in absolute terms in the light of the growing number of schemes and of insured persons.

**Table 4.3 Operating Costs**

| | 2001/02 | 2002/03 | 2003/04 | 2004/05 |
|---|---|---|---|---|
| Total operating costs (in GNF) | 4,246,270 | 4,246,168 | 6,833,450 | 9,487,150 |
| Total operating costs (in Euro) | 2,440 | 2,123 | 2,803 | 2,497 |
| Including general assembly costs | n.a. | 1,124 | 1,484 | 1,250 |
| Running costs / premium ratio (whole network) (%) | 32 | 27 | 24 | 21 |
| Running costs / premium ratio (MHOs over a year old) (%) | n.a. | 24 | 23 | 18 |

Running costs are relatively high in comparison to the collected premiums. This is explained by the importance given to the organization of the General Assemblies (twice a year), which are major community events. These are opportunities to strengthen the organization's governance and to promote the MHO. The cost of General Assemblies accounts for half of the total operating costs. However, there is a downward trend in running costs (from 32 to 21 percent) as result of a strict control over expenses and an increase in membership.

No commissions indexed to MHOs' turnover have been paid. From 2005/06, incentives paid to scheme managers will be at 4 percent of total collected premiums. Similarly, group leaders will receive an incentive of 2 percent of premiums collected from their respective groups. Finally, committee members will receive an incentive of 2 percent of total collected premiums. This change was decided by the MHOs leaders to boost the recruitment of new members and to compensate them for their efforts.

While there is no reinsurance system, there is an intervention fund with financing up to 2 percent of collected premiums. When their reserves fall under a safety threshold set by the guarantee system, contributing MHOs may apply to the intervention fund for a loan. The latter, condition to a number of recovery measures, is repayable in several instalments.

**Table 4.4 Consolidated Income Statement of 25 MHOs (in €), 2004/05**

| EXPENDITURES | Amounts | INCOME | Amounts |
|---|---|---|---|
| **I- Cost of benefits** | **5,167** | **I- Income from Health Insurance** | **9,250** |
| Third-party payment (hospitals) | 3,092 | Premiums allocated to benefits | 9,238 |
| Medicine/lab reimbursement | 263 | Other products Health Insurance | 12 |
| Third-party payment (health centres & posts) | 390 | | |
| Staff bonus – Primary care | 82 | | |
| Third-party payment (private providers) | 660 | | |
| Transport for the sick | 418 | | |
| Other care | 262 | | |
| | | | |
| **II- Operating expenses** | **2,713** | **II- Operating income** | **4,013** |
| Transport & travel | 373 | Premiums allocated to operation | 2,687 |
| Rent and upkeep of premises | 252 | CIDR operational grant | 695 |
| Meetings | 200 | Interests from investments | 426 |
| General Assemblies | 1,250 | Miscellaneous Income | 55 |
| Stationery and management tools | 102 | Miscellaneous donations | 150 |
| Communication & promotion | 201 | | |
| Incentive scheme manager | 264 | | |
| Bank fees | 32 | | |
| Other expenses | 39 | | |
| | | | |
| **III- UMSGF expenses** | 358 | **III- Membership fees** | **1,033** |
| Registration | 79 | | |
| Operating costs | 183 | | |
| Guarantee fund | 96 | | |
| | | | |
| **IV- Other operating expenses** | **230** | **IV- Other operating income** | **658** |
| Depreciation | 214 | CIDR grant to reserves | 536 |
| Extraordinary expenses | 1 | Extraordinary income | 117 |
| | | Other CIDR grants | 195 |
| (adjustments) | 15 | (adjustments) | 4 |
| **TOTAL EXPENSES** | **8,468** | **TOTAL INCOME** | **14,954** |
| | | | |
| Balance ( Surplus) | 6,486 | Balance ( **Deficit** ) | 0 |
| **TOTAL GENERAL** | **14,954** | **TOTAL GENERAL** | **14,954** |

*Subsidies*

There are three distinct types of subsidies: operating subsidies, equipment subsidies and subsidies for financial consolidation. All are essentially granted during the first budget year.

- Operating subsidies to organize General Assemblies and are between GNF300,000 to GNF450,000 depending on the size of the scheme (from €125 to €185 in the year 2004/05). This substantial contribution, which is twice the average operating budget of an MHO in its first year of operations, enables the organization of highly visible General Assemblies. From the second year on, the absence of subsidies is compensated by the growth in membership.

- MHOs also receive a subsidy in-kind costing about €50 at the start of their activities for office stationery, a cash box and a calculator.
- From the second year on, in-kind contributions are limited to supplying necessary stationery and communication tools used during committee and board meetings and in making membership cards. Manufacturing costs for these cards is about €0.1 per card.
- Equipment subsidies are intended for office furniture and renovating premises. In 2004/05, they amounted to GNF225,000, which is equivalent to €100 per MHO.

Finally, the support project subsidizes the reserves with an amount equivalent to the total collected membership fees at the beginning of the first budget year. Since the start of the program, close to GNF8.5 million (€4,500) have been contributed. In total, this external subsidy only amounted to 17 percent of the constituted reserves.

Unlike MHOs that quickly become autonomous, the Union has limited self-financing capacity. This can be explained by the network's small size and the low level of MHO's contributions to the Union's operations (2 percent). In the meantime, the project funds most of the Union's expenses. In 2004/05, the Union's budget showed projected expenditures of about GNF3.8 million (€1,500). This budget received a subsidy covering up to 85 percent of the expenses and the remaining balance was financed by MHOs' contributions.

The Union's guarantee system has also been heavily subsidised by the support project, as shown in Table 4.5. The intervention fund's value has been decreasing due to inflation, but has been partially offset by the interest earned.

**Table 4.5 Financial Position of the Intervention Fund (April 30, 2005)**

| Items | Amounts |
|---|---|
| 1- MHOs' membership fees: 18 MHOs x GNF 50,000 | € 236 |
| 2- MHOs' contributions (2 percent per year) | € 170 |
| 3- CIDR grant | € 1 483 |
| of which budget year 2001/02 | € 658 |
| of which budget year 2002/03 | € 263 |
| of which budget year 2003/04 | € 126 |
| of which budget year 2003/04 | € 436 |
| 4- Interests earned on term deposit account | € 159 |
| **Total available income** | **€ 2,048** |

At the close of the 2005 budget year, no MHO had to resort to the intervention fund since all of them recorded surpluses. Although it has not been used, the guarantee system enables MHOs' to obtain a 15-day repayment period from health providers without a down payment.

*Summary and Issues*

As indicated in Table 4.6, the increase in premiums in current Guinean franc terms has been largely insufficient given the sharp devaluation of the Guinean currency. Until the beginning of 2005, the political decision not to pass the devaluation on to health providers' rates enabled MHOs to remain financially stable since their loss ratios were primarily affected by members' health care seeking behaviours.

**Table 4.6 Loss Ratios, 2000-2005**

| | 2000/01 | 2001/02 | 2002/03 | 2003/04 | 2004/05 |
|---|---|---|---|---|---|
| Average premium (GNF) | 3,113 | 3,128 | 2,848 | 3,193 | 3,252 |
| Average premium (Euro) | 2.1 | 1.8 | 1.6 | 1.6 | 1.3 |
| Loss ratio | 42% | 27% | 37% | 33% | 42% |

Loss ratios rose in 2004 and will probably continue to rise in 2005. As a result, premiums for the budget year 2006/07 should rise significantly as well. It is indeed crucial to keep the loss ratio below 65 percent to ensure the production of a surplus intended to offset the depreciation of reserves.

## 4.5 Premium Collection

Scheme members decide on the premium amount during the General Assembly organized every year in January, three months before the end of the budget period. The principle adopted is that the whole premium must be paid before the start of the new budget year. On this basis, group leaders register members and inform heads of households of the total premium amount they have to pay. The latter have three months to come up with the funds. Most households prefer payment in two to three cash instalments.

Groups made up of civil servants or planters "under contract" with agribusinesses opt for premium deduction at source through two to three payments transferred to the MHOs' account or to the scheme manager.

In some rural MHOs, group members have organized themselves to use a plot of land to pay the premium of households' group members from the result of the sales.

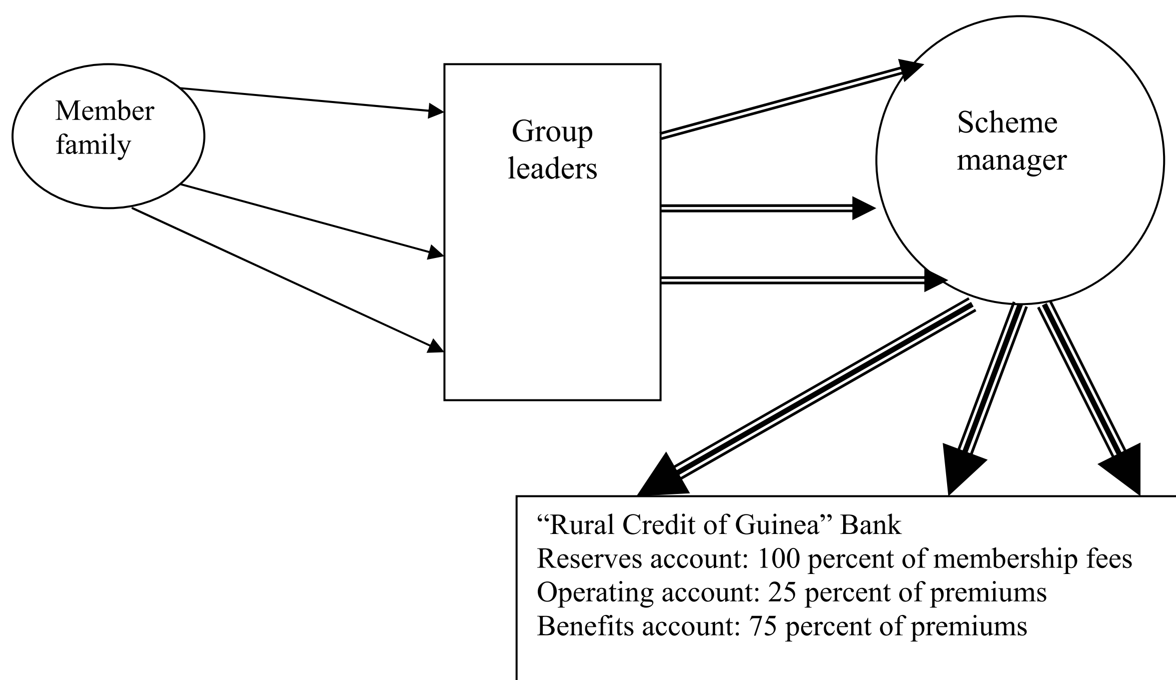
*Collection Processes*

Funds collected by group leaders are regularly gathered by the scheme manager during meetings attended by the members of the Executive Committee. The manager is in charge of depositing the funds into the Rural Credit of Guinea. When doing so, the manager divides the funds and deposits them into three separate accounts, corresponding to the scheme's reserves, operating budget and benefits budget (see Figure 4.2).

Premium collection is usually completed by the first day of the new budget year. Membership cards are often issued during the first month of operations. To boost premium collection, and ensure that the schemes run smoothly, the network has adopted common rules. Households may receive their cards once three conditions are satisfied:
1. They have paid all of their premiums
2. At least three quarters of the families that make up their group have paid their premiums
3. Their scheme has collected at least 80 percent of total premiums for the new budget year.

Families that are behind in their payments may still pay their premiums after cards are issued if they undergo a one to two month waiting period (depending on the MHO). Incomplete premiums are neither reimbursed nor considered as an advance for the following year.

**Figure 4.2 Premium Collection Process**




*Problems (and Solutions)*

This premium collection system has the advantage of accommodating the nature and level of rural households' disposable income. The system is flexible, favours geographic closeness and guarantees fund control as long as regular meetings take place between the scheme manager and Executive Committee members. Conversely, it multiplies intermediaries, thereby greatly increasing the risk of error, theft or embezzlement.

In urban settings, where some groups' households are scattered, the system is problematic for leaders who have to make frequent and costly trips. Nonetheless, as shown in Table 4.7, the collection and implementation rates of premiums due have been acceptable since the start of MHOs' activities.

Premiums due are calculated on the basis of the number of new families who have paid their membership fee and the number of member families who have indicated their intention to renew their membership and that of their dependants. The gap between premiums due and premiums received is attributed to families who did not pay their premiums or who made interrupted payments. Since no member card can be issued before the whole premium amount has been paid, the premium collection rate among covered scheme members is 100 percent.

**Table 4.7 Premium Collection**

| | 2004/05 | 2003/04 | 2002/03 | 2001/02 | 2000/01 |
|---|---|---|---|---|---|
| Premiums due (GNF) | 52,821,600 | 31,466,800 | 17,146,500 | 14,318,650 | N.a. |
| Premiums received (GNF) | 45,844,900 | 28,283,670 | 15,919,850 | 13,130,250 | 1,017,041 |
| Implementation rate (%) | 87 | 90 | 93 | 92 | n.s. |
| Average collection rate (%) | 100 | 100 | 100 | 100 | 100 |

There have been only two cases of significant premium embezzlement since the start of the network. In the first case, half of an MHO's group leaders misappropriated premiums collected from households. This was spotted quite late during the project's intervention. As a result, the members completely lost confidence in their leaders and the MHO is having difficulties overcoming the crisis.

A scheme manager was responsible for the second case. Annual premiums were collected by the manager in a factory when the producers were selling their crops to the company. This centralisation of the payment made embezzlement easier. The fraud was quickly spotted by the committee and the scheme president, who were able to mobilize the whole village and find a solution on their own. Unlike the first case, this matter proved to be within the scheme's capacity to control and had a positive impact on membership in the following year.

## 4.6 Claims Management

*Claims Settlement Process*

As depicted in Figure 4.3, the claims settlement process involves two payments: one to the members for transportation expenses, the other to the health care provider.

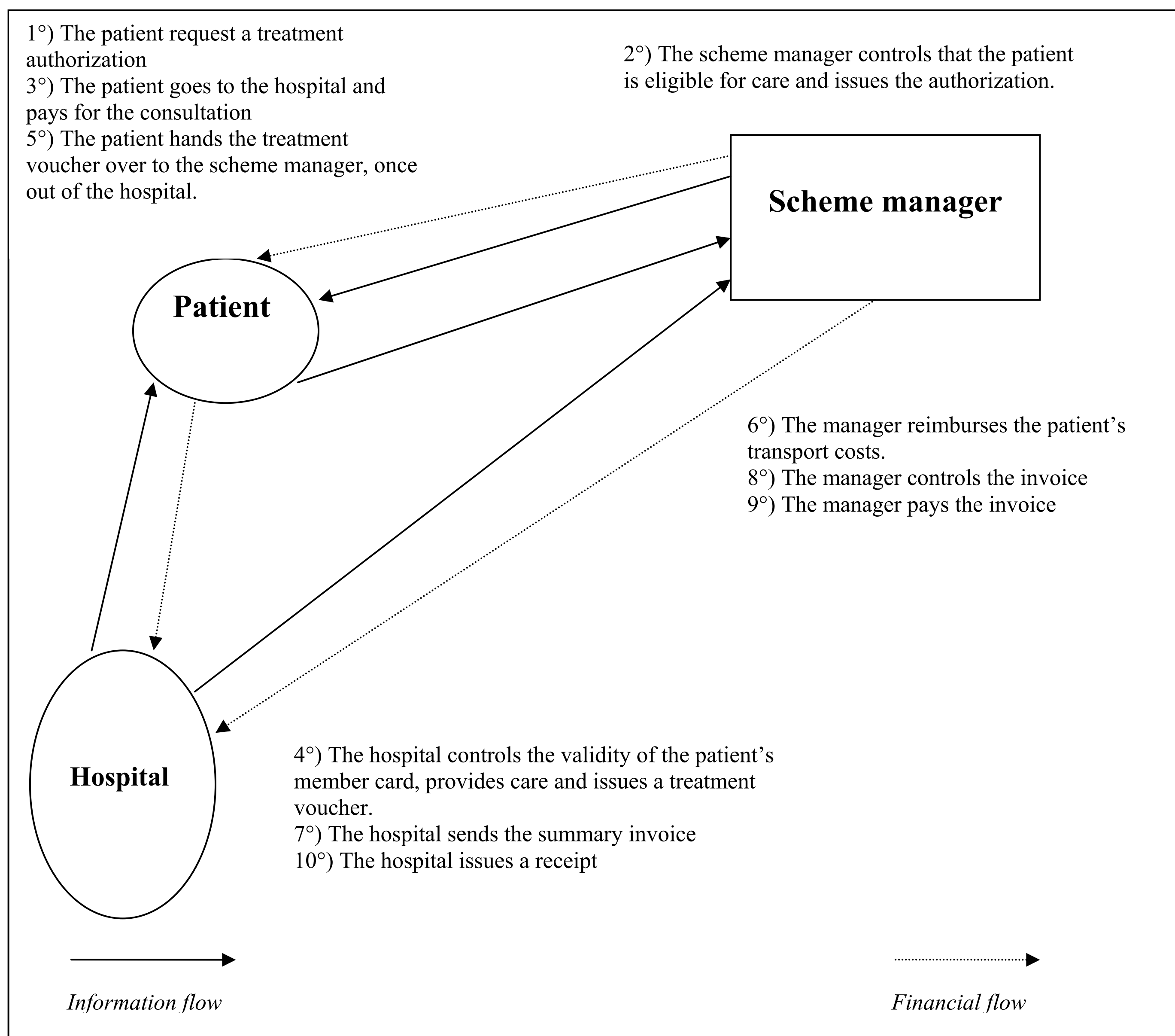
Before going to the health care facility, each insured patient wishing to receive benefits must request a "treatment authorization" from the scheme manager (or group leader for some sub-prefectorial MHOs). The patient goes to the hospital with his/her card and authorization where s/he is met by a staff member in charge of receiving insured patients (in N'zerekore's regional hospital, the facility's size and the frequent visits by insured members have led the project to hire a liaison officer). The insured pays the consultation fee (€0.20) out-of-pocket as a co-payment.

After the consultation, if the insured is admitted, s/he is given a bed and his/her treatment completely falls under the third-party payment principle. At the time of discharge, the hospital issues the insured with a treatment voucher as a proof of the typology and amount of the treatment received. Once back at home, the insured must call on the manager to give an account of the hospitalisation and hand him the treatment voucher issued by the hospital. Based on this document, which proves that the insured had indeed been hospitalised, the scheme manager pays the patient a "transport package" fee that was set during the previous General Assembly.

Each month, the hospital produces a summary third-party payment invoice listing all of the insured that received treatment during the month. The invoice states each patient's name, MHO, group identifier, card number, date, type and cost of care. A standard invoice is used for all of the partner health facilities. The scheme manager then compares the invoice received from the hospital against the authorizations for treatment issued and treatment vouchers received. The invoice must be paid within fifteen days upon receipt.

Payments are made in cash, either directly by the scheme manager to the hospital's administrative officer or by a third party (another scheme manager or project field agent) for distant rural MHOs. The hospital issues a receipt for payment.

**Figure 4.3 Claims Payment Process**




*Problems*

Indirect costs linked to the manager's trip to the hospital(s) to settle invoices are high (in terms of time and transport) compared to the amount of the payments made. Given the low level of banking in Guinea, procedures to settle invoices through inter-account transfers are currently impossible to set up. Depositing an "advance fund" at the hospital and spacing out adjustment operations could be a conceivable solution once scheme members and health providers trust each other.

Scheme managers often find billing errors in the invoices due to problems in identifying the insured (e.g., same last name, mix up between a patient's nickname, Christian name and

Animist name) or billing a patient more than once. Therefore, sometimes managers send invoices back to the hospital for corrections.

With the rise in MHOs' members and the development of the partner providers' network, the existing system that has been influenced by the absence of banking services and computerization in rural settings may cause problems in terms of managing information flows and controlling funds flows. Hence, invoices controlled by scheme managers capable of discussing knowledgeably about current administrative procedures with hospital staff represent a major challenge. In the event of a dispute, the presence of the liaison officer and the medical consultant are often necessary.

**Table 4.8 Claims Settlement Details**

| Issues | Observations |
|---|---|
| Parties involved in claims settlement | Scheme manager and Executive Committee |
| Documents are required for claims | Treatment authorization and treatment voucher |
| Claims payment method | Payment in cash (to health providers and the insured) |
| Time from insured event to claim submission | None |
| Time to pass through intermediaries | No intermediaries external to the MHO |
| Time from submission to payment | 2 weeks for health services, 3-4 days for the insured |
| Claims rejection rate | An estimated 2 to 3 percent, usually for members requesting excessive reimbursement of transport costs |

## 4.7 Risk Management and Controls

*Moral Hazard*

Traditional control mechanisms have been established:

- For hospitalisations: With co-payments and only partial cover of transport costs, "comfort" consumption is avoided and recourse to treatment is limited to emergency cases.
- For outpatient care: The existence of a co-payment has a dissuasive effect on medical consumption, thereby protecting the schemes' technical performance.

*Adverse Selection*

The principle of family membership was adopted as a key means to fight against adverse selection. The definition of the accumulation unit did not pose any particular problem. The average size of a polygamous family is made up of nine members. Since the premium collection phase is limited in time, enforcing a waiting period beyond the time needed to issue membership cards (about a week) is not appropriate. The choice to include planned surgical operation in the schemes' benefit packages presented a high risk of adverse selection.[18] A high rate of surgeries has been observed, but the impact has been limited since costs have been kept under control.

[18] Most of the pathologies eligible for planned surgical operations, such as fibroma, hernia and goitre, are known by the patient who may decide to register to a MHO to have it treated at a cheaper price.

*Fraud*

Fraud may take various forms and thus the project has set up a numerous procedures to limit its occurrence. The delivery of preliminary treatment authorizations by the scheme manager makes it possible to verify whether the requests for benefits are justified and whether the insured is indeed eligible. Along with the preliminary authorization, additional measures have been taken to verify the insured's identity when they reach the health facilities.

The medical consultant also has a retrospective verification function. S/he reports quarterly on MHOs' activities with health providers. An audit is carried out within the hospitals during which the medical consultant specifically analyses consumption (number of insured patients treated, pathologies, treatments provided) and cost indicators (at the MHO, insured patient, and health provider levels). S/he is also in charge of reviewing if health providers complied with agreements and assessing that therapeutic protocols were followed.

*Cost Escalation*

The Guinean health system provides flat-rate billing for health services. This measure has limited the risk of a sudden rise in rates. This situation however could change if the cost of drugs increases significantly, which would necessitate an adjustment to the premiums.

*Covariant Risk*

The covariant risk is limited by the constant increase in membership. Risk pooling is also reinforced by the fact that each MHO is financially independent. Therefore, no risk of domino effect is to be feared if a scheme were to fail.

## 4.8 Marketing

Scheme leaders carry out promotion activities, in some cases with the support of the project team. In previous years, this function was performed on a voluntary basis. In the 2005/06 budget year, group leaders and committee members will receive an annual incentive corresponding to a maximum of 4 percent of the total amount of collected premiums.

**Table 4.9 Marketing Responsibilities**

| Marketing, communication | Group | MHO | UMSGF | Support project |
|---|---|---|---|---|
| Who informs the members on the benefit package and their expansion? | Leaders | | | |
| Who looks for new families? | Leaders | | | |
| Who looks for new groups? | | Committee + manager | | |
| Who establishes new MHOs? | | | | Technical Unit |
| Who handles the promotion of the mutual movement (radio broadcast, posters, etc.)? | | | Committee | Technical Unit |

Table 4.9 details how functions are shared among the various actors. Communication activities are implemented to support and reinforce the promotion work of group leaders. They are financed by the project, but are designed with the Union's manager. Among the range of marketing activities, communication from scheme officials (with the support of the

project team) is the key activity given the importance of oral culture in Guinea. Thus, village meetings are organized involving moral and administrative authorities and announcements are made in places of worship or during ROSCA meetings. Radio programs are broadcasted during the three-month premium collection period and audio tapes have been recorded in various vernacular languages.

Moreover, a billboard was designed for the MHOs' network with a logo and its own colours. In each village, premises are outfitted and decorated with the network colours. Signposts have been set on main roads and promotional supplies are available in health facilities. Each year, T-shirts are handed out in new MHOs. Finally, a quarterly newsletter is distributed to all groups, health providers, a network of resource people, and local administrative and political authorities. The promotion budget is roughly around €2000 per year.

No indicator has been established to measure the impact of these marketing activities. However, there is no doubt that the network is quite visible in the three prefectures where it operates as shown by the repeated requests received by the project team from villagers or village authorities for the establishment of new MHOs. The number of insured and the scope of the health provider network also ensure the scheme's high visibility among health authorities in the region.

## 4.9 Customer Satisfaction

*Renewals*

Premium renewal rates are stable and at a satisfactory level (between 81 and 88 percent since inception). They are comparable to the ratio of contributing households in year N over the number of households having contributed at least once since the start of the scheme. These two indicators indirectly suggest a high level of satisfaction. The main reason former members have not renewed is essentially on material grounds, as indicated in Table 4.10.

**Table 4.10 Reasons for Non-renewals**

| **Material reasons** | **% of the surveyed having stated that reason*** |
|---|---|
| Money problems | 58.3 |
| Exceptional expenses | 16.7 |
| Very large families | 8.3 |
| Lack of information | 16.7 |
| Absent during premium collection period | 5.6 |
| **Product efficiency** | |
| Discouragement as never sick | 2.8 |
| Illnesses not covered | 19.4 |
| Insufficient coverage | 13.9 |
| **Lack of trust in the MHO** | 8.3 |

Survey conducted in 2003 and administered to 40 "non repeat contributors"
* Each respondent could give multiple answers

It should be noted that the two reasons reflecting some dissatisfaction with the product (illness not covered or insufficiently covered) come in second position after the lack of

money. Based on this information, the project team advised the MHOs to extend their benefit package to include outpatient care.

The “lack of information” is also an important element on which the schemes may improve. Among the socio-economic criteria on which data is available, the level of schooling—which is lower among non-renewing contributors—is the only variable differing significantly between contributors and non-renewing contributors. This confirms that the level of education, if not linked to income, influences the acceptability of health insurance.

*Member Satisfaction*

The satisfaction level expressed by surveyed members is high, as 50.5 percent of them said that they were “very satisfied” and 42.4 percent stated being “satisfied” with the services provided by MHOs. The vast majority of scheme members trust their leaders, even if some regret that little attention was given to their problems. The availability of Committee members and scheme managers is an important factor in satisfaction and in maintaining members’ trust.

Scheme members perceive that their relations with health providers have improved, although this has been to varying degrees depending on the health facilities. The presence of a liaison officer paid by the UMSGF is particularly appreciated.

This positive opinion does not stop members from wanting MHOs to expand their benefits. They particularly ask for coverage of specific illnesses (probably theirs) or full coverage of all treatments. Outpatient care is mentioned by 61.6 percent of the respondents; they also ask MHOs to solve the problems of drug shortages at health facilities. A few respondents want the MHOs to have their own hospitals.

# 5. The Results

## 5.1 Management Information

The project's database makes it possible to produce performance and impact indicators, and to put them in perspective over several years. Trend data is necessary to pre-empt the occurrence of risks such as over-consumption or a technical imbalance in the premium. Indicators were selected according to their usefulness when analysing the risk portfolio:

- Membership and premium (number of schemes, number of insured, total collected insurance premiums, written premium rate)
- Claims (number of insurance claims, total insurance claims amount, quality of risk portfolio, average cost of insurance claims, comparative average hospitalisation length of stay, average insurance frequency)
- Impact (penetration rate, gross growth rate, internal and external, premium renewal rates, average number of insured/scheme)
- Solvency ratios (cover ratio, loss ratio, net result, self-financing ratio)

Tools currently used provide a snapshot of the network at a given moment and make it possible to obtain information on risks to which MHOs may be exposed. They also enable updating the program monitoring and evaluation system used in CIDR headquarters. However, these tools do not permit precise risk monitoring and present a high risk of error because of the fragility of Excel files on which data is compiled and analysed. This situation confirms the importance of designing a specific risk management tool.

## 5.2 Operational Results

As shown in Figure 5.1, the number of insured has been rising regularly since the first MHOs were established. Growth is pulled up both by the increase in the number of schemes (from 6 in 2000/01 to 28 in 2005/06) and by internal growth. Indeed, as a sign of network vitality, the average scheme has risen from 270 to 563 insured members.

**Figure 5.1 Growth in Insured and MHOs**

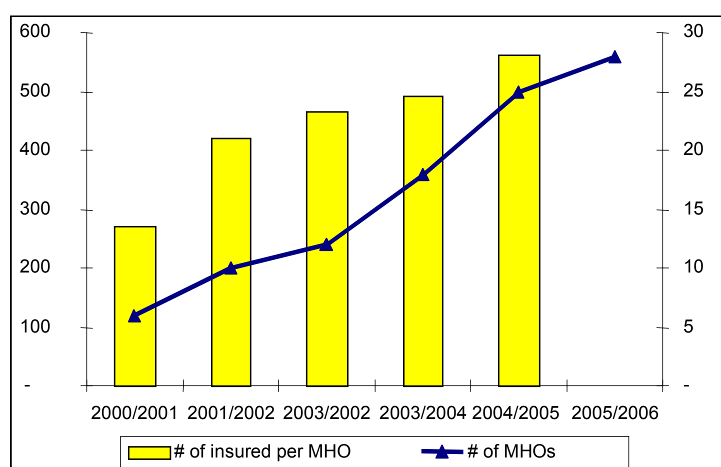
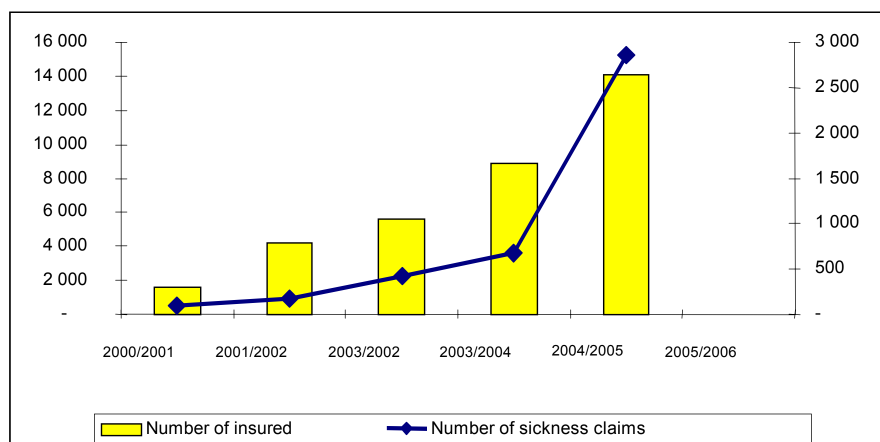


**Figure 5.2 Growth in Claims**




The number of claims compared to the number of covered members shows notable changes at the close of the period. The number of claims per insured rose significantly from 0.05 recourses in 2000/01 to 0.20 in 2004/05. This sharp increase has been offset by an equally significant drop in the average unit cost of claims, which went from €13.49 to €1.94. This can be explained by the modifications in the insurance products, especially the inclusion of outpatient risks in benefit packages (for treatment provided in health centres and posts).

**Table 5.1 Number and Cost of Claims (2000-2005)**

| Year | 2000/01 | 2001/02 | 2003/02 | 2003/04 | 2004/05 |
|---|---|---|---|---|---|
| # of claims per insured | 0.05 | 0.04 | 0.08 | 0.08 | 0.20 |
| Average unit cost of claims | 13.49 | 11.06 | 6.94 | 5.55 | 1.94 |

## 5.3 Financial Results

Network profitability and viability is analysed at two levels: the MHOs and the umbrella structures (the UMSGF and the soon-to-be Technical Unit). All of the MHOs reported a positive net result in the first five years of operation. Table 5.2 sums up the key results and performance indicators reported in the year 2004/05.

With a combined ratio of 71.7 percent, MHOs have reported a 28.3 percent underwriting profit on net written premiums. The current objectives for a primary MHO to become viable are as follows:

- Loss ratio should not exceed 65 percent. The overall network ratio was lower than 50 percent during the first years. It was 44 percent in 2004/05.
- The direct running costs (excluding contributions to the UMSGF) / total premiums ratio should be lower than 17.5 percent. In the previous budget year, the running costs / net premiums earned ratio reached 27.9 percent. The objective has not been achieved because of the high cost of the General Assemblies (40 percent of direct operating costs), which could be reduced in the future.

- Up to 17.5 percent of written premiums should go towards financing the network's operating costs. The current contribution level is 2 percent. It will gradually increase to reach the target.
- The reserve ratio should be maintained up to 75 percent of the claims paid out in the previous years. At the end of the previous budget year (2004/05), the reserve ratio was at 512 percent.

**Table 5.2 Income Statement and Key Indicators (2004/05)**

| Statement of income 2004/05 Budget Year (€) | |
|---|---|
| Gross written premium | 11,925 |
| Contribution to Guarantee fund | 96 |
| Net written premium | 11,829 |
| Unearned premium | 12 |
| Net premium earned | 11,817 |
| Claims paid | 4,923 |
| Added to claims costs | 244 |
| Claims costs | 5,167 |
| Operating expenses | 3,301 |
| Underwriting profit | 3,350 |
| **Key indicators (%)** | |
| Loss ratio | 43.7 |
| Expense ratio | 27.9 |
| Combined ratio | 71.7 |
| Underwriting profit | 28.3 |
| Operating profit | 3.0 |

The financial autonomy of the umbrella organization is a medium range objective for the program. To cover 50 percent of the expenses of the Union and its Technical Unit (around €36,000) through the payment of 17.5 percent of written premiums, membership should reach 65,000. This is a final objective in terms of membership that will allow the UMSGF to cover 70% of its expenses (including the Technical Unit costs). The remaining 30% has to be found through the selling of services (medical auditing, risk management) to other clients.

As shown in Table 5.3, the MHOs' network accumulated reserves are significant when compared to claims paid out. MHOs' operating surplus earned over the first few years make up 83 percent of the reserves, while grants from the program provide the remaining 17 percent. Reserves enable the schemes to bear new risks without having to resort to the guarantee fund.

**Table 5.3 Reserves and Claims (2000-2005)**

| | 2004/05 | 2003/04 | 2002/03 | 2001/02 | 2000/01 |
|---|---|---|---|---|---|
| Consolidated reserves (GNF) | 48,259,697 | 27,408,435 | 15,434,741 | 2,446,000 | 1,017,041 |
| Consolidated reserves (Euro) | 12,699 | 11,242 | 7,717 | 1,405 | 593 |
| Reserves / Claims n-1 | 512% | 466% | 437% | 142% | n.s. |
| Reserves / Claims n | 253% | 294% | 262% | 69% | n.s. |

**Table 5.4 Key Results**

| Results | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Net income (net of donor contributions) (Euros) | 3,444 | 8,408 | 8,535 | 13,260 | 13,719 |
| Total premiums (value) (Euros) | 2,944 | 7,546 | 7,841 | 11,605 | 11,925 |
| Claims / total premiums (%) | 42 | 27 | 37 | 33 | 42 |
| Administrative costs / premiums (%) (stationery and meeting expenses) | n.d. | 32 | 27 | 24 | 21 |
| Commissions / Premiums (%) | 0 | 0 | 0 | 0 | 0 |
| Reinsurance / Premiums (%) | 2 | 2 | 2 | 2 | 2 |
| Reserves added for the period / Premiums (%) | n.a. | 10.8 | 81.5 | 42.3 | 45.5 |
| Net income added for the period / Premiums (%) | 87 | 112 | 37.9 | 52.8 | 44.8 |
| Claims cost per total number insured | 0.76 | 0.48 | 0.52 | 0.41 | 0.35 |
| Growth in number of insured (%) | n.s. | 180 | 27 | 59 | 59 |
| Income earned from investment of premiums | 0.1 | 0.7 | 0.4 | 1.7 | 2.8 |
| Percentage of profit distributed | 0 | 0 | 0 | 0 | 0 |
| Renewal rate (%) | n.a. | 88 | 80 | 82 | 81 |

## 5.4 Impact on Social Protection Policy

The program has yet to conduct a formal impact evaluation. However, results obtained midway through the program, and disseminated during several workshops organized at the central level, give credibility to the mutual health insurance model. On the initiative of the MoH, the program took part in designing a legal framework of Mutual Health Insurance systems.

The impact of the MHOs on reducing illegal practices—such as the pressure that they exert so that health services improve their performance in terms of drug supply—indirectly contribute to reducing exclusions from the health care system that affect mutual members as well as non-members.

The program's lobbying efforts went towards raising the MoH's awareness of the advantages and the limitations of health microinsurance when it comes to reducing exclusions from health services. A complementary mechanism for providing free access to the poorest (equity fund) is in the pipeline with funding from the World Bank. The MHOs' potential involvement in managing this fund is being analyzed.

# 6. Product Development

Based on initial research, the main factors of viability of a microinsurance system were:
- Functionality and coverage of the health care system
- Regional social and economic features
- Open-mindedness of the potential partners towards the implementation of a self-managed health microinsurance program, and
- Financial difficulties faced by users of health services in the event of illness.

Once these opportunity factors were identified, a feasibility study was conducted to characterize the demand for health insurance and its solvency. Surveys on household budgets determined an affordable level of premium and were complemented with polls to learn about potential members' intentions to contribute.

These household surveys also identifyied the main risks confronting families when they fell sick. At this stage in the research, the variance of responses did not permit the selection of eligible benefits between outpatient care (minor risks) and hospitalisations (major risks).

The product development process took place without referring to other existing health insurance systems, since in the region, no such scheme was known to the population, except for the mechanisms put in place by the UNHCR to provide refugees with free care.

A monitoring and evaluation system was set up from the start of the first MHOs and then it was improved progressively. The initial penetration and renewal rates have been two objective indicators to assess MHOs' product appeal. Qualitative data was collected during Executive Committee meetings and General Assemblies.

## 6.1 Product Design

The first year of the program was dedicated to the design of the product and the MHOs' modes of organization and management. An in-depth diagnosis of health care delivery was carried out. Criteria of health services' technical and perceived quality were used to spot the strengths and weaknesses of potential partner service providers. Information meetings were organized to know their opinions on future MHOs. Health benefits that could potentially be covered by the schemes were selected.

It did not prove difficult to estimate the product cost since health facilities used flat-rate billing and the MoH had imposed that MHOs' members should be charged the same as non-members. Estimating projected consumption frequencies among the insured proved more difficult since no reliable statistical data was available. Frequency data from other mutual health programs supported by the CIDR was used instead.

A wide range of benefits was submitted to would-be members in five test-villages. One of the key decision criteria was the price of the corresponding premium. Potential members

primarily chose benefit packages that covered 100 percent of hospitalisation at a price in line with the average premium amount that they were willing to pay.

## 6.2 Risk Assessment and Tool Design

The program had originally planned a three-year pilot phase to validate the feasibility of mutual organizations in managing health insurance products. At the end of the program's first year, six "pilot" MHOs had been established to test third-party payment mechanisms with two hospitals. The decision taken to concentrate pilot MHOs in two prefectures made the program more visible to health providers.

The functionality of MHOs' microinsurance management procedures was appreciated as well. In the following year, a second wave of schemes was launched that adopted the same modes as those developed with the first MHOs before all procedures were formally validated. An evaluation was carried out at the end of the phase. It established a model that would be disseminated to a wider scale.

The conclusions of the evaluation led to the creation the health microinsurance products distributed by the MHOs. However, they found that health credit products managed by the groups are less appealing to members and more difficult to monitor. The program was advised to focus on insurance activities and let groups manage credit activities independently. The support for these activities had been interrupted at the time of launching new schemes in 2002. "Credit" activities could be set up within the groups on their own initiative and under their own responsibility, but the program could not be involved in monitoring them.

## 6.3 Product Development Costs

Because of its innovative nature for the country—where health insurance systems are scarce, where health microinsurance is a new concept and where there are neither available skills nor adequate support structures)—the program includes expenses for an international expert in mutual health insurance, training and staff costs for local managers and field agents, and the provision of financial support until the network achieves technical autonomy (planned for 2007). Total program cost over a six-year period from 1999 to 2005 amounted to €1.08 million. In that period, various organizations contributed to funding the program: the European Union, the Michelham Foundation, the French Ministry of Foreign Affairs and UNICEF.

Initiated and implemented by CIDR, the program benefited from a full-time CIDR expert, technical and methodological support missions from headquarters, and from occasional expert missions that dealt with health risk management and partner health providers' operating cost analysis. The managers of the UMSGF and of the upcoming Technical Unit were also trained on specific issues abroad.

# 7. Conclusions

## 7.1 Significant Plans

The long-term program objective is to create a sustainable regional network that can:

1. Strengthen the capacities of health service users to benefit from quality health care at a reasonable price and to negotiate their financial contribution.
2. Be linked with other financial mechanisms, such as an equity fund for the coverage of the disabled, who cannot afford paying insurance premiums.

To fulfil these objectives, the organization of an efficient network of MHOs is the main goal for the next three years. The institutionalisation process will include:

- Strengthening the Union's capacities by hiring a Secretary-General who is a health insurance expert.
- Structuring a specialized technical unit under the Union's governance consisting of a specialist in health risk management and a medical advisor. This service could then sell its services to other microinsurance systems.
- Providing advise and support to primary MHOs through three mutual network agents.

A growth strategy adopted to reach recruitment objectives that corresponds with network viability has several components:

- Promoting existing MHOs' internal growth to reach a 30 percent penetration rate (insured members/target population).
- Broadening the benefit packages currently offered and deciding whether to launch new products (in accordance with each MHO's decision).
- Partnering with an NGO (Santé Sud) to set up medical practices that would be contracted out by the MHOs.

The five-year development plan designed with the UMSGF intends to strengthen 30 MHOs, 20 in rural areas and 10 in urban settings. The network's financial viability will be reached when smaller MHOs merge to raise their membership base to about 2,800 insured. Grouping several villages within a single MHO has already been done, but will be further encouraged.

## 7.2 Key Issues Summary

*Major Breakthroughs*

**Importance of the context in which to establish health microinsurance**
Multiple factors affect the decision to form or join a scheme. Among them, the economic factor is a significant restrictive element. Membership trends are particularly sensitive to changes in the economic context. The decision to join is difficult for a potential member when his/her income has decreased, even though in that situation one would most need

protection from exceptional financial risks. Thus far, the program has enjoyed favourable economic conditions due to sustained prices for farm produce from which villagers draw most of their income.

Social features have also to be considered: individual capital, (level of education, risk perception, and capacity to anticipate), quality of social links (self-help and solidarity), as well as collective social capital (capacity to work together on a common objective). Concerning this factor, despite the ethnic tension, the context has been favourable.

The delivery of quality care at affordable prices is the second-most important element of the program's success. In this respect, while the public health services' monopolistic position did not offer a conducive context (lack of resources, absence of competition), the rates charged by these providers make it possible to offer an attractive product at a reasonable price.

**Degree of necessary support to promote health microinsurance**
In a context marked by a lack of skilled human resources, the option was taken to turn to professional health insurance management. One of the support operator's main missions was capacity-building necessary at local (MHO) and regional levels.

Another key mission was consolidating and giving credibility to the institution from the perspective of scheme members, health providers and the administrative environment. The project plays a major role through its expertise, its capacity to have professional discussions with stakeholders, and the guaranty fund. However, more important to health providers was the fact that MHOs were always in a position to comply with their commitments.

**Structuring MHOs in a regional network**
Setting up a specialized technical unit was the necessary consequence of choosing to go with professional management. This network structure is also a logical step for MHOs that want to reinforce their negotiating clout with the Health Administration and some providers (the Regional Hospital) that are inexperienced in negotiating with community-based structures.

Network structuring is also an appropriate strategy to consolidate and regulate MHOs. Technical and statutory rules, decided and enforced by the UMSGF, contribute to maintaining a dynamic between self-organization and stringent management.

**The mutual approach to managing health microinsurance**
Opting for member-based governance and management of health microinsurance is more than just choosing one model among others to distribute a product. It was an element of the program's feasibility in a region where populations were scattered (12 inhabitants per square kilometre) and living in remote villages with strong social cohesion. The local social capital expressed in terms of human resources and solidarity practices was taken into account when selecting a mutual approach to managing health microinsurance.

The mutual option has also been a strategic choice that gives users of public services the possibility to influence the functioning of these services. Even if the effects of the contracts should not be over-estimated—not all of service providers' commitments were respected and the issue of drug availability remains unsolved—this represents a rare opportunity for consumers to make their wishes and expectations known.

**Duration of a program**
Health microinsurance is new for MHO members as well as for health providers. In this context, it would be incorrect to believe that sustainable results could be obtained quickly. A ten-year timeline appears reasonable for an MHO network to become autonomous and viable.

Internal and external control crisis should not be feared, but anticipated and solved. As with other financial institutions, effective internal and external control is necessary to maintain members' confidence in the organization and to make its financial viability possible.

The result of this program shows that an unsolved embezzlement or one solved too late may jeopardize an MHO. But an embezzlement found quickly and dealt with appropriately increases the confidence of members in the organization.

*Challenges*

**Institutionalising the network and making it viable**
Primary MHOs can cover their internal expenses, but the viability of the system is determined by their capacity to cover the network structures' indirect costs. Reaching sufficient membership (about 60,000 members) is the first condition to create financial autonomy for the network. To take up this challenge, MHOs have room for improvement—they only cover an average of 10 percent of the population in a position to subscribe.

Growth is also conditional on sustaining a satisfactory level of benefit quality at an affordable price. The recent entry of private health care providers will be advantageous for the scheme's development. The partnership established with an NGO (Santé Sud) specialized in opening rural medical clinics is part of a strategy to improve health services. Reinforcing the MHOs' involvement in solving public facilities' malfunctions will also be necessary.

Enabling local actors to handle the schemes' governance and management functions is yet another challenge for the program. To address this, it began an institutionalising process to transfer responsibilities to the Union over a three-year period.

**Integrating the MHOs in their environment and establishing partnerships**
Utilizing the comparative advantages of mutual insurance represents another challenge. Several lines of action have been identified and some have already been implemented. For example, MHO representatives are participating in defining local health policy through their representation within the public health facilities' management committees. Partnerships with programs offering efficient prevention measures for diseases covered by the schemes (particularly malaria and AIDS) will be formalized in the years to come.

*Lessons Learned*

The main lessons and recommendations drawn the program's experiences are as follows:

**Product design**
The operator has a strong capacity to influence product design. CIDR encouraged MHOs to begin with benefits that corresponded to the least frequent, most costly and easiest-to-control treatments. The premium amount was an essential element for members to select benefits.

Those that chose to join the schemes find the product appealing because of its excellent coverage of hospitalisation expenses. Indeed, MHOs have adopted minimal risk control measures (e.g., no waiting period or exclusions).

Scheme members chose a single product since paying a single premium amount was considered as an identification factor with the MHO. Member satisfaction surveys conducted three years after the product was launched showed that it only partially met the members' potential demand. Inclusion of outpatient care (consultations and medication) in the benefits package is still strongly in demand and is being taken into consideration by the schemes.

**Marketing and communication strategy**
The communication strategy relies on the involvement of mutual groups and the program staff, but it has had mixed results. While scheme members receive good information on the product and the functioning of the system, many non-members (36.7 percent) stated that the lack of information was the reason they had not joined a scheme. Scheme officials and group leaders' capacity to sensitise the target population should not be over-estimated. The involvement of the project team was deemed indispensable to increase membership.

Scheme members, even if initially properly informed, often need to receive practical information when they actually fall sick. Easy access to information at the time they turn to their MHO is an important factor of member satisfaction.

**Sustainability strategy**
As its target market, the program chose low-income populations, working primarily in the informal economy, with an average-to-low level of education, residing primarily in rural areas. Because of their limited ability to pay, it is impossible for the network to reach full financial autonomy by only serving this market. The Technical Unit will cover its costs by diversifying its market base and providing services to higher-income groups.

*Advice for Others*

**Product design**
Designing an appealing product at a reasonable price is necessary to obtain a significant membership base. During the participative process of selecting benefits, the demand expressed by initial members for a broad coverage must be handled by the support operator so that the product remains affordable to as many people as possible.

The target group's intentions to contribute are a necessary but insufficient means to estimate the demand. Caution should be used not to over-estimate the target group's propensity to contribute to a service for which they have yet to use. During the preliminary study, almost 95% of the interviewed people said they were willing to join the scheme. Among them, 50% indicated an amount of premium equal or above the premium asked by the MHOs. However, only an average of 10% initially joined.

In the course of learning the product, new requests of various types emerge from members. If it is feasible given the premium amount, extending the benefit package to cover to new services is the best strategy if the premiums can remain the same. Failing that, the effect of an

increase in premium on the membership should be assessed before deciding between a single product or differentiated products.

MHOs in different locations may require different benefit packages. For example, rural schemes needed assistance with transportation, which was not a priority for urban MHOs.

Do not subsidise the claims expenses. Experience has shown that the decision to offer the product at the estimated price proved right. It gave the MHOs a chance to accumulate reserves, which in turn fostered members' trust in their organizations without having to go through a lengthy trial period. Since health expense forecasts have been slightly over-estimated, this choice made it possible to include new services at a constant premium level.

**Premium collection processes**
Premium collection is labour intensive. By issuing cards only to members that have paid their premiums, the MHOs reduce the costs of premium collection by creating pressure on members to pay. MHOs have to avoid providing coverage to persons who have not paid their premiums.

Paying insurance premiums is seldom a priority for low-income households, particularly those who not accustomed to the services provided by MHO. UMSGF uses a closed enrolment period to help make premium payments a priority—if households do not pay now, they will miss their chance. This approach only works, however, when the enrolment period occurs during a time when most households have a positive cash flow.

MHOs must grasp every opportunity to cooperate with existing socio-professional organizations. For example, at-source premium collection for the members of these voluntary organizations reduces collection costs.

**MHOs' management and governance principles**
The elected officials' capacity and availability should not be overestimated. The sharing of responsibilities, functions and tasks between elected officials and salaried technical staff should abide by MHOs' statutory constraints and aim at improving performance.

At the MHO level, hiring a manager paid on commission for a part-time job, under the control of the scheme's Executive Committee, worked well. The network managers are receiving incentives corresponding to 2 percent of the collected premiums. This rate could be increased to 5 percent depending on the evolution of membership. Allowing MHO managers to earn a commission does not fit with the principles of western mutual health organizations; however, flexibility has to be introduced in the administrative rules to fit with the socio-economic context.

The social relations—sensitisation and communication with members—come under the responsibility of the MHO officials. Experience has shown that when they have serious difficulties in delivering correct information, they call in the project agents. The concern that MHOs should become independent as soon as possible should not mean that the necessary information and communication support from the program staff should be stopped.

Whatever the adopted strategies, the issue of providing accurate information to scheme members remains only partially solved. Additional action research will be needed to determine the most efficient modes of delivering quality information to members and non-members that the MHOs could master in the long run.

At the level of the UMSGF, the limits of health insurance management have been clearly identified. The elected officials' forecasting capacity is a priority, not a given, and the dynamics of network development will rest on the skills and powers of professionals to forge a common vision with elected officials. Committed agents have to be selected, recruited and trained to carry out that role.

**Tracking and controlling health risk**

Flat rates limit the risk of cost escalation and avoid the possibility that MHOs incur exceptional expenses. Applying flat rate billing often requires the backing of health providers on management issues. In Guinea, the application of flat rates was made possible thanks to: 1) a preliminary analysis by the Ministry of Health (with the support of external organizations, e.g., Doctors without Borders Belgium, GTZ) of the hospitals' health care costs; and 2) the establishment of standard therapeutic protocols.

The medical consultant plays a key role in developing professional relations between MHOs and health providers. His/her expertise is indispensable when it comes to verifying whether services provided are real and appropriate (control of excessive hospitalisations) and whether prescribed treatments are relevant (conform with therapeutic protocols). The medical consultant should be trusted and recognized by his/her peers so s/he can fulfil this role.

Collecting, processing and analysing technical health insurance data are complex and labour-intensive tasks that make using computers necessary. The design of an MIS should take into account the implementation cost of the corresponding tasks. It is also important to make sure that centralizing information does not limit primary MHOs' autonomous decision-making: the level of technical autonomy should be carefully determined. Scheme managers and elected officials should be trained in data entry as well as in the use of data processed at the network level.

**Mutualist group promotion**

The promotion of mutual groups helped facilitate the registration and premium collecting processes. The role of the groups in sensitising the target population is perceptible since 10 percent of scheme members and 25 percent of non-members said that they were informed by a group. Even if mutual groups' usefulness may decrease as members become more familiar with the scheme's benefits, they are a useful mobilization strategy at the inception stage. Various approaches are possible to create mutual groups: approaching existing traditional groupings is sometimes inconclusive and the promotion of new groups is often necessary.

**Relations with health providers**

Receiving proper care at health facilities is a determining factor of member satisfaction and renewal. Even when an agreement has been signed with health facilities, conflicts between health care staff and scheme members may occur. Health care staff may not accept the new financial conditions that are not to their advantage, while scheme members may require ineligible treatments, either due to a lack of information or trying to take advantage of the

situation. To prevent these difficulties, a liaison based in the health facilities and paid by the MHOs has proven to be an appropriate solution.

**Structuring the MHOs in a network: Do not put off embarrassing questions/issues.**
Structuring MHOs in a network is a challenge that must be approached early on. MHO managers must appreciate the support services that would be provided by the network. To succeed in shaping an effective network, MHO elected officials have to be a part of the development process and to have a medium-range outlook. The running costs of the network's structures should also be integrated into the premium from inception and the corresponding share of the premium should be paid out as soon as the structure has been established.

**Choosing the right level of risk management**
While risk management at the village-level presents many advantages—nearness of the scheme's manager, greater trust in the scheme management, better flow of information—it also presents disadvantages that make it necessary for MHOs that cannot reach a critical number of insured to merge. Social cohesion has to be favoured. Technical solutions, like reinsurance, have to be found if the size of the groups does not allow the risk pooling between members. Although merging is an integral principle of the natural history of mutual organizations, its effects on social control and leaders' commitment towards scheme management have to be monitored closely.